Mixed-Methods Exploration of Group Therapy for Substance Use Disorders: Prospects for Evidence-Based Practice

by

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DEDICATION

To Candice

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LIST OF ACRONYMS

AA	Alcoholics Anonymous
ASAM	American Society of Addiction Medicine
CBT	Cognitive behavioral therapy
COREQ	Consolidated criteria for reporting qualitative research
CPS-SUD	*Clinical Practices Survey for Substance Use Disorders*
CRA	Community reinforcement approach
DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders* (fourth edition)
EBT	Evidence-based treatment
EBTs	Evidence-based treatments
IOP	Intensive outpatient program
MET	Motivational enhancement therapy
MI	Motivational interviewing
NAADAC	Association for Addiction Professionals (formerly National Association of Alcoholism and Drug Abuse Counselors)
ND	New Day (clinic pseudonym)
RS	Recovery Services (clinic pseudonym)
SUD	Substance use disorder
SUDIC	Substance Use Disorder Intensive Clinic (clinic pseudonym)
SUDs	Substance use disorders
TAU	Treatment-as-usual
TSF	Twelve-step facilitation
VA	Veterans Affairs

ABSTRACT

Evidence-based treatments (EBTs) for substance use disorders (SUDs) often are not utilized in clinical practice or lag years behind in their uptake. One underappreciated dimension of this research-practice gap is a mismatch in treatment modality: Whereas research efforts have focused on individual therapy, the majority of SUD treatment is in group format. In this mixed-methods three-study dissertation, I aim to narrow this gap by exploring how SUD clinicians facilitate group therapy. First, I conducted a national online survey with 566 SUD group therapy clinicians about their most commonly utilized group practices. Survey results confirm that group therapy is the most widely used SUD treatment modality, with especially high prevalence of open groups; clinicians also reported high utilization of EBT components (especially motivational interviewing and cognitive behavioral therapy) but with varying use of 35 specific practices and moderate use of questionable/less-effective practices. For the remaining two studies, I conducted qualitative thematic content analyses of semi-structured interviews with 13 clinicians at three outpatient SUD specialty clinics in the Midwestern U.S. The first qualitative analysis, which also included interviews with clinical directors, focused on organizational factors that facilitate and impede EBT implementation. Results indicate considerable challenges for integrating EBTs within each clinic, in terms of complexities with clinics' provision of group therapy, exclusive use of open groups, use of treatment structures (e.g., group duration and session length) that are not readily compatible with existing EBTs, and use of a suite of treatments rather than standalone interventions; considerable adaptations are thus necessary to utilize existing EBTs. For the second qualitative analysis, I present complexities and barriers for

group therapy facilitation, including use of EBTs, among individual clinicians. Results indicate that clinicians emphasized the importance of providing individualized and engaging treatment, necessitating considerable flexibility for group facilitation; however, clinicians also had serious challenges in this regard, due to complex group dynamics and organizational deficits and barriers (limited group therapy experience, limited quality control efforts, the predominance of psychoeducation, and limited attention to clients' demographic diversity). For each study, I discuss recommended strategies for researchers and clinicians toward improved innovation and implementation of evidence-based practice.

CHAPTER I

Introduction

The past 15 years has seen a tremendous increase in the study and utilization of evidence-based treatments (EBTs) for substance use disorders (SUDs; Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Miller, Sorensen, Selzer, & Brigham, 2006). However, a significant and deeply entrenched gap remains between scientific research and everyday practice. EBTs often are not utilized in treatment settings or lag years behind in their uptake, resulting in clients receiving compromised or potentially harmful care (Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Manuel, Hagedorn, & Finney, 2011). Several reasons have been identified for this research-practice gap, but one underappreciated dimension is a mismatch in treatment modality: Whereas clinical trial and EBT implementation research has focused nearly exclusively on individual therapy, a large majority of real-world SUD treatment is in group format. According to previous surveys, group therapy is offered by over 90% of SUD treatment facilities (Crits-Christoph, Johnson, Connolly Gibbons, & Gallop, 2013; Weiss, Jaffee, de Menil, & Cogley, 2004), and for many facilities it is the overwhelming focus (Fletcher, 2013). In spite of this high prevalence, research efforts have focused predominantly on individual therapy, as evidenced in clinical trial efficacy and effectiveness research (see Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004).

This treatment modality gap is significant, in that individual therapies do not translate easily into group format. Greater flexibility and skill is typically required of clinicians, due to groups being more unpredictable as a function of consisting of several clients (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012; Yalom & Leszcz, 2005). Furthermore, open groups—for which clients initiate and terminate from treatment on an open-enrolling basis, and therefore sessions cannot substantively build on each other conceptually—are very common and likely the norm in SUD treatment facilities (Morgan-Lopez & Fals-Stewart, 2008). Yet there is minimal research or guidance on adapting EBTs for open groups.

For this dissertation, I have taken preliminary and exploratory steps to narrowing this treatment modality mismatch between research and clinical contexts for SUD treatment. The overall aim in this regard is to document and analyze common practices and complexities for group therapy facilitation in real-world treatment settings. Questions guiding this investigation include: What do SUD clinicians do in terms of group therapy facilitation? What practices are most likely to be used? What organizational factors influence group therapy curricula and facilitation, including the use of EBTs? How do clinicians balance structure (including use of treatment manuals) with group process? How are open groups managed, in terms of delivering content that cannot build on itself conceptually? Exploring these and other questions may be helpful in bridging the gap between research and practice, by informing researchers about clinical complexities that are often neglected in SUD treatment research.

My dissertation consists of this brief introductory chapter (Chapter I), three major chapters (Chapters II-IV), and a brief concluding chapter (Chapter V). Each of the three major chapters has been formatted as a manuscript to be submitted for publication in a peer-reviewed

journal. As such, each of the three chapters is intended to stand alone, inclusive of a title, abstract, introduction, method section, results section, discussion section, bibliography, and tables/figures. As a result of this formatting, some material is redundant, particularly in chapter introductions and method sections. The first study (Chapter II) is a national online survey conducted with 566 SUD clinicians about group therapy practices (particularly from EBTs) that they typically facilitate; results include descriptive data about these practices as well as inferential analyses concerning clinician and organizational predictors for greater or lesser use of various practices. The second study (Chapter III) is based on in-depth semi-structured interviews with 13 clinicians and three clinical directors from three diverse outpatient specialty SUD clinics in the same metropolitan area. Using qualitative data analysis, I describe and discuss organizational factors—both unique and shared among the clinics—that facilitate and impede EBT implementation. The third study (Chapter IV) is based on the same semi-structured interviews as the second study, albeit limited to the 13 clinician participants. I also utilized qualitative data analysis for this study to present themes that individual clinicians discussed concerning complexities and barriers for group therapy facilitation, including use of EBTs and/or manualized therapies.

Collectively, the three studies are to my knowledge the most comprehensive presentation of SUD group therapy facilitation to date. Each study provides a different level of analysis, beginning with a big-picture national survey (Chapter II), then examining the details of specific clinics (Chapter III), and finally exploring complexities for individual clinicians (Chapter IV). Although each study is limited to one type of data (qualitative or quantitative), collectively the studies are guided by a mixed methods approach, in which both qualitative and quantitative data are used to provide a fuller picture about a phenomenon. Mixed methods designs can take several

forms on the basis of the relative weight of qualitative vs. quantitative data, as well as the relationship between the two forms of data (e.g., sequential or simultaneous). This project is best categorized as a *QUAL + quan* design, meaning that the qualitative data are a more substantive part of the data collection and analysis than the quantitative data, and that the relationship between the two types of data collection is simultaneous rather than sequential (Palinkas & Soydan, 2012). According to Palinkas and Soydan (2012), a *QUAL + quan* design is used "when the theoretical drive is inductive in nature, and typically used when some portion of a phenomenon may be measured and this measurement enhances the qualitative description or interpretation" (p. 131). In the case of this project, the quantitative portion (the national survey) provides a broad, national context that supplements the localized nature of the qualitative data.

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CHAPTER II

Group Therapy for Substance Use Disorders:

A National Survey of Clinician Practices

Abstract

A formidable research-practice gap continues to impede implementation of evidence-based treatments (EBTs) for substance use disorders (SUDs). An underappreciated dimension of this gap is a nearly exclusive focus of clinical trials on individual therapy, versus a large majority of real-world treatment being delivered in group format. This study aims to narrow this gap through a national survey of 566 clinicians who facilitated SUD group therapy within the past two years in the U.S., recruited from the membership of NAADAC, the Association for Addiction Professionals. Respondents were surveyed online about their most commonly used group therapy practices, using an adaptation of the *Clinical Practices Survey for Substance Use Disorders*. Results include the most commonly used group therapy practices, categorized in terms of 35 specific treatment components and three questionable/less-effective practices. These results indicate that group therapy is the most frequently delivered treatment modality, that open groups are especially predominant, and that group therapy session times vary considerably. Results also indicate that clinicians report high utilization of EBT components, especially for motivational interviewing and cognitive behavioral therapy, but with varying use of individual practices and moderate use of questionable/less-effective practices. Results also include exploratory *t*-test analyses indicating clinician and organizational variables associated with greater use of various

practices. These results are discussed in terms of specific strategies for improved implementation of EBTs in group settings.

Introduction

The past 15 years has seen a tremendous increase in the study and utilization of evidence-based treatments (EBTs) for substance use disorders (SUDs; Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Miller, Sorensen, Selzer, & Brigham, 2006). Several specific and relatively brief EBTs have been developed and vetted through replicated randomized clinical trials. In spite of these developments, however, a significant and deeply entrenched gap remains between scientific research and everyday practice (Glasner-Edwards & Rawson, 2010; Manuel, Hagedorn, & Finney, 2011). EBTs often are not utilized in treatment settings or lag years behind in their uptake, resulting in clients receiving compromised or potentially harmful care (Carroll & Rounsaville, 2007; Manuel et al., 2011). Several reasons have been identified for this gap, including organizational barriers and constraints (Carroll et al., 2011; Carroll & Rounsaville, 2007); the complexity of providing comprehensive recovery-oriented services for a chronic frequently-relapsing condition (Lash, Timko, Curran, McKay, & Burden, 2011; Wells, Saxon, Calsyn, Jackson, & Donovan, 2010); the difficulty of balancing treatment fidelity with individualized care (Aarons, Miller, Green, Perrott, & Bradway, 2012; Lundgren, Amodeo, Cohen, Chassler, & Horowitz, 2011); pessimistic beliefs or ambivalent attitudes among clinicians about EBTs (Knudsen, Ducharme, & Roman, 2007; Manuel et al., 2011); and limited evidence linking EBT adherence with improved outcomes in real-world treatment settings (Carroll & Rounsaville, 2007; Wells et al., 2010).

One underappreciated dimension of this research-practice gap—likely cutting across each of the aforementioned obstacles—is a mismatch in treatment modality: Whereas clinical trial and

EBT implementation research has focused nearly exclusively on individual therapy, a large majority of real-world SUD treatment is in group format. According to previous surveys, group therapy is offered by over 90% of SUD treatment facilities (Crits-Christoph, Johnson, Connolly Gibbons, & Gallop, 2013; Weiss, Jaffee, de Menil, & Cogley, 2004), and for many facilities it is the overwhelming focus (Fletcher, 2013). Group therapy may include psychoeducational presentations, recovery skills training, interpersonal process groups, "check in" groups, and specialty topic groups (Weiss et al., 2004). In addition to financial considerations, the dominance of group therapy is reflective of the massive infrastructure of mutual support groups (e.g., Alcoholics Anonymous; AA) and the historically dominant "Minnesota model" of SUD treatment (an approach that originated in Minnesota residential programs, characterized by group-based didactic education and milieu support based on a disease model of addiction and twelve-step principles; Fletcher, 2013, pp. 70-71). Although data are limited, group therapy can also be justified on evidentiary grounds. According to a meta-analysis of 24 studies, group therapy is generally equally effective as individual therapy for SUD treatment (Weiss et al., 2004; see also Sobell & Sobell, 2011).

In spite of the clinical predominance of group therapy, research efforts have focused predominantly on individual therapy for SUDs. This focus is evidenced in clinical trial efficacy and effectiveness research, likely due to the individualized nature of most medical treatment (in which the clinical trials research paradigm originated) as well as the difficulty in ensuring control in conditions with interdependent group members (see Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004). Moreover, the distinction between individual and group therapy is rarely discussed in much depth in the EBT implementation literature for SUDs. This omission is significant, given that skills required for quality group facilitation are not obviously transferable

from individual service delivery, evidence-based or otherwise. These skills generally include building cohesion among group members, managing confrontation and conflict between members, navigating clients who monopolize group discussion or stray off topic, managing unhelpful advice given from one member to another, encouraging participation from quiet members, and eliciting client participation rather than lecturing (Sobell & Sobell, 2011; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012; Yalom & Leszcz, 2005).

In addition, significant particularities of many types of SUD group therapy further complicate group facilitation. Perhaps most notably, open groups—for which clients initiate and terminate from treatment on an open-enrolling basis, and therefore sessions cannot substantively build on each other conceptually—appear to be very common in SUD treatment facilities (Morgan-Lopez & Fals-Stewart, 2008). Unfortunately, open groups are almost never studied in clinical trials, due to formidable difficulties involved in controlling for equivalent group comparisons and in analyzing data (Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004). (An exception is a recent clinical twelve-step facilitation trial for stimulant addiction that utilized open groups; Donovan et al., 2013). Furthermore, there is little if any published guidance for adapting EBTs for open groups—again highlighting an enormous gap between research and practice.

The gap between individual and group treatment is likely a symptom of researchers not adequately meeting real-world clinics and clinicians where they are. A preliminary step in this regard is to better understand and document treatment-as-usual (TAU), in order to dovetail implementation efforts with existing practices and infrastructures (Baer et al., 2007; Santa Ana et al., 2008). Historically, little attention has been paid to describing TAU, especially beyond broad-scale surveys (Gifford et al., 2012; Miller, 2007; Santa Ana et al., 2008). Because of this

lack of in-depth examination of TAU, it has been referred to as the “black box” of SUD treatment (Carroll & Rounsaville, 2007; Miller, 2007). In recent years, researchers have increasingly discussed or documented TAU in SUD specialty clinics, especially in relationship to EBTs (e.g., Eliason, Arndt, & Schut, 2005; Gifford et al., 2012; Santa Ana et al., 2008). A “peek” into TAU has been especially provided through the National Institute on Drug Abuse’s Clinical Trials Network, which has frequently compared EBTs with TAU (Carroll et al., 2011, p. 276; see also Ball et al., 2007; Carroll et al., 2009; Donovan et al., 2013; Peirce et al., 2006; Petry et al., 2005; Winhusen et al., 2008). These studies have generally shown that EBTs have modestly superior outcomes to TAU (although in some cases outcomes are equivalent, such as motivational enhancement therapy vs. TAU for treating non-alcohol drug addiction). However, these studies have either been limited to individual therapy or have not distinguished between individual and group therapies. (An exception is the recent clinical trial, mentioned above, for stimulant addiction twelve-step facilitation that included open groups, and for which short-term outcomes generally exceeded TAU; however, detailed information on TAU from this trial has not been published; Donovan et al., 2013.)

Although the literature documenting TAU is small and has not focused on group practices, a tentative composite picture of TAU in relationship to EBTs can be gleaned from this literature: Clinicians generally report high and eclectic use of certain EBTs, especially motivational interviewing (MI)/motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT; Eliason et al., 2005; Gifford et al., 2012). Reports of MI use appear to be moderately consistent with observations for basic but not advanced MI adherence; otherwise, clinicians appear to overestimate their adherence to EBTs, especially CBT, in comparison to observer fidelity measurement based on audiotaped sessions (Santa Ana et al., 2008). When

clinicians do utilize EBTs, their observed competence is quite high, often comparable with competence from clinicians trained in EBT comparison groups (Santa Ana et al., 2008). The use of twelve-step facilitation (TSF) and community reinforcement approach (CRA) therapies are only moderately reported (Eliason et al., 2005; Gifford et al., 2012), and contingency management is infrequently reported (Gifford et al., 2012). Finally, certain questionable or less-effective practices are frequently reported and/or observed: psychodynamic practices for which clinicians are not competent (e.g., helping clients recognize the power of unconscious thoughts), didactic education, unstructured group therapy, excessive informal discussions, assertions of therapeutic authority, and excessive clinician self-disclosure (Bamatter et al., 2010; Eliason et al., 2005; Gifford et al., 2012; Martino, Ball, Nich, Frankforter, & Carroll, 2009; Santa Ana et al., 2008).

In this study, I aim to extend this line of research on TAU into group therapy in particular, through a national survey of clinician practices. This survey, which relies on clinicians' self-reported responses, was designed to assess specific, concrete practices (rather than broad theoretical orientations or EBTs) in an attempt to maximize accuracy of reports of what clinicians do in group therapy. This survey is intended to be an initial exploration of group therapy for SUDs, in an effort to assist researchers and clinicians to more collaboratively work with each other in terms of predominant modes of treatment delivery in real-world clinics.

Method

Participants

Participants were recruited from among the membership of NAADAC, the Association for Addiction Professionals (formerly called the National Association of Alcoholism and Drug Abuse Counselors). With 8000 members, NAADAC is reportedly "the largest national

organization for addiction-focused health care professionals" in the U.S. (NAADAC, n.d.). Study participation was limited to licensed/certified clinicians who have facilitated group therapy for SUDs within the past two years in the U.S.; students, physicians, and minors were excluded in order to ensure that reported experiences were from clinicians fully trained to provide psychosocial therapies. Of those eligible, 701 participants initiated the online survey, with 566 participants completing the survey. The survey completion rate (80.7%) is comparable with other published studies surveying NAADAC members (see Davis & Rosenberg, 2013; Rosenberg & Davis, 2014; Steenbergh, Runyan, Daugherty, & Winger, 2012).

Characteristics of the 566 respondents who completed the survey are summarized in Table II.1. The sample is diverse in gender (67% women), age (range from 23-82 years; mean of 52), and personal recovery status (43% endorsed), as well as in characteristics of respondents' primary work setting. The sample is more homogeneous in terms of respondents' race/ethnicity (84% non-Hispanic Whites), profession (82% addiction counselors/therapists), and highest degree (64% Master's); moreover, 80% of respondents worked primarily in private organizations (41% non-profit; 39% for-profit). These demographics are comparable with recent published studies surveying NAADAC members (see Davis & Rosenberg, 2013; Rosenberg & Davis, 2014; Steenbergh et al., 2012) as well as with the organization's published membership statistics (NAADAC, 2011).

Measure

The majority of the online survey consisted of an adaptation of the *Clinical Practices Survey for Substance Use Disorders* (*CPS-SUD*), in addition to demographic items and questions about respondents' primary work setting. The *CPS-SUD* was designed by Gifford et al. (2012) to inquire about practices in SUD treatment specialty clinics from Veterans Affairs (VA) and

community clinicians. Unlike other surveys of clinical practice—which inquire about theoretical orientation or utilization of specific therapies—the *CPS-SUD* inquires about specific practice components independently from associated treatments. These practices consist of items from fidelity monitoring measures for six EBTs for SUD (MI, CBT, TSF, CRA, contingency management, and structured family and couples therapy), but items are not explicitly associated in the survey with their respective EBTs. Decoupling component practices from EBTs allows for more specific reports of what clinicians do in therapy, with recognition that clinicians may utilize some but not all components of EBTs, perhaps independently of deliberate EBT adoption. Using a cluster analysis, Gifford et al. found that clinician practices clustered into seven categories: (a) Empathy/Support, (b) Therapeutic Engagement/Behavioral Activation, (c) Recovery Maintenance, (d) Abstinence Initiation, (e) Medication Support, (f) Family Therapy, and (g) Contingency Management. Typically each cluster is predominantly associated with a single EBT (e.g., the Empathy/Support cluster consists of mostly MI practices) but EBT items also commonly cut across clusters (e.g., CBT items were among each of the first three clusters). Gifford et al.'s (2012) survey also included items for practices that prior research suggests are questionable or less effective: (a) didactic education about alcohol/drug use, (b) confrontational style for the majority of the session, and (c) free-form discussion groups. Finally, the *CPS-SUD* included basic questions about the most commonly used treatment modalities and approaches that respondents have utilized, as well as the length of therapy sessions facilitated.

In Gifford et al.'s (2012) original *CPS-SUD*, respondents were asked to indicate the proportion of their clients for which various practices were utilized during a typical month (without consideration of group vs. individual modalities). In order to assess group therapy practices in particular, I adapted questions from the *CPS-SUD* in terms of what proportion of

group sessions clinicians have engaged in given practices in a typical month. (See Table II.4 for a full list of group practice items, as categorized by cluster and labeled in terms of their associated EBTs.) The revised survey included only items that ordinarily might be utilized in group format, meaning that contingency management and structured family and couples therapy items were omitted (including the omission of three structured family and couples therapy items that were also associated with CRA). As with the original *CPS-SUD*, respondents were asked to rank items on a 1-5 Likert scale (1=none/almost none; 2=some; 3=half; 4=most; 5=almost all/all). The revised instrument also included an item about the percent of facilitated groups that were open groups. (This item was added later in the survey administration and is limited to the last 123 participants who completed the survey.) See Appendix A for the complete revised survey.

Procedure

After full review, this study was designated as exempt from oversight by the University of Michigan Health Sciences and Behavioral Sciences institutional review board. Email solicitations for survey respondents were sent from NAADAC to its members every 1-2 weeks from April 7 to May 28, 2014. These email messages included a brief description of the study rationale and survey content, eligibility requirements, and a hyperlink to an online survey administered through Qualtrics. Email subjects were entitled, "What do you actually do in group therapy?" and included the following message:

> Group therapy is everywhere in substance abuse treatment, and yet the vast majority of research efforts and treatment resources are based on work with individuals. You can help to change this. Please consider taking this brief survey (15-35 minutes) for a University of Michigan dissertation about your experiences facilitating group therapy.

Your responses will help researchers, clinicians, and the public better understand real-world complexities of group therapy.

As an incentive, survey completers had the option to enter a drawing for one of twenty $50 gift cards from Amazon.com. Prior to taking the survey, participants were required to review an informed consent document and indicate their consent anonymously. Identifying information was not collected from respondents; names and email addresses for the gift card drawing were stored in a separate file and not linked with survey responses. Participant responses were securely stored on the Qualtrics platform and converted to a data file for analysis.

Statistical analyses were computed using STATA data analytic software (version 12). Descriptive statistics were generated for a number of variables pertaining to clinician practices, including the percent of clients to receive various treatment modalities and approaches, the structure of group therapy sessions facilitated (length of sessions and percent of open groups), and clinicians' group therapy practices. Group therapy practice composite scores were calculated in terms of means from all items associated with each of the four EBTs (MI, CBT, TSF, and CRA). Inferential analyses (two-tailed *t*-tests) were then conducted, in order to explore any correlations between clinician and organizational variables (detailed in Table II.1) and group therapy practices. Alpha level for statistical significance was set at $p < .05$. For each statistically significant finding, effect sizes were calculated using Cohen's *d* statistic.

Results

Treatment Modalities and Approaches

In terms of overall treatment modalities utilized, most of respondents' clients (M=3.94; SD=1.26) reportedly received group therapy in a typical month, while more than half received individual therapy (M=3.33; SD=1.45); family therapy was much less frequently received

(*M*=1.78; *SD*=1.08). In terms of treatment approaches (across modalities), clinicians reported on average that most of their clients received motivational interviewing/enhancement (*M*=4.05; *SD*=1.08) and (traditional) CBT approaches (*M*=3.85; *SD*=1.11) in a typical month, while about half received TSF (*M*=3.09; *SD*=1.50) and third-wave CBT approaches (e.g., acceptance and commitment therapy and dialectical behavior therapy; *M*=2.82; *SD*=1.39). Less frequently reported treatment approaches were behavioral, supportive-expressive, Rogerian/humanistic, and CRA. Relatively few clients received emotion-focused/gestalt/experiential, family/marital, body therapies (relaxation/acupuncture), faith-based, or psychodynamic/psychoanalytic treatment approaches, based on clinician reports (see Table II.2).

Group Therapy Structure

The reported length of group therapy sessions varied, with the most frequent durations being 90 minutes (31%), 60 minutes (24%), over 120 minutes (22%) and 120 minutes (18%; see Table II.3). A large majority of groups were open groups; 69% of clinicians reported that 100 percent of their facilitated groups were open groups, with 10% reporting that 0% were open groups (see Table II.3).

Utilization of Clinical Practice Components from Evidence-Based Treatments

Table II.4 indicates the prevalence of practice components reported by clinicians. The table includes the EBT(s) from which each practice component derives, and the practices are also organized according to the clusters identified by Gifford et al. (2012), as discussed above. Results are reviewed below in terms of both specific EBTs and Gifford et al.'s identified practice clusters.

Prevalence of EBTs. Practice components from MI were most frequently utilized (*M*=4.14; *SD*=0.67), followed by CBT (*M*=3.79; *SD*=0.82), CRA (*M*=3.59; *SD*=0.82), and TSF (*M*=3.11; *SD*=0.83) practice components, based on clinician reports.

Table II.5 shows clinician and organizational variables that predicted greater or lesser reported use of practices associated with EBTs. The most robust and frequent findings pertained to TSF. In terms of organizational variables, TSF practices were more likely to be delivered in intensive outpatient SUD programs (vs. standard outpatient SUD programs; *d*=.40), clinics in the Southern U.S. (*d*=.27), and for-profit clinics (vs. non-profit clinics; *d*=.24); TSF practices were less likely to be delivered in clinics in the Western U.S. (*d*=.26). In terms of clinician variables, TSF practices were more likely to be delivered by clinicians who have been in recovery (*d*=.25) or who have more years of SUD treatment experience (*d*=.20). In regard to other EBT composite scores, racial/ethnic minority clinicians were more likely to deliver CRA (*d*=.23) and CBT (*d*=.22) practices. No statistically significant correlations were found for reported use of MI practices.

Prevalence of practice clusters. In terms of Gifford et al.'s (2012) practice clusters, the most frequently reported practices were in the Empathy/Support cluster (*M*=4.19; *SD*=0.73), which consisted of five practices utilized in MI (with one shared with CBT). The next highest reported practices were in the Therapeutic Engagement/Behavioral Activation cluster (*M*=3.88; *SD*=0.77), which consisted of 17 practices utilized in MI, CBT, and/or CRA (including two practices that are shared with TSF). The third highest cluster consisted of 10 Recovery Maintenance practices (*M*=3.08; *SD*=0.84), which are largely associated with TSF (with one item each from CBT and CRA). The fourth and fifth clusters consisted, respectively, of two

Abstinence Initiation practices (*M*=2.95; *SD*=1.15) and one Medication Support practice (*M*=2.87; *SD*=1.50), both of which are utilized in CRA.

Table II.6 shows statistically significant clinician and organizational variables that predicted greater or lesser reported use of practices associated with these clusters. The most robust and frequent findings pertained to organizational predictors for the Medication Support cluster. Based on clinician reports, clients were much more likely to have received group therapy support for prescribed medications for SUDs from clinicians working in clinics that provided opioid replacement medication (*d*=.85) and harm reduction options (*d*=.50), as well as by clinicians working in standard outpatient SUD programs (vs. inpatient programs; *d*=.35) and private clinics (*d*=.25). Conversely, clients in the Southern U.S. were less likely to receive medication support (*d*=.33). After Medication Support, the most robust findings were for the Abstinence Initiation cluster; these practices were more frequent in standard outpatient SUD programs (vs. inpatient SUD programs; *d*=.27) and in clinics where harm reduction options were available (*d*=.23). Several significant findings also were observed for the Recovery Maintenance cluster. In terms of organizational predictors, greater use of these practices were reported by clinicians working in for-profit private clinics (vs. non-profit private clinics; *d*=.24); moreover, clients in the Southern U.S. were more likely to receive these practices (*d*=.21) and clients in the Western U.S. were less likely (*d*=.25). In terms of clinician predictors, clinicians who had been in recovery (*d*=.18) or had more years of SUD treatment experience (*d*=.16) were more likely to utilize recovery maintenance practices. Only one statistically significant correlation was observed for the Therapeutic Engagement/Behavioral Activation cluster: Clinicians in the Northeastern U.S. were reportedly less likely to provide these practices (*d*=.20). No statistically significant correlations were found for the Empathy/Support cluster.

Use of Questionable/Less-Effective Practices

On average, more than half of respondents' clients received group education about alcohol and/or drug use in a lecture or teaching format (*M*=3.10; *SD*=1.30), with less frequently reported use of free-form discussion groups (*M*=2.35; *SD*=1.20) and confrontational style for the majority of the session (*M*=1.79; *SD*=1.06), based on clinician reports.

Table II.7 shows clinician and organizational variables that predicted greater or lesser reported use of these practices. Free-form groups were more likely to be utilized by clinicians who had not been in recovery (*d*=.22) or who worked in private (vs. public) clinics (*d*=.22), and a confrontational style was more likely to be utilized when opioid replacement options were not available in the clinic (*d*=.25). No statistically significant correlations were found for reported use of group didactic education.

Discussion

For this study, I explored SUD group therapy practices as reported by a national sample of clinicians in the U.S. Because little has been previously published regarding SUD group therapy, this study sheds important light on TAU for SUD treatment. Several important interpretive comments and suggestions are in order, in the service of helping to reduce the gap between research and practice.

First, if there was any doubt, this study confirms that the predominant treatment modality in SUD treatment settings is group therapy. This finding suggests that attempts to integrate research with practice ought to treat group therapy as the norm. Indeed, in terms of ecological validity concerns, a strong case can be made for establishing EBTs at the group level and then adapting for individual clients, rather than the status quo in which the opposite is the case. Furthermore, this study demonstrates that open groups are used far more frequently than are

closed groups. Although the survey question about open groups (added later in the survey administration) was limited to a fraction of respondents, its outcome—almost 70% of respondents facilitated *only* open groups—leaves little doubt about the overwhelming prevalence of this practice. This finding suggests the importance of an alternative strategy for EBT research and delivery, given that EBT manuals generally assume that content builds conceptually as treatment progresses. In this regard, clinicians might consult treatment manuals that have been designed specifically for open groups (see, e.g., Wenzel et al., 2012; Donovan et al., 2013.). A basic general strategy is to provide a brief orientation to the treatment model (e.g., CBT) at the beginning of every session, followed by a new topic or activity each session.

Second, these results demonstrate that the primary treatments that clients reportedly receive are also those that have a strong evidence base, at least generally speaking. This is the case for the top five most prevalent treatment categories reported by participants: MI/MET, CBT (traditional), TSF, CBT (third-wave), and behavioral approaches. By contrast, most of the lesser-used reported treatments have less of an evidence base, at least for SUD treatment. Although this result is self-reported and does not indicate anything about the quality and fidelity of treatment, it nonetheless signifies that most SUD treatment facilities and/or clinicians are at least theoretically interested in or willing to use EBTs. Moreover, respondents' highly reported use of EBTs extended beyond general endorsement, in terms of specific group practices reported by therapists. Practice components from EBT fidelity scales were highly reported, especially for MI and CBT, providing a more concrete glimpse into what clinicians may be doing in group sessions. Likewise, treatment components derived from MI and CBT (e.g., Empathy/Support and Therapeutic Engagement/Behavioral Activation clusters) were highly reported. Practices that were unique to CRA, especially Abstinence Initiation and Medication Support practices, were

less likely to be reported, as were TSF and Recovery Maintenance practices. These results suggest that the treatment-practice gap may have little to do with opposition to the theoretical frameworks and general practices associated with specific EBTs. Rather, clinicians may genuinely struggle with having the training and organizational support needed to use EBTs in group format. As mentioned above, I recommend for clinicians to review and utilize treatment manuals specifically adapted for open groups (e.g., Wenzel et al., 2012; Donovan et al., 2013). However, it also may be necessary for researchers to recognize that greater flexibility may be needed for SUD group treatment than is typically the case for psychosocial therapies (see Chapters III and IV). One idea in this regard is for the creation and dissemination of research-based single-session group protocols that can be flexibly used by clinicians in open groups.

Third, these results highlight specific EBT components that were less frequently utilized, perhaps as a function of group format particularities (as shown in Table II.4). A few noteworthy examples include the following: First, although MI and Empathy/Support practices were highly reported, one of these practices (i.e., treating group members as partners, including allowing their perspectives to help guide treatment) was less commonly reported, perhaps suggestive of greater difficulty to engage in this practice in group format. Second, although Therapeutic Engagement/Behavioral Activation practices were highly reported, it is noteworthy that homework review was the lowest reported of these practices. This finding is troubling given the role of homework in many EBTs (e.g., CBT and TSF), while also possibly reflecting the greater complexity of homework review in group format (especially open groups). Third, wide variation in frequency of TSF practices was reported, suggesting that clinicians are not typically utilizing manualized TSF protocols in group settings or at least not doing so with high fidelity. In light of these findings, it would seem important for clinicians to recognize which aspects of EBTs are not

adequately addressed in group format and to explore ways for these aspects to be addressed in individual therapy (see Chapters III and IV for more on this issue).

In terms of clinician and organizational variables, this study reveals several predictors of greater or lesser use of group therapy practices (albeit with generally modest effect sizes). Some of these findings are predictable: Medication Support was more frequent in clinics that provide opioid replacement therapy, and TSF and Recovery Maintenance practices were more frequent from clinicians who have been in recovery themselves or who have more clinical experience; moreover, clinicians in standard outpatient clinics (vs. inpatient settings) and/or clinics with harm reduction options were more likely to utilize Medication Support and Abstinence Initiation practices. Other findings are perhaps more surprising. First, I was surprised at the number of regional effects. In particular, clinicians in the Southern U.S. were more likely to utilize TSF and Recovery Maintenance practices, and less likely to utilize Medication Support practices—perhaps suggesting greater cultural value in the South for twelve-step approaches. Second, TSF and Recovery Maintenance practices were more likely to be utilized in for-profit (vs. non-profit) clinics, and TSF practices were also more likely to be used in intensive outpatient (vs. standard outpatient) programs. This finding may suggest that TSF practices are seen as more fitting for clinics and programs that seek to maximize the number of clients who can be serviced. Third, for reasons that are unclear, racial/ethnic minority clinicians reported greater use of CBT and CRA practices, in comparison to non-Hispanic White clinicians. However, it should be stressed that this study was exploratory and that its basic statistical findings may be more nuanced or better explained by multivariate analyses. These analyses are beyond the scope of this exploration but may be conducted in the future.

Finally, this study shows that many clients continue to receive a considerable amount of therapies that are questionable or less effective. This was especially the case with didactic group education, with no statistically significant variation in comparative analyses among clinician and organizational variables. Thus, didactic group education appears to be widespread in SUD treatment, in spite of it having a minimal evidence base. There likely are many reasons for this emphasis on education: it is an integral part of the Minnesota model (see above), it can be delivered in large groups, and it is easier to train and sustain (see Chapter IV). On the other hand, this study suggests that another common practice in the past—confrontational style—is on the decline. This result converges with reports from other observers that the rise of MI has been associated with a rapid decline of confrontational approaches to SUD treatment in community settings (e.g., Carr, 2013). This study adds the finding that confrontational approaches are reportedly used even less frequently in clinics that provide opioid replacement therapy. Concerning the use of didactic group education, one recommendation is for clinicians to give greater emphasis to skills that are actively practiced within sessions, such as roles plays, mindfulness exercises, and distress tolerance techniques (see, e.g., Wenzel et al., 2012).

Limitations

Several limitations should be considered in the interpretation of this study. First, a self-reported survey is limited in its accuracy about what clinicians actually do. Because clinicians were asked about specific treatment components, some problems of self-report may be mitigated. Moreover, even if reports are inflated overall, this survey can nonetheless show the relative frequency of clinician practices. Nonetheless, it is possible that clinicians have limited accuracy in their reports about what they do in group therapy, and clearly observation of clinicians in group settings is needed and recommended. A limitation is especially noted concerning the low

self-report of utilizing a confrontational style, given the likelihood that this style is seen as less desirable today.

Second, it is unclear how representative this sample is of SUD group therapy clinicians in the U.S. As discussed above, the sample was homogeneous in certain dimensions, especially the majority of clinicians being addiction counselors/therapists rather than social workers and psychologists. However, these demographics were consistent with several previous surveys indicating that SUD treatment clinicians tend to be White, middle-aged, and female, with a strong majority being addiction counselors, more than half having Master's degrees, and a very small minority having doctorates (see Libretto, Weil, Nemes, Linder, & Johansson, 2004; Mulvey, Hubbard, & Hayashi, 2003; Rieckmann, Farentinos, Tillotson, Kocamik, and McCarty, 2011). Moreover, the demographics of the sample are roughly equivalent with data published by NAADAC on its membership, as discussed above.

Finally, although this study provides some light on what group therapy clinicians are doing, it does not provide information on how exactly practices are delivered, in terms of quality of care, how various practices are integrated and utilized, and how clinicians utilize certain best practices of group therapy generally. Many important questions remain in this regard, some of which I have recently explored qualitatively (see Chapters III and IV).

Conclusion

An underappreciated dimension of the research-practice gap for SUD treatment is a nearly exclusive focus of clinical research on individual therapy, versus a large majority of real-world treatment being delivered in group format. An important step for working to reduce this gap is by exploring and documenting TAU for group therapy in SUD treatment settings. This study is a preliminary investigation in this regard, utilizing a national survey of clinicians about

their most commonly utilized group therapy practices, especially in relation to practice components of EBTs for SUD treatment. This study confirms the predominant use of group therapy in SUD treatment settings, including the predominant use of open groups. It also shows that clinicians report high utilization of EBT components, especially for MI and CBT, but with varying use of individual practices and continued frequent use of questionable/less-effective practices. Future clinical research and implementation strategies would likely be most effective by beginning with a group therapy delivery context in mind, including the particular findings reported in this study.

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Tables

II.1: Characteristics of Sample: Clinician and Organizational Variables

Characteristic	*N*	%
Gender		
Men	185	32.7
Women	379	67.0
Other	2	0.4
Age		
21-29	25	4.4
30-39	70	12.4
40-49	119	21.0
50-59	183	32.3
60-69	137	24.2
70 or more	32	5.7
Race/ethnicity		
White (non-Hispanic)	475	83.9
Black	38	6.7
Latino/Hispanic	15	2.7
American Indian/Alaska Native	14	2.5
Multiracial / Other	24	4.2
Highest degree		
High school	22	3.9
Associate's	30	5.3
Bachelor's	97	17.1
Master's	363	64.1
Doctorate	42	7.4
Other	12	2.1
Personal recovery status		
Has not been in recovery	302	53.4
Has been in recovery	242	42.8
Preferred not to answer	22	3.9
Profession		
Addiction counselor/therapist	462	81.6
Social worker	47	8.3
Marriage and family therapist	20	3.5
Psychologist	14	2.5
Other	23	4.1
Years treating substance use disorders (SUDs)		
0-9	181	32.0
10-19	161	28.4
20-29	150	26.5

30 or more	74	13.1
Primary work role		
Direct services	386	68.2
Supervision and/or administration	111	19.6
Assessment	37	6.5
Case management and/or referral	32	5.7
Work setting (of primary clinic)		
Outpatient SUD clinic	167	30.0
Private practice	99	17.5
Inpatient/residential SUD clinic	97	17.1
Outpatient mental health agency	83	14.7
Intensive outpatient/day hospital (SUD)	52	9.2
Other	68	12.0
Operational structure (of primary clinic)		
Private non-profit	234	41.3
Private for-profit	221	39.1
City/county government	39	6.9
State government	36	6.4
Federal government	26	4.6
Other	10	1.8
Region (of primary clinic)		
Southern U.S.	163	28.8
Western U.S.	141	24.9
Midwestern U.S.	132	23.3
Northeastern U.S.	126	22.3
U.S. Territory	4	0.7
Medication options for opioid use disorder (at primary clinic)		
Yes	140	24.7
No	426	75.3
Harm reduction options (at primary clinic)		
Yes	136	24.0
No	430	76.0

Note: Respondents were allowed to indicate only one response per item, and percentages may not always sum to 100% due to rounding. For primary work role, direct services do not include assessment or case management; research and/or evaluation was provided as an option, but no respondents endorsed it. Regions are divided as follows: Southern (AL, AR, FL, GA, LA, MS, NC, OK, TX, TN); Western (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY); Midwestern (IA, IL, IN, KS, KY, MI, MN, MO, ND, NE, OH, SD, WI); and Northeastern (CT, DC, DE, MD, ME, MA, NH, NJ, NY, PA, RI, VA, VT, WV). For harm reduction options, an affirmative response indicated that formally advertised, long-term harm-reduction (non-abstinence) options were available at the respondent's primary clinic (medication-assisted treatment was not sufficient to count as harm reduction).

II.2: Substance Use Disorder Treatment Approaches Delivered by Clinicians

Treatment Approach	*M*	*SD*
Motivational interviewing/enhancement	4.05	1.08
Cognitive behavioral	3.85	1.11
Twelve-step facilitation	3.09	1.50
"Third wave" cognitive behavioral	2.82	1.39
Behavioral	2.62	1.38
Supportive/expressive	2.50	1.42
Rogerian/humanistic	2.38	1.42
Community reinforcement approach	2.35	1.43
Emotion-focused, gestalt, or experiential	2.05	1.18
Family or marital systems	2.04	1.17
Body therapies (relaxation/acupuncture)	1.85	1.16
Faith-based	1.72	1.05
Psychodynamic/psychoanalytic	1.61	1.04

Note: Respondents were asked, "In a typical month, for approximately how many of your substance use disorder clients do you personally use each of the following approaches?" Responses were rated on a 1-5 Likert scale (*1*=None or Very Few; *2*=Some; *3*=Half; *4*=Most; *5*=Almost All or All).

II.3: Structure of Group Therapy Sessions Facilitated

Variable	%
Length of facilitated group sessions	
30 minutes	1.2
45-50 minutes	11.1
60 minutes	23.7
75 minutes	6.9
90 minutes	30.9
120 minutes	18.2
> 120 minutes	22.4
Percent of facilitated groups that are open-enrolling*	
0	9.8
1-50	10.6
51-99	10.6
100	69.1

Note: For length of facilitated group sessions, respondents were asked to select any of the options that indicate the approximate length of group therapy sessions personally facilitated in a typical month.

*This item was added later in the survey administration and thus was limited to the last 123 participants who completed the survey.

II.4: Reported Utilization of Clinical Practice Components from Evidence-Based Treatments

Practice Component	EBT*	*M*	*SD*
Cluster 1: Empathy/Support		**4.19**	**0.73**
Try to understand group members' perspectives	MI	4.49	0.83
Encourage individual group members by saying something positive or complimentary about their strengths or efforts	MI	4.31	0.88
Convey your positive perception of each group member as a person, regardless of whether you agree with their behaviors	MI	4.21	1.04
Make comments conveying sympathy, compassion or understanding	CBT, MI	4.20	1.01
Treat group members as partners, including allowing their perspectives to help guide treatment	MI	3.73	1.23
Cluster 2: Therapeutic Engagement/Behavioral Activation		**3.88**	**0.77**
Ask open-ended questions with the purpose of getting group members to talk more	MI	4.50	0.78
Emphasize that group members are in control of their recovery	MI	4.25	1.01
Attempt to enhance motivation and commitment to change	MI	4.16	1.04
Encourage group members to develop substance-free recreational activities	CRA	4.16	1.03
Examine thoughts and emotions that lead to use	CBT, CRA	4.03	1.03
Help group members identify and prepare for possible triggers or situations that might lead to use	CBT, CRA	4.01	1.08
Listen and then repeat or rephrase what group members had said	MI	3.95	1.12
Encourage group members to anticipate future high risk situations and to formulate appropriate ways to manage these situations	CBT, CRA	3.91	1.15
Help group members notice and change thoughts that lead to drinking/drug use	CBT	3.87	1.11
Assist group members in defining specific treatment goals in a variety of life areas	CBT, CRA	3.84	1.18
Discuss high risk situations group members encountered in the past and explore specific actions they took to avoid or cope with the situation	CBT, CRA	3.79	1.15
Examine the negative consequences of using (short-term or long-term)	CBT, CRA	3.78	1.16
Ask group members to do one or more specific tasks between sessions	CBT, TSF	3.67	1.18
Discuss, teach, show, or rehearse how to cope with difficult situations without using alcohol other drugs	CBT, CRA	3.64	1.22

Suggest a different meaning for a group member's experience, placing it in a new light	MI	3.61	1.19
Identify and provide training for specific skills group members lacked	CRA	3.52	1.22
Review group members' reactions to previously assigned tasks, including problems they may have encountered in carrying out these tasks	CBT, TSF	3.33	1.25
Cluster 3: Recovery Maintenance		**3.08**	**0.84**
Encourage and assess group members' involvement with self-help groups	TSF	3.70	1.24
Discuss that group members' addiction is a disease	TSF	3.67	1.32
Discuss that one use (a "slip") does not have to become a full relapse	CBT	3.42	1.35
Assess how happy group members were in different areas of life	CRA	3.30	1.24
Explore group members' denial of their addiction	TSF	3.13	1.29
Discuss the 12 steps to recovery	TSF	3.06	1.32
Discuss group members' resistance to participating in a twelve-step recovery program	TSF	2.86	1.28
Help group members accept his/her identity as an addict	TSF	2.84	1.39
Promote group members' relationships with God or their Higher Power	TSF	2.84	1.36
Describe your own life experiences or beliefs with the intent of providing suggestions for problem-solving or emotional support	TSF	2.00	1.00
Cluster 4: Abstinence Initiation		**2.95**	**1.15**
Examine the positive consequences of using (short-term or long-term)	CRA	3.00	1.43
Help group members develop a plan to try out a period of abstinence as an experiment	CRA	2.90	1.42
Cluster 5: Medication Support		**2.87**	**1.50**
Support group members' use of prescribed medications for their substance use	CRA	2.87	1.50

Note: Practices are organized here in clusters identified in cluster analysis by Gifford et al. (2012). For each item, respondents were asked, "In a typical month, for how many of your total substance use disorder group sessions do you personally . . . " Responses were rated on a 1-5 Likert scale (*1*=None or Almost None; *2*=Some; *3*=Half; *4*=Most; *5*=Almost All or All). Statistics are provided for individual items as well as averages for each cluster.

* Signifies the evidence-based treatment (EBT) associated with the clinical practice component, in terms of correspondence with explicit treatment fidelity instructions: motivational interviewing (MI), cognitive behavioral therapy (CBT), community reinforcement approach (CRA), and twelve-step facilitation (TSF).

II.5: Clinician and Organizational Predictors for Utilization of Clinical Practice Components from Evidence-Based Treatments

EBT	Comparison Groups	*N*	*M*	*SD*	*SE*	*df*	*t*		*d*
CBT	*Racial/ethnic minority*	91	3.94	0.85	0.09	564	1.94	*	.22
	White (non-Hispanic)	475	3.76	0.81					
TSF	*Intensive outpatient substance use disorder (SUD) program*	52	3.37	0.80	0.13	217	2.50	**	.40
	Standard outpatient SUD program	167	3.04	0.83					
	Southern region	163	3.26	0.83	0.08	560	2.87	**	.27
	Rest of U.S.	399	3.04	0.82					
	Western region	141	2.95	0.81	0.08	560	-2.65	**	.26
	Rest of U.S.	421	3.16	0.83					
	Has been in recovery	242	3.23	0.72	0.07	542	2.85	**	.25
	Has not been in recovery	302	3.02	0.89					
	For-profit clinic	221	3.21	0.83	0.08	453	2.54	**	.24
	Non-profit clinic	234	3.02	0.83					
	> 15 yrs. SUD treatment experience	279	3.19	0.82	0.07	564	2.42	*	.20
	≤ 15 yrs. SUD treatment experience	287	3.03	0.83					
CRA	*Racial/ethnic minority*	91	3.75	0.79	0.09	564	2.03	*	.23
	White (non-Hispanic)	475	3.56	0.82					

Note: Results of two-tailed *t*-test analyses comparing clinician and organizational variables for average use of evidence-based treatment components. Only statistically significant results ($p < .05$) are shown. *Italicization* of a variable indicates *greater use* of the treatment component. Effect sizes (Cohen's *d*) are provided for each means comparison. (EBT=evidence-based treatment; CBT=cognitive behavioral therapy; CRA=community reinforcement approach; TSF=twelve-step facilitation.)

* $p < .05$
** $p < .01$

II.6: Clinician and Organizational Predictors for Utilization of Clinical Practice Components from Evidence-Based Treatments (Organized by Practice Clusters)

Practice Components	Comparison Groups	*N*	*M*	*SD*	*SE*	*df*	*t*		*d*
Therapeutic Engagement / Behavioral Activation	Northeastern region	126	3.76	0.83	0.08	560	-2.01	*	.20
	Rest of U.S.	436	3.91	0.75					
Recovery Maintenance	Western region	141	2.92	0.83	0.08	560	-2.60	**	.25
	Rest of U.S.	421	3.13	0.84					
	For-profit clinic	221	3.19	0.82	0.08	453	2.51	**	.24
	Non-profit clinic	234	2.99	0.84					
	Southern region	163	3.21	0.85	0.08	560	2.27	*	.21
	Rest of U.S.	399	3.03	0.83					
	Has been in recovery	242	3.17	0.75	0.07	542	2.14	*	.18
	Has not been in recovery	302	3.02	0.90					
	> 15 yrs. substance use disorder (SUD) treatment experience	279	3.15	0.82	0.07	564	1.93	*	.16
	≤ 15 yrs. SUD treatment experience	287	3.01	0.85					
Abstinence Initiation	*Standard outpatient SUD program*	167	3.00	1.09	0.14	262	2.14	*	.27
	Inpatient SUD program	97	2.70	1.14					
	Harm-reduction options available	136	3.15	1.14	0.11	564	2.37	*	.23
	Abstinence-only	430	2.88	1.14					
Medication Support	*Opioid replacement available*	140	3.76	1.30	0.14	564	8.72	****	.85
	Opioid replacement not available	426	2.57	1.44					
	Harm-reduction options	136	3.41	1.41	0.14	564	5.06	****	.50
	Abstinence-only	430	2.69	1.48					
	Standard outpatient SUD program	167	2.99	1.52	0.19	262	2.76	**	.35
	Inpatient SUD program	97	2.46	1.49					
	Southern region	163	2.52	1.45	0.14	560	-3.57	***	.33
	Rest of U.S.	399	3.01	1.50					
	Private clinic	455	2.94	1.50	0.16	554	2.30	*	.25
	Public clinic	101	2.56	1.47					

Note: Results of two-tailed *t*-test analyses comparing clinician and organizational variables for average use of clinical practice component clusters. Only statistically significant results ($p < .05$) are shown. *Italicization* of a variable indicates *greater use* of the practice component. Effect sizes (Cohen's *d*) are provided for each means comparison.

* $p < .05$
** $p < .01$
*** $p < .001$
**** $p < .0001$

II.7: Clinician and Organizational Predictors for Utilization of Questionable/Less-Effective Group Therapy Practices

Practice Component	Comparison Groups	*N*	*M*	*SD*	*SE*	*df*	*t*		*d*
Free-form Groups	*Has not been in recovery*	302	2.44	1.29	0.10	542	-2.59	**	.22
	Has been in recovery	242	2.18	1.05					
	Private clinic	455	2.40	1.21	0.13	554	1.98	*	.22
	Public clinic	101	2.14	1.13					
Confrontational Style	*Opioid replacement not available*	426	1.85	1.11	0.10	564	-2.59	**	.25
	Opioid replacement available	140	1.59	0.86					

Note: Results of two-tailed *t*-test analyses comparing clinician and organizational variables for average use of questionable/less-effective group therapy practices. Only statistically significant results ($p < .05$) are shown. *Italicization* of a variable indicates *greater use* of the practice. Effect sizes (Cohen's *d*) are provided for each means comparison.

* $p < .05$
** $p < .01$

CHAPTER III

Meeting Clinics Where They Are:

Organizational Challenges for Evidence-Based Substance Use Disorder Treatment

Abstract

Although several psychosocial evidence-based treatments (EBTs) for substance use disorders (SUDs) have been developed and evaluated over the past 15 years, real-world implementation of EBTs is a daunting task due to a research-practice gap with several formidable barriers. One important reason for this gap is a mismatch between EBT protocols and the organizational infrastructures of real-world SUD specialty treatment settings. In order to best dovetail research with practice efforts, it is important to document and understand organizational infrastructures that may facilitate or impede utilization of established EBTs. This study aims to do so through qualitative description of three outpatient SUD specialty clinics—diverse in their operational structures, missions, clientele, and services—located in the same Midwestern U.S. metropolitan area. Data consist of semi-structured interviews with three clinical directors and 13 clinicians from among the three clinics. Interview questions addressed organizational characteristics, services provided, group therapy curricula, and use of manualized and/or evidence-based treatments. Results include comparative analysis of the three clinics, in terms of similarities and differences in their operational structure, mission, treatment philosophy, clinical staff, client characteristics, overview of services, group therapy curriculum, use of individual services, client progress and flow, and approach to evidence-based practice. These results provide a glimpse into

treatment-as-usual for SUD specialty treatment, as well as highlight important and frequently overlooked gaps between research and practice. In particular, the organizational infrastructure of the three clinics have significant challenges for implementing existing EBTs, in terms of complexities with their provision of group therapy, exclusive use of open groups, use of treatment structures (e.g., session length, number, and duration) that are not readily compatible with existing EBTs, and use of a suite of treatments rather than standalone interventions. These results are discussed in terms of specific strategies for improved innovation and implementation of EBTs for specialty SUD treatment settings.

Introduction

The past 15 years has seen a tremendous increase in the study and utilization of evidence-based treatments (EBTs) for substance use disorders (SUDs; Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Miller, Sorensen, Selzer, & Brigham, 2006). Several specific and relatively brief EBTs have been developed and vetted through replicated randomized clinical trials. In spite of these developments, however, a significant and deeply entrenched gap remains between scientific research and everyday practice (Glasner-Edwards & Rawson, 2010; Manuel, Hagedorn, & Finney, 2011). EBTs often are not utilized in treatment settings or lag years behind in their uptake, resulting in clients receiving compromised or potentially harmful care (Carroll & Rounsaville, 2007; Manuel et al., 2011). One widely documented reason for this gap is pessimistic beliefs or ambivalent attitudes among clinicians about EBTs (Knudsen, Ducharme, & Roman, 2007; Manuel et al., 2011).

Organizational Challenges

Beyond the beliefs and attitudes of individual clinicians, however, a genuine mismatch exists between most EBT protocols and the organizational infrastructures of real-world SUD

specialty treatment settings. This mismatch pertains to limitations in institutional capacity, the complexity of providing long-term recovery-oriented treatment, the difficulty with balancing treatment fidelity with flexible client care, and the predominance of group therapy.

Institutional capacity. First, institutional barriers such as limited resources, inadequate training, high staff turnover, and disorganized organizational leadership impede implementation of EBTs, even among clinics that profess their routine use (Carroll et al., 2011; Carroll & Rounsaville, 2007). Adoption and sustainability of EBTs is costly, with some treatments being more costly than others (Olmstead, Abraham, Martino, & Roman, 2012). Many treatment facilities struggle to stay afloat financially, and so the additional burden that comes with the adoption and sustainable use of EBTs is often not possible without additional resources. This problem is exacerbated further given the complex history of SUD treatment in the U.S., in which specialty care has long operated outside of the professionalized health services industry, and thus may be ill equipped to remodel itself after the medicine-inspired parameters of EBTs (see Fletcher, 2013; White, 1998).

Complexity of long-term recovery-oriented treatment. Second, comprehensive SUD treatment is complex, typically involving much more than the brief individual interventions that are the predominant focus of EBT trials. SUD treatment often occurs in intensive treatment settings (e.g., intensive outpatient, residential, or inpatient treatment), where clients typically receive several different kinds of group programming along with case management pertaining to medical needs, housing, employment, legal issues, and family problems (Lash, Timko, Curran, McKay, & Burden, 2011). Furthermore, the chronic and frequently relapsing/remitting nature of SUDs often requires extensive engagement in treatment, mutual support groups, and other social services. This reality has received increased attention in recent years from researchers, clinicians,

service workers, and policy makers, resulting in the "recovery-oriented systems of care" movement, which conceptualizes recovery in terms of long-term engagement in various social services and recovery-oriented behaviors (Kelly & White, 2010; Lash et al., 2011; White, Boyle, & Loveland, 2002). Although the conceptualization of addiction as a chronic and long-term illness has become more prominent in the SUD literature, the design and evaluation of SUD interventions has struggled to move beyond unitary, time-limited interventions (Wells, Saxon, Calsyn, Jackson, & Donovan, 2010)—further evidence of the wide gap between EBTs and clinical realities.

Difficult balance between treatment fidelity and flexibility. Third, even within the relatively narrow confines of discrete EBTs for SUDs, treatment delivery is still more complex than is often appreciated by many clinicians and researchers. A recurring problem reflective of the research-practice gap is balancing treatment fidelity with real-world adaptation. Extensive adaptations and modifications to existing EBTs often are necessary in order to address programming constraints, complex group dynamics, client resistance, client diversity, and comorbid mental disorders (Aarons, Miller, Green, Perrott, & Bradway, 2012; Lundgren, Amodeo, Cohen, Chassler, & Horowitz, 2011). Although EBTs allow for a certain degree of flexibility and accommodation, adequate treatment guidelines are lacking for how and when to select and adapt various EBTs while staying faithful to their core principles and processes (Carroll & Rounsaville, 2007). Even among clinicians who profess a strong commitment to using EBTs, "drift" from treatment guidelines is widespread, with many clinicians (and administrators) overestimating the extent to which EBTs can be adapted without compromising fidelity (Carroll & Rounsaville, 2007; Lundgren et al., 2011). These problems suggest the need for improved (and likely costly) training and supervision for real-world use of EBTs. Unfortunately, training is

often inadequate and supervision is “virtually nonexistent” in SUD treatment settings (Carroll & Rounsaville, 2007, p. 854; cf. Olmstead et al., 2012).

Predominance of group therapy. Finally, a mismatch in treatment modality may be a barrier for EBT implementation. Whereas EBTs are typically designed for use with individual patients, group therapy is offered by over 90% of SUD treatment facilities (Crits-Christoph, Johnson, Connolly Gibbons, & Gallop, 2013; Weiss, Jaffee, de Menil, & Cogley, 2004), and for many facilities it is the overwhelming focus (Fletcher, 2013). This mismatch is rarely discussed and little is published on the use of EBTs in group settings—a significant problem, given that skilled group clinicians do not provide serial individual therapy segments, but rather facilitate group dynamics and processes with constant negotiation between the good of the group and the good of its individual members (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012; Yalom & Leszcz, 2005). Because of this individual-group tension, skills required for quality group facilitation are not obviously transferable from individual service delivery, evidence-based or otherwise. Matters are complicated further, given that SUD treatment groups are more likely to have open enrollment (in which clients begin and end at different times), and therefore sessions cannot substantively build on each other conceptually (Morgan-Lopez & Fals-Stewart, 2008; Wenzel et al., 2012; see also Chapter II). There is only limited published research or recommendations for adapting EBTs for open groups—again highlighting an enormous gap between research and practice.

Meeting Clinics Where They Are

What can be done to square these gaps between research products and clinical realities? The current trend for research funding priorities may be moving further away from SUD

specialty care, instead focusing efforts on neuroimaging and genetics research, biological and computerized interventions, and primary care integration, among other pursuits (e.g., as reflected in the National Institute on Drug Abuse's funding priorities; National Institute on Drug Abuse, 2015). Although these endeavors are noble, in the absence of radical scientific breakthroughs or changes in SUD treatment funding, specialty clinics will continue to play an indispensable role in SUD treatment for the foreseeable future. I suggest, then, that researchers and policymakers should take a page from the clinical adage of "meeting clients where they are," albeit adapted to "meet *clinics* where they are." In other words, it would behoove researchers and policymakers to pay closer attention to what is actually happening in SUD specialty clinics, in order to better design, adapt, and implement treatment approaches that can realistically be used.

It should be noted that recent attention has been given to research investigations of usual care, or treatment-as-usual, for SUD treatment, particularly through studies funded by the National Institute on Drug Abuse's Clinical Trial Network. These studies have yielded important findings, such as clinicians using basic motivational interviewing (MI) skills (Santa Ana et al., 2008), clinicians having moderately high competence with EBTs when they are used (Santa Ana et al., 2008), and a surprisingly high frequency of informal chatting between clinicians and their clients (Bamatter et al., 2010; Martino, Ball, Nich, Frankforter, & Carroll, 2009). However, this research is nonetheless somewhat abstracted from the full context of SUD treatment in real-world specialty settings; for example, these studies are limited to individual therapy within the context of discrete treatment trials. Therefore, treatment-as-usual studies still fail to reveal much from the "black box" of what happens in SUD treatment. This study aims to draw back the curtain further, through qualitative description of organizational infrastructures that may impede or facilitate EBT adoption and delivery. Through this exploratory study, readers will "meet"

three SUD specialty clinics, diverse in their operational structures, missions, clientele, and services.

Method

Settings

The data for this article derive from a broader study, consisting of interviews with clinicians and clinical directors from three SUD specialty outpatient clinics located in the same metropolitan area in the Midwestern U.S. (Clinic names provided throughout this article are pseudonyms.) Participating clinics were selected on the basis of being among the largest and most visible outpatient SUD treatment facilities in the metropolitan area. Two other clinics were recruited; one declined participation (due to being in the midst of a major overhaul of its programming) and the other was not selected because of costly and lengthy internal institutional review requirements for interviewing its staff.

The three participating clinics collectively showcase a diversity of characteristics, in terms of treatment philosophy, interventions offered, types of clientele, and funding sources. The first clinic, New Day, was part of a large non-profit SUD treatment organization, with a strong focus on twelve-step principles and community reintegration. The second clinic, Recovery Services, was operated by a state medical school, and included an intensive outpatient track and a standard outpatient track. The third clinic, SUD Intensive Clinic, was an intensive outpatient clinic operating within a Veterans Affairs (VA) medical center. Although each clinic operated within organizations that offered a range of SUD services (including residential programs, housing, and detoxification), this study is focused on the specialty adult outpatient services of the specific clinics. Clinics are described in more depth in the Results section.

Participants

Clinical directors and clinicians from each of the three clinics (above) were recruited to participate. Each of the three clinical directors participated. Criteria for clinician respondents included being a full- or part-time licensed provider who has spent any time facilitating psychosocial outpatient therapy for SUDs in the past two years; physicians and non-licensed trainees were excluded in order to ensure that reported experiences were from clinicians fully trained to provide psychosocial therapies. All eligible clinicians from the three clinics were recruited, and six from New Day (100%), four from Recovery Services (57%), and three from SUD Intensive Clinic (100%) participated (81% total participation rate).

Characteristics of the 13 clinician respondents are summarized in Table III.1. The sample was diverse in gender (67% women), age (range from 25-65 years; mean of 39 years), years providing SUD services (range from 1-45 years; mean of 10 years), and personal recovery status (31% endorsed). The sample was more homogeneous in terms of race/ethnicity (83% non-Hispanic Whites), profession (77% social workers), and highest degree (83% Master's degree). Two noteworthy differences existed between participants when categorized by clinic. First, clinicians from Recovery Services were much older (*M* = 51 yrs.) and had considerably more SUD treatment experience (*M* = 23 yrs.) than those from New Day (*M* = 36 yrs. of age; *M* = 4 yrs. experience) and SUD Intensive Clinic (*M* = 27 yrs. of age; *M* = 2 yrs. experience). Second, New Day had greater diversity in clinician professions (including two addiction counselors and one recovery support specialist), whereas all eligible clinicians from New Day and Recovery Services were social workers.

Measures

The primary measures consisted of semi-structured interviews (1-2 hours) completed between October 2013 and June 2014. Participants were asked about their clinic's mission,

treatment philosophy, and goals; its strengths and weaknesses; and details concerning its group therapy curriculum. Clinical directors were also asked to provide specific details regarding the clinic's history, providers, clients, and practices. Clinicians were also asked about their attitudes and beliefs about evidence-based practice. (See Appendices B and C for interview guides; Appendix C was pilot tested with a social work trainee). Demographic information also was provided by clinician participants (as reported in Table III.1).

Procedure

After full review, this study was designated as exempt from oversight by the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board. Clinical directors of the three clinics were contacted, and each director agreed to be interviewed and for their clinic's clinicians to be recruited for interviews. Recruitment of clinicians consisted of visiting staff meetings and/or email solicitations. Clinicians were free to decline participation without knowledge of or reprisal from their employers. Participants were interviewed privately by me, either on site at their respective clinics or at a university office. In most cases, interviews were completed in one visit; for two of the participants, interview completion required two visits. Clinical directors were reimbursed at a rate of $40 per hour; clinicians, $30 per hour.

Although a semi-structured interview protocol was utilized with each participant, the major unit of analysis was the clinic. Most information reported in this article consisted of factual information that was solicited from and verified by participants. For example, the first participant from a clinic would be asked about the clinic's group therapy structure; this information would then be confirmed or clarified by subsequent participants from that clinic, in a cumulative manner until data saturation was reached. Interviews were audio recorded and transcribed according to conventional transcription standards. Transcripts were then analyzed

using principles of conventional thematic content analysis (Braun & Clarke, 2006; Hsieh & Shannon, 2005). This process required broad familiarity with the entire corpus of data, including reading and re-reading transcripts while noting initial impressions, and coding data into categories determined to be most relevant for EBT adoption and delivery. Brief summaries for each clinic were then written, organized according to the coded categories (specified in the Results section below). All information provided in these descriptions was either factual information provided by the clinical director and/or issues discussed or verified by at least two participants per clinic. The results reported in this article are drawn from a portion of the coded and analyzed material (i.e., the portion coded as pertaining to organizational factors). Given the relatively straightforward nature of the coded material, participant quotations are not provided (they are, however, provided in a separate analysis; see Chapter IV).

As is often the case with qualitative research, the time-intensive nature of this project and the length of interviews prohibited the use of additional raters or returning transcripts or findings to participants (neither of which is a requirement of content analysis; Braun & Clarke, 2006). However, several processes were used to ensure rigor of analysis. First, coding of interviews were content-based for straightforward responses, thereby minimizing the need for inter-rater triangulation efforts. Second, intra-rater consistency of coding was facilitated through the use of NVivo qualitative data analysis software (version 10), used to code textual material and interpret hierarchical relationships between identified themes. Third, I adhered to a 15-point checklist for content analysis (see Braun & Clarke, 2006), including guidelines such as, “Themes have been checked against each other and back to the original data set,” and, “All relevant extracts for each theme have been collated” (p. 96). Finally, I adhered to a 32-item checklist for reporting information from qualitative studies. This checklist is called the consolidated criteria for

reporting qualitative research (COREQ) and includes commonly reported aspects of published qualitative studies (e.g., researcher characteristics, relationship with participants, theoretical framework, participant selection, setting, data collection, data analysis, and reporting; Tong, Sainsbury, & Craig, 2007); all relevant items from the checklist are reported in this article.

Researcher Characteristics and Relationship with Participants

Finally, as is customary with qualitative research reporting, some information about my own experience/training, perspective, and relationship with participants is warranted. I have had extensive coursework and training in qualitative inquiry, including having previously conducted and published an interview-based study utilizing conventional thematic content analysis (Wendt & Gone, 2012). I have long had an academic interest in EBT implementation considerations, and my interest for conducting this study was motivated in part by my clinical training working as a SUD group facilitator, in which I first became aware of many complexities with integrating research and practice for SUDs (discussed above). My research and clinical experience have led me to characterize myself as a "middle man" between researchers and clinicians, with the belief that a balance between top-down and bottom-up processes is necessary for sustainable EBT implementation. This personal background, along with my guiding assumptions, was communicated to each participant at the time of recruitment and/or prior to each interview. Prospective participants also were informed that the study was part of my doctoral dissertation and was intended to bridge the gap between researchers and clinicians through portraying real-world complexities with treatment delivery. Respondents seemed to enjoy participating in the study and providing their unique perspectives, based on their engagement and direct feedback.

In terms of my relationships with participants, it should be noted that prior to data collection I received one year of clinical training at SUD Intensive Clinic. As a result, I had a

previous relationship with the clinical director and each of the clinic's participants. My training experiences are not utilized as data for this study, but they cannot possibly be divorced from my conceptualization of the clinic. Although this experience may raise concerns about bias, it should be stressed that this study is not a program evaluation, nor is it a horse race between the three clinics. Moreover, my involvement with the clinic should not be construed as an endorsement.

Results

Summaries for each clinic are provided below, organized by the following categories: operational structure, mission, treatment philosophy, clinical staff, client characteristics, overview of services, group therapy curriculum, use of individual services, client progress and flow, and approach to evidence-based practice. These results are summarized in Table III.2. Although New Day and Recovery Services provided adolescent services, summaries of most categories (clients, group therapy curriculum, use of individual services, and client progress and flow) are limited to adult clients and programming. When exact figures are provided (e.g., the percent of clients corresponding to a certain category), these were communicating by the clinical director while he/she was referring to collated organizational data. In most cases, figures were estimated by the clinical director; the qualifier "estimated" is used throughout this article to indicate such.

Clinic 1: New Day

Operational Structure. New Day was a community outpatient specialty SUD clinic. The clinic was one of several locations within a non-profit parent organization that included residential treatment, non-medical detoxification services, housing, and corrections services. The organization began in the 1970s as a labor-based residential program and gradually expanded to offer increased services. The clinic's funding was primarily through local government contracts

(e.g., for Medicaid, court-ordered, and incarcerated clients), private donations from alumni, and out-of-pocket pay (with a sliding scale based on income, with lowest rate at $5 per session); private insurance was not accepted.

Mission. The primary mission of the clinic and its parent organization was to serve as a "bridge" to the "recovery community," especially through facilitating Alcoholics Anonymous (AA) participation and sponsorship. Respondents viewed professional treatment as secondary to long-term community-mediated recovery, and a frequently cited goal was to "remove barriers" between clients and the recovery community. The primary stated reason for this mission was the chronic, frequently relapsing nature of addiction necessitating more long-term support than the clinic could offer, along with the myriad social problems (e.g., homelessness or lack of social support) that clients face.

Treatment Philosophy. New Day's treatment philosophy was rooted in AA principles and all clients were required to attend AA meetings. The clinic and its parent organization also had a strong abstinence focus. For the parent organization, this focus included an opposition to addiction medications (e.g., methadone and buprenorphine), except as needed for safe detoxification. However, the organization also prided itself on client-centered treatment, in terms of having a variety of services and levels of care, and had reportedly become less confrontational and more recovery-focused over the years. The clinic was the only unit in the organization where patients could be prescribed addiction medications (externally) while in treatment. Although the clinic occasionally worked with clients with non-abstinence goals, it did not offer formal harm-reduction options.

Clinical Staff. New Day's director was a Master's level social worker, and clinicians consisted of three social workers, two addiction counselors, one recovery support specialist, and

one social work trainee. The social workers and addiction counselors had Master's degrees and the recovery support specialist had a Bachelor's degree.

Client Characteristics. An estimated 60-70% of adult clients were male and an estimated 70% were non-Hispanic White clients; the majority of racial minority clients were African American. More than half of clients (54%) were court-ordered; male clients were more likely to be court-ordered for intoxicated driving or disorderly conduct charges, whereas female clients were more likely be court-ordered by Child Protective Services. Clients generally had substance abuse or dependence diagnoses, based on the fourth edition of the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*). Primary substance problems were alcohol (48%), heroin/opiates (25%), marijuana (15%), and cocaine (8%).

Overview of Services. Outpatient services consisted primarily of individual assessment and group therapy, with a separate track for adolescents. The clinic contracted with a psychiatrist, who prescribed medications for Medicaid clients (through a state contract). Many clients resided in the parent organization's transitional housing.

Group Therapy Curriculum. New Day had four progressive phases of adult group programming, designed in terms of client motivation and readiness for change. Each phase was 10 weeks long, and clients were admitted on an open-enrolling basis for 90-minute weekly sessions. Groups typically had between 8-15 clients and one facilitator. Clients were expected to attend each session; if two sessions were missed, then clients were typically required to start the phase over. Phase 1 was a psychoeducational group aimed at increasing motivation for clients who are pre-contemplative in their readiness to change; this group focused on introducing clients to AA and facilitating twelve-step initiation and involvement. Phase 2 was designed for clients in

the contemplation and planning stages of change; it aimed at helping clients initiate or resume engagement with the recovery community and to accept being powerless against their addiction as a chronic disease. Phase 3 was designed for clients in the planning and action stages of change; it focused on identifying triggers and preventing relapse. Phase 4 was designed for clients in the maintenance stage of change, who were extensively engaged with the recovery community and actively "working the steps" of AA; topics focused on relationship building, recreation, education/job preparation, and skills training.

Phase 1 had a structured curriculum, consisting of 10 psychoeducational topics about addiction and twelve-step recovery. Uniform curricula did not exist for Phases 2 and 3; clinicians generally chose topics based on their perceptions of what group members needed. (At the time of data collection, the clinic was in the process of combining Phases 2 and 3 into one 24-week phase, with a revamped curriculum that integrated dialectical behavior therapy skills training.) Phase 4 groups were process-oriented and open-ended, with an emphasis on clients setting the agenda and providing each other support. Across phases, clinicians reported that group materials were usually idiosyncratically collected and used; clinicians cited "a book of ideas," "some printouts from the Internet," and a binder with "vague and unhelpful websites and copies." As a result, some clinicians reported, group preparation was sometimes rushed or inadequate. Common sources of group materials included Hazelden and The Change Companies. Clinicians identified these materials as being at least loosely related to cognitive behavioral therapy (CBT), relapse prevention, and motivational enhancement therapy (MET), in addition to a twelve-step focus.

Use of Individual Services. Beyond initial assessment and placement, New Day did not routinely provide individual services. Clinicians reported that they often met briefly with

individual clients on an ad hoc basis before or after groups for special needs, such as discussing crises or addressing problematic group behaviors. In rare cases, individual therapy was provided in lieu of group therapy for clients who did not work well in groups or had special needs; this required clinicians adding work to their caseload.

Client Progress and Flow. New clients were individually assessed and placed for treatment within the parent organization (e.g., detoxification, residential treatment, or outpatient treatment) on the basis of American Society of Addiction Medicine (ASAM) placement criteria. Clients typically began in Phase 1 but would occasionally start in advanced phases depending on their motivation and recovery history. An estimated 50% of clients did not progress past Phase 1, which was primarily attributed to court-ordered clients being required to complete only the first phase and then not wanting or needing additional treatment. Client retention was estimated as being much higher through the remaining three phases. Sometimes clients chose to repeat a phase because of their recovery status or their schedule.

Approach to Evidence-Based Practice. The director and clinicians generally were confident in a twelve-step approach to treatment, based on their clinical experience and the success of AA. This approach, according to the respondents, was buttressed with general awareness of recovery movement literature (e.g., the work of William White; see White, 2007) and skepticism about acute-care brief treatment approaches. Focus was placed on common factors (e.g., the therapeutic relationship) and client feedback (routinely collected in groups but not systematically analyzed). Clinicians varied widely—from naïve to very informed—in their understanding of the role of randomized controlled trials and awareness of common clinician biases in appraising treatment effectiveness.

Respondents believed it was important for treatment to be informed by evidence, but not necessarily in terms of specific EBTs. A formal twelve-step facilitation (TSF) EBT was not utilized. Clinicians were generally open to using manualized therapies—and especially saw their benefit for training purposes—as long as they could be used flexibly and enough time was given to personalize treatment and discuss relapses and crises. Clinicians stressed the importance of allowing clients to have some control over treatment, and also cited clients' dislike of homework assignments.

Clinic 2: Recovery Services

Operational Structure. Recovery Services was the sole specialty SUD clinic at a state medical school. This outpatient clinic included an intensive outpatient program (IOP) and standard outpatient services. Over 30 years old, the clinic was originally part of a joint venture with a local community hospital; within the past 10 years, it separated from this arrangement and moved to a new location. The clinic's services have been dramatically reduced over the years due to funding cuts. Services were reimbursed primarily through private health insurance.

Mission. The director and clinicians consistently distinguished the clinic from other treatment programs in terms of its expertise in treating addiction alongside co-occurring psychiatric disorders (including severe mental illness) utilizing a combination of biomedical and psychosocial approaches. Its mission also involved its identity as part of a teaching and research hospital with medical residents and other trainees.

Treatment Philosophy. Recovery Services' treatment philosophy was eclectic and abstinence-based, although harm reduction approaches were occasionally offered on an individual basis (e.g., for certain clients with dual diagnoses). The clinic strongly recommended,

but did not require, mutual support group involvement (broadly construed, including Smart Recovery and Women for Sobriety) and a weekly AA meeting was held on site.

Clinical Staff. The director was a psychiatrist, and clinicians consisted of seven Master's level social workers, four part-time psychiatrists, and two nurses. The clinic also had addiction psychiatry fellows, medical residents, and social work trainees.

Client Characteristics. An estimated 60-70% of adult clients were male and an estimated 90-95% were non-Hispanic White clients. An estimated 50% had co-occurring psychiatric disorders. The typical client was described as middle-class and having private insurance. Clients had *DSM-IV* diagnoses of substance abuse or dependence. Primary substance problems were alcohol (estimated 67%) and heroin/opiates (estimated 25%).

Overview of Services. Services included individual assessment, individual and group therapy, as well as psychiatry visits and medication for addiction and dual diagnoses. A separate track was provided for adolescents, and a group was also available for family members. The clinic also provided ambulatory detoxification, typically for medication-assisted therapy for opiate addiction.

Group Therapy Curriculum. The five-week IOP met three times weekly for three hours of group therapy each day. The IOP was open-enrolling and typically had 12 clients and two facilitators. The first half of daily programming consisted of process-oriented groups. The second half consisted of psychoeducation about alcohol and drug use, with topics selected by clinicians on the basis of client needs.

Standard outpatient groups had open-enrolling 90-minute sessions, with one facilitator and an estimated 6-8 clients on average, and did not have a fixed duration for a given client. Most clients enrolled in one of three Early Recovery groups, each of which was facilitated by a

different clinician; duration for the average client was four weeks. The clinic also provided specialty groups for clients who are health professionals, dually-diagnosed clients, and medically stable clients with buprenorphine prescriptions.

Groups generally lacked formal group therapy curricula. Clinicians identified group activities as being at least loosely related to CBT and relapse prevention, in addition to a twelve-step focus. One clinician reported working from a psychodynamic orientation.

Use of Individual Services. In addition to individual assessment and psychiatric services, the clinic provided some individual psychotherapy. Individuals were generally expected to engage in a course of group therapy prior to receiving individual psychotherapy. Reasons for receiving only individual therapy included client preferences and client factors that complicate group treatment (e.g., psychotic or belligerent clients). In addition, clinicians would occasionally meet briefly with clients before or after group sessions for special needs. Group and individual clinicians would discuss clients in team meetings, but intensive coordination was not typically implemented for clients receiving the two modalities concurrently.

Client Progress and Flow. Recovery Services provided individualized intake assessments and medical evaluations, after which clinicians would coordinate care in the clinic and/or any other SUD or psychiatric treatment needed through referral; ASAM patient placement criteria were used to assist with placement decisions. Of clients who received an initial assessment, an estimated 60-80% enrolled in the IOP; most other clients received individual therapy only. (Atypically, clients with at least one month of abstinence could be eligible for initial placement with a standard outpatient group.) Of clients who began the IOP, an estimated 60% finished and an estimated 30% of completers continued to standard outpatient groups.

Thirty days of sobriety were required before initiating standard outpatient services. Referrals for residential treatment were made to a neighboring treatment facility.

Approach to Evidence-Based Practice. The clinic emphasized common factors such as the therapeutic relationship and group cohesion, and respondents endorsed the view that many therapies are generally equivalent in their processes and outcomes. The director endorsed the importance of treatment being grounded in research but said that introducing EBTs was not a priority, due in part to limited evidence for specific group therapies; what was most important to the director was for clinicians to not utilize certain proscribed treatments (e.g., confrontation-based or psychoanalytic treatment). The director desired to incorporate effectiveness and outcome research into the clinic, but had not yet done so due to lack of resources. Three of the four clinicians expressed a strong aversion to using manualized therapies, with two saying they would consider quitting if forced to do so. These clinicians reported that manualized therapies were "rote," less therapeutic, and not what they were trained to do; moreover, they said that clients typically disliked this level of structure and were not compliant with homework assignments. Clinicians expressed more openness to entertain manualization if provision was made for ample flexibility, including clients being able to connect with and draw support from others in the group.

Clinic 3: SUD Intensive Clinic

***Operational Structure*.** SUD Intensive Clinic was an abstinence-based clinic operating within a VA medical center, providing 3-4 weeks of intensive services (typically 10 hours weekly per client). Less than five years old, the clinic was an outgrowth of a partial hospitalization program for psychiatric disorders. The clinic existed in cooperation with a standard outpatient SUD clinic in the same center; brief medical detoxification services were

also available via the medical center's psychiatric residential unit. Services were funded through the federal budget allocated to the Veterans Health Administration.

Mission. The clinic's mission was to provide acute stabilization for moderate to severe SUDs. The primary goal was to help clients maintain abstinence for 3-4 weeks—or to address any relapses during that period—and then transition to longer-term standard outpatient treatment. Additional goals included community integration and practice of basic relapse prevention skills.

Treatment Philosophy. The treatment philosophy was eclectic but predominantly cognitive behavioral, and inclusive of TSF, relapse prevention, and MI. The clinic's staff prided itself on providing client-centered care, albeit with an abstinence agenda. This approach included a team effort at providing an "MI spirit." Three hours of external weekly "community integration" activities were expected for each client; this typically consisted of mutual support group involvement. AA meetings were held three times weekly at the medical center.

Clinical Staff. The clinical director was a clinical psychologist, and additional clinicians consisted of three Master's level social workers, two part-time psychiatrists, and one nurse. The clinic also had a psychiatry resident (rotating each month) and psychology and social work trainees.

Client Characteristics. All clients were veterans of a variety of ages and service eras. An estimated 90-95% of clients were male, and an estimated 65% were non-Hispanic White clients; an estimated 20-25% were Black. Clients were required to have a *DSM-IV* diagnosis of substance dependence. Primary substance problems were alcohol (about 40-60%), cocaine (about 30-40%), and heroin/opiates (about 20%). Many clients had comorbid PTSD (with some being referred from the hospital's PTSD treatment facility), and many had been through the intensive SUD program at least one time in the past. Clients were typically referred from regional VA

medical and psychosocial programs, including the medical center's psychiatric inpatient unit ("step down" care).

Overview of Services. Services primarily consisted of group therapy. Additional services included weekly psychiatry visits and medication for addiction and dual diagnoses, as well as weekly case management visits. The program had limited off-site unmonitored housing available for the treatment duration; about half of clients utilized this housing. Clinicians provided individualized assessment and coordinated care in the clinic and/or any other SUD or psychiatric treatment needed through referral; ASAM criteria were used to assist with placement decisions.

Group Therapy Curriculum. The clinic had an open-enrolling four-week curriculum, in which clients met three times weekly for 3-4 50-minute sessions of group therapy. The curriculum consisted of 40 unique sessions, each of which was manualized and adapted from EBT protocols. Each client would ideally receive each session, albeit not in the same order (due to open enrollment), and with the recognition that some kinds of treatment would resonate more for a given client than for others. Each client received a binder with all group handouts and worksheets. Groups typically had one facilitator and 8-12 clients.

The group curriculum had recently transitioned from being organized topically (e.g., Healthy Support or Problem Solving) to being organized in terms of various EBT approaches. The updated curriculum included eight sessions of CBT (twice weekly), eight sessions of group MET (twice weekly), six sessions of TSF (1-2 times weekly), four sessions of acceptance and commitment therapy (once weekly), four sessions of dialectical behavior therapy (once weekly), four sessions of CBT for insomnia (once weekly), four sessions of emotional regulation psychoeducation (once weekly), one session of medication psychoeducation, and one orientation session to the medical center's standard outpatient services. Although clinicians reported that the

curriculum allowed for clients to discover what approaches are most helpful for them, clinicians also worried that some clients were overwhelmed by the multiple theories, concepts, and ideas covered in the curriculum.

Use of Individual Services. In addition to individual psychiatric services, each client was assigned a case manager (from among the social workers), who provided individual assessment, assisted the client with forming a treatment plan, and met with the client at least once weekly to monitor client goals and progress. In rare cases, individual psychotherapy was also provided by the case manager. The clinic was attempting to review clients' group homework assignments via case management, but this process was early in development at the time of the study and was reported to be haphazard and idiosyncratic in execution.

Client Progress and Flow. An estimated 50% of referred clients initiated treatment and an estimated 70-75% of initiators completed the four-week program. The clinic did not collect data for how many clients continued with standard outpatient treatment but the director estimated that the majority did not—one of the most pressing concerns for the staff.

Approach to Evidence-Based Practice. The curriculum was heavily manualized according to adaptations of EBTs (listed above). Clinicians were generally positive about utilizing EBTs and manualized therapies, especially in terms of standardization among clinicians and to provide structure for less experienced clinicians and trainees. Moreover, respondents reported that clients appeared to have better outcomes with the revised curriculum.

At the same time, the clinic reported considerable growing pains with treatment delivery, especially with balancing standardization and flexibility. Clinicians varied in their response to this tension, with some being reluctant to deviate and others doing so regularly, especially in terms of substituting material that they felt more passionate about or more comfortable with

presenting. A significant aspect of this difficulty pertained to group sessions being only 50 minutes long, making it difficult to cover material while still being able to discuss individual needs, relapses, group cohesion difficulties, and weekend plans. A frequent result was facilitators talking more than was optimal, information being disseminated too rapidly, and minimal time being spent on skills practice. Moreover, clinicians were inconsistent in assigning and reviewing homework, in spite of it being a part of most group protocols. According to the director, the clinic had become more flexible in its EBT delivery over time, and the clinic desired to revise the curriculum further to include more time for client discussion and skills training/practice.

Discussion

For this study, I have provided summaries of organizational characteristics for three outpatient SUD specialty clinics located in the same Midwestern U.S. metropolitan area, based on qualitative interview data with clinical directors and clinicians. As I will discuss, these summaries highlight certain complexities—shared and unique—concerning the clinics' (potential) adoption and use of established EBTs for SUDs. A discussion of these complexities may be helpful in anticipating collaborative solutions for narrowing the research-practice gap.

Limitations

Prior to this discussion, two limitations should be addressed. First, it is unclear the extent to which the three clinics generalize to other SUD specialty clinics. As discussed below, the three clinics have many commonalities with what is known about SUD specialty clinics nationally, and based on my research and clinical experience many of the broad issues and complexities for these three clinics are at least generally consistent with many if not most specialty SUD clinics in the U.S. One noteworthy distinction is that each of the three programs relies heavily or entirely on social workers for delivering psychosocial therapies (perhaps due to

a prominent social work school being in the area); in contrast, surveys of the SUD treatment workforce indicate that addiction counselors are the predominant profession (see Libretto, Weil, Nemes, Linder, & Johansson, 2004; Mulvey, Hubbard, & Hayashi, 2003; Rieckmann, Farentinos, Tillotson, Kocamik, and McCarty, 2011). It should be stressed, however, that the purpose of this article is not to present data on SUD specialty clinics in an abstract, general, or aggregated manner. Rather, through a case-based approach, the goal is to concretely elucidate the organizational infrastructures of three *particular* clinics. This focus is intentional, in that EBT implementation—or barriers to such—generally happens at the level of *specific* organizations.

Second, this study did not include direct observation of SUD treatment, as such was not possible in my role as a researcher. Observation certainly would help to provide a fuller picture of each clinic, especially in ways that do not match respondents' accounts. To compensate, care was taken to receive detailed accounts of services, group curricula, and therapeutic tasks.

Similarities and Differences among the Clinics

Before discussing complexities with EBT utilization, it may be helpful to review similarities and differences among the three clinics. In terms of similarities, all three clinics had an abstinence-based treatment philosophy, primarily utilized social workers for psychosocial services, provided a range of services (with a focus in group therapy), and utilized open-enrollment for all groups. According to a national survey of SUD clinicians in the U.S. (see Chapter II), these characteristics are normative for SUD specialty treatment facilities, with the exception of the primary use of social workers (addiction counselors are most predominant nationally).

In most respects, however, the three clinics were quite different. New Day differed in its operating outside of a medical model and managed care. As such, it was relatively more oriented

to long-term psychosocial dimensions of recovery, was most aligned with a twelve-step treatment philosophy, was directed by a social worker, did not directly provide medical treatment nor employ medical providers, had by far the most court-referred clients, and provided the least amount of individual care. Recovery Services differed in its reliance on private insurance, its servicing a more privileged population (overwhelmingly White and middle class), its being directed by a psychiatrist, its clinicians being considerably older and having more treatment experience, its focus on dual diagnoses, its provision of individual treatment, and its minimal utilization of specific EBTs or manualized treatments. Finally, SUD Intensive Clinic differed in its focus on acute stabilization, its servicing a veteran population, its being directed by a clinical psychologist, its diverse and highly structured intensive group curriculum (utilizing a wide range of approaches in relatively brief sessions), and its nearly exclusive utilization of manualized EBTs in group format.

Considerations for EBT Adoption and Utilization

These similarities and differences among the clinics are suggestive of several considerations concerning EBT adoption and utilization. As discussed above, much attention has been paid to individual clinician attitudes about and utilization of EBTs, whereas less attention has been paid to organizational factors. In this section, I address considerations for EBT use at the organizational level, most of which would likely remain regardless of characteristics or attitudes of individual clinicians. In this regard, the question is, given what is known about the three clinics, what might one expect if clinician variables about EBTs were not an obstacle? By drawing attention to this question, it is hoped that researchers, clinicians, and administrators can better collaborate in realistically fitting research products to organizational infrastructures, and vice-versa.

To maximize the concreteness and relevance of this discussion, these considerations are discussed here in relation to compatibilities and challenges for utilizing three prominent manualized EBTs for SUDs: CBT, MET, and TSF. Although multiple variations of these three treatments exist, they are conceptualized here in terms of the freely available treatment manuals used in Project MATCH, an eight-year multi-site clinical trial that compared the effectiveness of the three EBTs for treating alcohol use disorders (National Institute on Alcohol Abuse and Alcoholism, n.d.). As is routinely the case with SUD treatment manuals, each manual was designed for use with individual clients. The CBT (Kadden et al., 2003) and TSF (Nowinski, Baker, & Carroll, 1999) protocols consist of twelve sessions (eight core sessions and four elective sessions from among 14 elective topics), with flexibility for session order (except for the first and last sessions). The MET protocol (Miller, Zweben, DiClemente, & Rychtarik, 1999) consists of four sessions—one introduction session involving psychoeducation, assessment, and feedback, followed by three highly individualized "followthrough sessions" (p. 54).

Compatibilities with Using the Three EBTs

The general missions and treatment philosophies of each of the three clinics were relatively consistent with the assumptions of each of the three EBTs. Each EBT strongly encourages an attempt at abstinence, which is compatible with the general agenda of abstinence for the three clinics. Moreover, each clinic had goals that are broadly consistent with each EBT, with an especially high congruence between New Day and TSF, in light of both having a goal of clients' integration into the recovery community and promotion of a disease model of addiction. SUD Intensive Clinic, through its reported embodiment of an "MI spirit," focus on CBT relapse prevention principles, and encouragement of mutual support group participation, had a treatment approach that encompassed all three EBTs. This congruence was somewhat vague for Recovery

Services, in light of clinicians having idiosyncratic treatment approaches; however, the director and clinicians generally endorsed openness to or utilization of principles embodied in each EBT. In terms of existing programming, the most obvious compatibility is with SUD Intensive Clinic, in terms of the clinic's utilization of all three EBTs into its curriculum. Moreover, the director and clinicians of the clinic expressed a high value for manualized EBTs and each of the three treatment approaches in particular. Finally, Recovery Service's utilization of some individual therapy is compatible with the individualized nature of the three EBTs.

Challenges with Using the Three EBTs

Challenges for EBT implementation among the three clinics far outnumber compatibilities. These challenges, which generally pertain to a mismatch in treatment modality, include each of the EBTs (a) being designed for individual clients, (b) requiring progressive and individually-tailored sessions, (c) having limited flexibility for treatment duration and session length, (d) being intended as standalone interventions, and (e) being designed without consideration of group therapy principles.

Designed for individual clients. Each EBT was designed and evaluated for use with individual clients, necessitating adaptation into group format for them to be utilized by the three clinics. This adaptation would be quite challenging, given that each EBT relies upon individualized tasks and processes that are difficult to translate into group use. Some of these elements (e.g., orientation, assessment, check-ins, homework review, and termination) could conceivably be addressed adjunctively on an individual basis—a potentially viable approach for Recovery Services and SUD Intensive Clinic, given that both clinics offered individual therapy or case management, respectively. Even then, this integration would require greater coordination

between group and individual treatment than the clinics have been accustomed, and may inevitably require hiring more clinicians (which likely would be cost-prohibitive).

Beyond these elements, much of the therapy content of the three EBTs would be difficult to adapt in group format. This is especially the case for MET, which requires intensive individualized assessment and feedback, as well as a communicative style (i.e., MI) that is considerably more difficult to facilitate in group settings. Although limited resources have been developed about using MI in groups (e.g., Wagner, Ingersoll, & Contributors, 2012), this work is in its infancy and, as reported elsewhere, participants struggled with incorporating MI principles within groups (see Chapter IV). Moreover, MET relies on helping clients to progress developmentally—at their own pace—in their readiness to change, whereas in groups clients have variable change trajectories. In terms of CBT, the protocol would be moderately difficult to adapt in group settings, due to its reliance on role plays and other individualized tasks that require individual instruction, observation, and feedback. TSF has perhaps the most promise for group adaptation, due to its content being primarily educational and discussion-based—and with the advantage of socializing clients to group processes they may experience in mutual support groups. Notably, SUD Intensive Clinic attempted to adapt all three EBTs (using manuals with similar content and structure as the Project MATCH manuals); however, the director and clinicians reported considerable compromises and difficulties with this adaptation.

Require progressive and individually-tailored sessions. To make matters more complicated, all groups in the three clinics had open-enrolling sessions, meaning that therapy content would be unable to progressively build on itself conceptually. Open-enrollment would especially be a problem for the use of MET, as clients' readiness to change would inevitably be more variable than in closed groups. CBT and TSF have greater promise for adaptation to open

groups, in that with the exception of introductory and terminating sessions, therapy modules could be used in any order. SUD Intensive Clinic attempted to adapt EBTs for open groups, by having a brief introduction to basic therapy principles at the beginning of each group. Even so, the intent of the EBT manuals was for session order and choice (among electives) to be collaboratively chosen with the individual client—a task that would be greatly compromised if not impossible in a group setting.

Limited flexibility for treatment duration and session length. Other challenges lie with differences in the structures available for group sessions (e.g., number, length, and frequency of sessions). Adoption of any of the three EBTs would require structural adaptation by each of the three clinics. The greatest congruence would be New Day adopting TSF for its Phase 1 curriculum; the clinic's 10-session 90-minute curriculum would lend itself well to the 10-session 60-minute TSF protocol, especially in light of budgeting for additional time for group processing. In similar manner, the 12-session CBT curriculum could be adopted into the clinic's Phase 2 or 3, just as a dialectical behavior therapy curriculum was in the process of being integrated into these two phases at the time of data collection. The 90-minute standard outpatient groups for Recovery Services could conceivably have similar adopted use. Structural adaptations are not insurmountable, but they would involve considerable adaptation from the treatment manuals and likely ongoing difficulties. This is especially the case for groups that need to be less than an hour; respondents from SUD Intensive Clinic reported that adaptation of EBTs into 50-minute groups was a Herculean task, in terms of feeling rushed to cover needed material, assign and review homework assignments, and facilitate discussion in light of clients' needs.

Intended as standalone interventions. Additional programmatic complexities for EBT use in open groups would remain for clinics' intensive outpatient group programming (i.e., all of

SUD Intensive Clinic's and a portion of Recovery Services' group programming). Although SUD Intensive Clinic incorporated all three EBTs, among others, into their programming—consistent with the clinic's desire to provide a range of perspectives—the use of multiple EBTs raises several questions: Will clients be overwhelmed by or confused about the differing approaches and their associated assignments and tasks? Should homework be assigned differently, or should clients simply do homework assignments as manualized for each group type? Will the assumptions and therapeutic styles of certain treatments (e.g., MET vs. TSF) clash or even be contradictory? In each case, the inevitable process would differ considerably from the conditions in which the EBTs were originally evaluated (i.e., clients receiving one EBT at a time). Concerning Recovery Services' intensive outpatient groups, it is unclear how the three EBTs might be utilized into the clinic's structure of one psychoeducational and one open-ended process group each day. The psychoeducational group could potentially incorporate principles from each EBT (especially TSF); however, psychoeducation is only a portion of each EBT. None of the three EBTs would seem to mesh well with an open-ended process group, though process groups could certainly be adjunctive to EBT groups.

Designed without consideration of group therapy principles. Finally, a deeper complexity is whether the three EBTs—or virtually any well-established EBT for SUDs—are even in principle the best fit for group therapy. Because the three EBTs were designed for use with individual clients, they do not incorporate unique group processes and mechanisms of change, such as group cohesion and interpersonal learning (see American Group Psychotherapy Association, 2007; Wenzel et al., 2012; Yalom & Leszcz, 2005). Thus, the simplest group adaptation of these EBTs would be to simply use groups as a vehicle for treatment delivery en masse, rather than for the group itself to be an essential ingredient of the treatment. The problem

here is that the latter approach would seem to be quite important for each clinic, in that the most commonly cited reasons for utilizing extensive group therapy was—in addition to financial considerations—to facilitate peer support and group accountability. The "vehicle" approach appears to be the outcome of SUD Intensive Clinic's implementation of the EBTs, although not without clinicians' concerns that there was not enough time for exploring group processes or facilitating peer support. Moreover, Recovery Services' resistance to manualized therapies was motivated at least in part by concerns about this approach dampening peer support and process groups in which the group is conceptualized as a central rather than peripheral treatment component. Although a synergy between these two approaches to group therapy could almost certainly be reached, this outcome is rarely achieved in SUD treatment settings and published information or treatment protocols for such are scarce (for exceptions, see Donovan et al., 2013; Sobell & Sobell, 2011; Wenzel et al., 2012).

Conclusions and Recommendations

As discussed above, organizational challenges for integrating EBTs into the three clinics are considerable, in spite of a theoretical compatibility with at least one EBT for each clinic. These challenges generally centered on the predominance of open groups at each clinic. Considerable adaptations would be (or were) necessary to utilize EBTs in group format, especially for open groups. These adaptations would not be cosmetic and there is a general lack of resources to aid in this endeavor. Even for SUD Intensive Clinic, which attempted to implement a highly structured manualized group curriculum from EBTs, many difficulties and compromises remained in terms of balancing individual and group care. Furthermore, deeper questions remain about the function that group therapy—as a distinctive modality—ought to serve in relation to established EBTs tested for individual clients.

Although the case-based nature of this study of course is limited in its generalizability, these clinics are diverse in multiple respects and their shared characteristics are quite similar to most other SUD specialty clinics, as discussed above. If anything, these clinics—especially New Day and SUD Intensive Clinic—are exemplary in their attempts to integrate research and practice. The inclusion of SUD Intensive Clinic, in particular, highlights complexities with this endeavor even for a SUD specialty clinic with a high commitment to EBT utilization. Thus, generalizability limitations notwithstanding, several lessons may be applicable to other SUD specialty clinics, as well as to clinical researchers. In the spirit of attempting to narrow the research-practice gap, I conclude with brief recommendations for researchers and clinicians.

The general recommendation for researchers is to make greater efforts in collaborating with real-world clinics, in terms of sizing up "where clinics are at." The major lesson here is the predominance of group therapy, especially open groups. Based on a recent survey (see Chapter II), open-enrolling group therapy is the predominant form of treatment delivery in SUD treatment settings. Therefore, a strong case can be made that the current state of affairs—adapting EBTs designed for individuals into group settings—is in fact backwards, and that a more ecological approach would prioritize the design and testing of open group therapies that then could be adapted into other formats as needed. Of course, this approach has logistical and methodological challenges, but it is time for these challenges to be reckoned with and met by the clinical research community and their funders. On the other hand, these complexities may suggest that testing and implementing brief discrete treatments is not the best fit for SUD specialty programs, anyway. An alternative approach is more emphasis on measuring and documenting best practices for whole organizations, with an emphasis on group therapy facilitation and provision of individualized care and case management, with the assumption of

addiction being a chronic frequently relapsing condition rather than an acute problem. Researchers could be tremendously helpful by working with clinics and clinicians to adapt existing EBTs and best practices in a manner in which they could be more flexibly utilized and widely available, and with greater attention to group therapy as a distinctive modality. In particular, researchers might develop and make more widely accessible EBTs that can be flexibly utilized in open groups. Although limited, some researchers have published SUD group therapy protocols in which they aim to balance flexibility, group therapy principles, and evidence-based principles (e.g., Donovan et al., 2013; Sobell & Sobell, 2011; Wenzel et al., 2012).

For clinicians, greater attention can be given to principles of group therapy facilitation, with the recognition that individual therapy training or experience does not automatically translate to group therapy facilitation. For the three clinics in this study, it was common for clinicians to have minimal if any group therapy training in graduate school, as well as for them to be expected to know how to facilitate groups with minimal on-the-job observation and training (see Chapter IV for more information). In order to avoid simply using groups as vehicles to deliver content, clinics would benefit from basing clinicians' readiness for group therapy on their competency with facilitating group *process* (American Group Psychotherapy Association, 2007). Experience with group process might be enhanced through discussion or, better yet, practice during clinical meetings and/or between co-facilitators. An obstacle, of course, is time, considering that many clinicians are already burdened with their caseloads; it is worth stressing, nonetheless, that quality group therapy ought to require considerably more time for preparation, practice, documentation, and debriefing than does individual therapy. Another consideration in this regard is for clinicians to intentionally facilitate groups with greater interaction and skills training, rather than merely psychoeducational approaches (see Chapter IV). Finally, greater

attention for balancing the needs of individuals with those of groups would be important, and a requirement for more successful integration of EBTs in group format (e.g., in providing individualized assignments and feedback). Where possible, clinics are recommended to adapt therapy structures (e.g., length and duration of groups) so that EBT principles can be utilized while at the same time providing adequate attention to group processes and unpredictable individual needs. In this regard, clinicians might benefit from consulting treatment manuals that have been adapted for use with open groups (e.g., Donovan et al., 2013; Wenzel et al., 2012).

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Tables

III.1: Clinician Characteristics

Characteristic	New Day				Recovery Services				SUD Intensive Clinic				Total			
	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*
Gender																
Women	67	4			50	2			100	3			69	9		
Men	33	2			50	2			0	0			31	4		
Age			35.8	3.8			51.3	8.3			26.7	1.5			38.5	10.8
Race/ethnicity																
White (non-Hispanic)	83	5			75	3			67	2			77	10		
Black	17	1			25	1			0	0			15	2		
Asian American	0	0			0	0			33	1			8	1		
Highest degree																
Master's	83	5			100	4			100	3			92	12		
Associate's	17	1			0	0			0	0			8	1		
Has been in recovery																
No	50	3			75	3			100	3			69	9		
Yes	50	3			25	1			0	0			31	4		
Profession																
Social worker	50	3			100	4			100	3			77	10		
Addiction counselor/therapist	33	2			0	0			0	0			15	2		
Recovery support specialist	17	1			0	0			0	0			8	1		
Yrs. treating substance use disorders			3.7	4.6			23.0	14.8			3.0	1.7			9.5	12.3

Note: Based on survey completed by each clinician participant. Respondents were allowed to indicate only one response per item.

III.2: Clinic Characteristics

Characteristic	New Day	Recovery Services	SUD Intensive Clinic
Operational structure			
Parent organization	Private non-profit community substance use disorder (SUD) treatment facility	State medical school	VA medical center
Funding	Government contracts Donations Sliding-scale out-of-pocket pay	Private health insurance reimbursement	Federal budget
Mission	Assist clients to connect with recovery community (e.g., AA)	Provide medically-supervised care for addictions and comorbid psychiatric problems	Provide acute medically-supervised stabilization for moderate to severe SUDs
Treatment philosophy			
Abstinence agenda?	Yes	Primarily (harm-reduction individual therapy occasionally provided)	Yes
Treatment orientation	Twelve-step	Eclectic	Cognitive behavioral; motivational interviewing
Clinical staff			
Clinical director	Social worker	Psychiatrist	Clinical psychologist
Clinical staff professions	Social workers Addiction counselors Recovery support specialist	Psychiatrists Social workers Nurses	Psychiatrists Clinical psychologist Social workers Nurse
Client characteristics (adults)			
Sex	Est. 60-70% men	Est. 60-70% men	Est. 90-95% men
Race/ethnicity	Est. 70% non-Hispanic White	Est. 90-95% non-Hispanic White	Est. 65% non-Hispanic White Est. 20-25% Black

Primary substance problems	48% alcohol 25% opiates/heroin 15% marijuana	Est. 67% alcohol Est. 25% opiates/heroin	Est. 40-60% alcohol Est. 30-40% cocaine Est. 20% opiates/heroin
Other	54% court-ordered	Est. 50% with comorbid psychiatric disorders	U.S. military veterans (all)
Overview of services	Individual assessment Group therapy Housing available off-site	Individual assessment Individual psychotherapy Group therapy Medical/psychiatry services	Individual assessment Individual case management Group therapy Medical/psychiatry services Housing available off-site
Group therapy curriculum (adults)			
Intensive outpatient	N/A	Five-week program (3 hr. daily)	Four-week program (3-4 hrs. three times weekly)
Standard outpatient (weekly)	Four 10 wk. phases	Several weekly outpatient groups of flexible duration; several specialty groups offered	N/A
Type of groups	Psychoeducational Skills training Process	Psychoeducational Process Specialty	Psychoeducational Skills training
Session length	90 min.	60-90 min.	50 min.
Open groups	100%	100%	100%
Use of individual services	Ad hoc individual visits	Individual therapy available; not intensively coordinated with group sessions	Individual case management for all clients; not intensively coordinated with group sessions
Client progress and flow	Est. 50% did not progress past first phase; retention much higher in remaining phases	Est. 60-80% initially enrolled in intensive program; est. 60% completion rate of intensive program; est. 30% continued on to weekly outpatient group	Est. 70-75% completed program

Approach to evidence-based practice			
Overall approach	Evidence-informed; focus on common factors	Evidence-informed; focus on common factors	Manualized evidence-based treatments
Clinician perspectives	Open to utilizing evidence-based treatments, if sufficient flexibility	Generally opposed to utilizing evidence-based treatments	Supportive of evidence-based treatments; difficulty balancing fidelity and flexibility

Note: Information is based on qualitative analysis of interviews with clinical directors and clinicians from each clinic.

CHAPTER IV

"Meeting Clients Where They Are At":

The Challenge of Evidence-Based Group Therapy for Substance Use Disorders

Abstract

Although there has been a tremendous increase in the study and utilization of evidence-based treatments (EBTs) for substance use disorders (SUDs), EBTs often are not used in treatment settings or lag years behind in their uptake. One underappreciated dimension of this research-practice gap is a mismatch in treatment modality: Whereas clinical trial and EBT implementation research has focused nearly exclusively on individual therapy, a large majority of SUD treatment is in group format, with open groups being most common. This study aims to narrow this research-practice gap by exploring how clinicians facilitate group therapy. Data consist of semi-structured interviews and surveys with 13 group clinicians from among three outpatient SUD specialty clinics—diverse in their operational structures, missions, clientele, and services—located in the same Midwestern U.S. metropolitan area. Interview questions addressed organizational characteristics, services provided, group therapy curricula, and use of EBTs or other structured treatments. Results provide a glimpse into treatment-as-usual for SUD specialty treatment, as well as highlight significant challenges for group therapy facilitation, including difficulties for adoption and use of EBTs. Clinicians emphasized the importance of providing individualized and engaging treatment, necessitating considerable flexibility in treatment

delivery in groups. However, they also evidenced serious challenges with group therapy facilitation, due to factors that are likely endemic to any attempt at group therapy (complex, unpredictable group dynamics) as well as challenges that pertain to organizational deficits and barriers (e.g., clinicians with inadequate group therapy experience, limited quality control efforts, the predominance of psychoeducation, and limited attention to clients' demographic diversity). These results are discussed in terms of specific strategies for improved innovation and implementation of EBTs for SUD group therapy.

Introduction

The past 15 years has seen a tremendous increase in the study and utilization of evidence-based treatments (EBTs) for substance use disorders (SUDs; Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Miller, Sorensen, Selzer, & Brigham, 2006). Several specific and relatively brief EBTs have been developed and vetted through replicated randomized clinical trials. In spite of these developments, however, a significant and deeply entrenched gap remains between scientific research and everyday practice (Glasner-Edwards & Rawson, 2010; Manuel, Hagedorn, & Finney, 2011). EBTs often are not utilized in treatment settings or lag years behind in their uptake, resulting in clients receiving compromised or potentially harmful care (Carroll & Rounsaville, 2007; Manuel et al., 2011). Several reasons have been identified for this gap, including organizational barriers and constraints (Carroll et al., 2011; Carroll & Rounsaville, 2007); the complexity of providing comprehensive recovery-oriented services for a chronic frequently-relapsing condition (Lash, Timko, Curran, McKay, & Burden, 2011; Wells, Saxon, Calsyn, Jackson, & Donovan, 2010); the difficulty of balancing treatment fidelity with individualized care (Aarons, Miller, Green, Perrott, & Bradway, 2012; Lundgren, Amodeo, Cohen, Chassler, & Horowitz, 2011); pessimistic beliefs or ambivalent attitudes among

clinicians about EBTs (Knudsen, Ducharme, & Roman, 2007; Manuel et al., 2011); and limited evidence linking EBT adherence with improved outcomes in real-world treatment settings (Carroll & Rounsaville, 2007; Wells et al., 2010).

One underappreciated dimension of this research-practice gap—likely cutting across each of the aforementioned obstacles—is a mismatch in treatment modality: Whereas clinical trial and EBT implementation research has focused nearly exclusively on individual therapy, a large majority of real-world SUD treatment is in group format. According to previous surveys, group therapy is offered by over 90% of SUD treatment facilities (Crits-Christoph, Johnson, Connolly Gibbons, & Gallop, 2013; Weiss, Jaffee, de Menil, & Cogley, 2004) and for many facilities it is the overwhelming focus (Fletcher, 2013). Group therapy may consist of psychoeducational presentations, recovery skills training, interpersonal process groups, "check in" groups, and specialty topic groups (e.g., anger management; Center for Substance Abuse Treatment, 2005; Weiss et al., 2004). In addition to financial considerations, the dominance of group therapy is reflective of the massive infrastructure of mutual support groups (e.g., Alcoholics Anonymous; AA) and the historically dominant "Minnesota model" of SUD treatment (an approach that originated in Minnesota residential programs, characterized by group-based didactic education and milieu support based on a disease model of addiction and twelve-step principles; Fletcher, 2013, pp. 70-71).

In addition to these considerations, there is a consensus among SUD treatment professionals about certain benefits of group therapy (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012). These benefits include providing positive peer support from others with similar problems, reducing stigma, fostering greater

accountability, providing corrective feedback about interpersonal problems, and instilling hope through seeing the successes of others (see also Yalom & Leszcz, 2005). A meta-analysis of 24 studies suggested that group therapy is generally equally effective as individual therapy for SUD treatment (Weiss et al., 2004; see also Sobell & Sobell, 2011).

In spite of the high prevalence of and rationale for group therapy for SUDs, research efforts have focused predominantly on individual therapy. This focus is evidenced in clinical trial efficacy and effectiveness research, reflecting the individual nature of most medical treatment—in which the clinical trials research paradigm originated—as well as difficulties in ensuring control in conditions with interdependent group members (see Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004). Moreover, the distinction between individual and group therapy is rarely discussed in much depth in the EBT implementation literature for SUDs. This treatment modality gap is significant, in that individual therapies do not translate easily into group format. Greater flexibility and skill is typically required of clinicians, due to groups being more unpredictable as a function of consisting of several clients. Skilled group clinicians do not provide serial individual therapy segments, but rather facilitate group dynamics and processes with constant negotiation between the good of the group and the good of its individual members. Because of this individual-group tension, skills required for quality group facilitation are not obviously transferable from individual service delivery. These skills include building group cohesion among group members, managing confrontation and conflict between members, redirecting clients who monopolize group discussion or stray off topic, managing unhelpful advice given from one member to another, encouraging participation from quiet members, and eliciting client participation rather than lecturing (American Group Psychotherapy Association,

2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel et al., 2012; Yalom & Leszcz, 2005).

In addition, significant particularities of many types of SUD group therapy further complicate group facilitation. Perhaps most notably, open groups—for which clients initiate and terminate from treatment on an open-enrolling basis, and therefore sessions cannot substantively build on each other conceptually—are very common and likely the norm in SUD treatment facilities (Morgan-Lopez & Fals-Stewart, 2008). In a recent national survey of group therapy SUD clinicians, 69% reported that all of their facilitated groups were open groups, with only 10% reporting that none of their groups were open (see Chapter II). Unfortunately, open groups are almost never studied in clinical trials, due to formidable difficulties involved in controlling for equivalent group comparisons and in analyzing data (Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004). (An exception is a recent twelve-step facilitation clinical trial for stimulant addiction that utilized open groups; Donovan et al., 2013). Furthermore, there is little if any published guidance for adapting EBTs for open groups—again highlighting an enormous gap between research and practice.

What should be done about this treatment modality mismatch between research and clinical contexts? Some may believe that the burden is on clinicians to adapt EBTs into group formats. However, this adaptation would likely be a daunting task, especially in light of limited resources and training for doing so. At any rate, remarkably little research exists concerning what SUD clinicians actually do in group therapy, and thus the extent to which a treatment modality gap is a formidable barrier in EBT implementation is unknown, at least among researchers. A first step, then, would be to explore what real-world SUD clinicians do in terms of group therapy facilitation. How do they balance structure (including use of treatment manuals) with group

process? What practices are most likely to be used? How are open groups managed, in terms of delivering content that cannot build on itself conceptually? These and other related questions relative to group therapy facilitation are the focus of this study. This exploration may be helpful in bridging the gap between research and practice, by informing researchers about clinical complexities that often are neglected in SUD treatment research.

Method

Settings

This study consists of interviews with 13 clinicians from three SUD specialty outpatient clinics located in the same metropolitan area in the Midwestern U.S. Participating clinics were selected on the basis of being among the largest and most visible outpatient SUD treatment facilities in the metropolitan area. Two other clinics were recruited; one declined participation (due to being in the midst of a major overhaul of its programming) and the other was not selected because of costly and lengthy internal institutional review requirements for interviewing its staff. The three participating clinics collectively showcased a diversity of characteristics, in terms of treatment philosophy, interventions offered, types of clientele, and funding sources. Clinics are identified here by pseudonyms. The first clinic, New Day, was part of a large non-profit SUD treatment organization, with a strong focus on twelve-step principles and community reintegration. The second clinic, Recovery Services, was operated by a state medical school, and included an intensive outpatient track and a standard outpatient track. The third clinic, SUD Intensive Clinic, was an intensive outpatient clinic operating within a Veterans Affairs (VA) medical center. Although each clinic operated within organizations that offered a range of SUD services (including residential programs, housing, and detoxification), this study is limited in scope to the specialty adult outpatient services of the specific clinics.

All three clinics provided extensive group therapy programming, all of which was in open-enrolling format. First, New Day had four progressive 10-week "phases" of group programming, designed in terms of client motivation and readiness for change; each phase was 10 weeks long and consisted of 90-minute weekly sessions. Second, Recovery Services had a five-week intensive outpatient program as well as standard weekly outpatient groups. Intensive outpatient groups met three times weekly for three hours of group therapy (half process-oriented and half psychoeducational) each day; standard outpatient group sessions lasted 90 minutes and these groups did not have a fixed duration for a given client. Third, SUD Intensive Clinic had a four-week intensive outpatient curriculum, in which clients met three times weekly for 3-4 50-minute sessions of group therapy; the curriculum consisted of 40 unique sessions, each of which was manualized and adapted from EBT protocols—with a focus on cognitive behavioral therapy (CBT) and motivational enhancement therapy. The three clinics and their group therapy curricula are described in more detail elsewhere (see Chapter III).

Participants

Clinicians from each of the three clinics were recruited to participate. Inclusion criteria included being a full- or part-time licensed provider who has facilitated group psychosocial outpatient therapy for SUDs in the past two years; physicians and non-licensed trainees were excluded, in order to ensure that reported experiences were from clinicians fully trained to provide psychosocial therapies. All eligible clinicians from the three clinics were recruited, and six from New Day (100%), four from Recovery Services (57%), and three from SUD Intensive Clinic (100%) participated (81% total participation rate). Characteristics of participants are summarized in Table IV.1. The sample was diverse in gender (67% women), age (range from 25-65 years; mean of 39 years), years providing SUD services (range from 1-45 years; mean of 10

years), and personal recovery status (31% endorsed). The sample was more homogeneous in terms of race/ethnicity (83% non-Hispanic Whites), profession (77% social workers), and highest degree (83% Master's degree).

Measure

The primary measure consisted of a semi-structured interview (1.5-2 hours) with each participant, completed between October 2013 and June 2014. Participants were asked about their clinic's mission, treatment philosophy, and goals; its strengths and weaknesses; its group therapy curriculum; and its approach to EBT and manualized therapies. Participants also were asked about their SUD treatment background and experience; details about a specific group they have facilitated recently; their approaches to SUD treatment; and their attitudes and beliefs about evidence-based practice. (See Appendix C for interview guide, which was pilot tested with a social work trainee.) Demographic information also was provided by participants (as reported in Table IV.1).

Procedure

After full review, this study was designated as exempt from oversight by the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board. Clinical directors of the three clinics were contacted, and each director agreed for clinicians to be recruited. Recruitment consisted of visiting staff meetings and/or email solicitations; clinicians were free to decline participation without knowledge of or reprisal from their employers. Participants were interviewed privately by me, either on site at their respective clinics or at a university office. In most cases, interviews were completed in one visit; for two of the participants, interview completion required two visits. Participants were reimbursed at a rate of $30 per hour for the interview, and $15 for completing the survey.

Interviews were audio recorded and transcribed verbatim according to conventional transcription standards. Transcripts were analyzed using conventional thematic content analysis. This analysis is a constructive, iterative, and interpretive process of categorizing codes and shared themes qualitatively (Braun & Clarke, 2006; Hsieh & Shannon, 2005). Major steps of this kind of analysis include (a) broad familiarity with the entire corpus of data, including reading and re-reading transcripts while noting initial impressions, (b) systematic generation of initial codes, (c) tentative identification of major themes and organization of codes into these themes, and (d) an iterative process of reviewing, restructuring, and refining codes and themes (see Braun & Clarke, 2006). Data saturation was repeatedly assessed throughout this process and was generally reached for the major themes reported in this article. The results reported in this article are drawn from a portion of the coded and analyzed material (i.e., the portion coded as pertaining to group therapy facilitation).

As is often the case with qualitative research, the time-intensive nature of this project and the length of interviews prohibited the use of additional raters or returning transcripts or findings to participants (neither of which is a requirement of content analysis; Braun & Clarke, 2006). However, several processes were used to ensure rigor of analysis. First, coding of interviews were content-based for straightforward responses, thereby minimizing the need for inter-rater triangulation efforts. Second, intra-rater consistency of coding was facilitated through the use of NVivo qualitative data analysis software (version 10), used to code textual material and interpret hierarchical relationships between identified themes. Third, I adhered to a 15-point checklist for content analysis (see Braun & Clarke, 2006), including guidelines such as, “Themes have been checked against each other and back to the original data set,” and, “All relevant extracts for each theme have been collated” (p. 96). Finally, I adhered to a 32-item checklist for reporting

information from qualitative studies. This checklist is called the consolidated criteria for reporting qualitative research (COREQ) and includes commonly reported aspects of published qualitative studies (e.g., researcher characteristics, relationship with participants, theoretical framework, participant selection, setting, data collection, data analysis, and reporting; Tong, Sainsbury, & Craig, 2007); all relevant items from the checklist are reported in this article.

Researcher Characteristics and Relationship with Participants

Finally, as is customary with qualitative research reporting, some information about my own experience/training, perspective, and relationship with participants is warranted. I have had extensive coursework and training in qualitative research, including having conducted and published an interview-based study utilizing conventional thematic content analysis (Wendt & Gone, 2012). I have long had an academic interest in EBT implementation considerations, and my interest for conducting this study was motivated in part by my clinical training working as a SUD group facilitator, in which I first became aware of the magnitude of the treatment modality mismatch between research and practice (discussed above). My research and clinical experience have led me to characterize myself as a “middle man” between researchers and clinicians, with the belief that a balance between top-down and bottom-up processes is necessary for sustainable EBT implementation. This personal background, along with my guiding assumptions, was communicated to each participant at the time of recruitment and/or prior to each interview. Prospective participants also were informed that the study was part of my doctoral dissertation, and that the study was intended to bridge the gap between researchers and clinicians through portraying real-world complexities with group therapy facilitation. Respondents seemed to enjoy participating in the study and providing their unique perspectives, based on their engagement and direct feedback.

In terms of my relationships with participants, it should be noted that prior to data collection I received one year of clinical training at SUD Intensive Clinic. As a result, I had a previous relationship with the clinical director and each of the clinic's participants. My training experiences are not utilized as data for this study, but they cannot possibly be divorced from my conceptualization of the clinic. Although this experience may raise concerns about bias, it should be stressed that this study is not a program evaluation, nor is it a comparison between the three clinics. Moreover, my involvement with the clinic should not be construed as an endorsement.

Results

The following results include a presentation of major interpretive themes as a result of systematic coding and thematic content analysis of qualitative data. Selected vignettes have been included throughout, in order to provide greater validity for data interpretation as well as to articulate themes in richer detail and in participants' own words. Care was taken to provide vignettes that are most exemplary and illustrative of the presented themes, while also being balanced among the three clinics and 13 participants. Participants are identified by pseudonyms, along with their respective clinics (with abbreviations ND for New Day, RS for Recovery Services, and SUDIC for SUD Intensive Clinic). Results are divided into four major categories: the importance of individualized treatment, the necessity of flexibility for group facilitation, group dynamic complexities, and clinician and organizational challenges and barriers. This article is limited to themes that cut across the three clinics; clinic-specific considerations are reported and discussed elsewhere (see Chapter III).

Importance of Individualized Treatment

As described in this first set of themes, clinicians emphasized the importance of providing individualized treatment. This emphasis included a general concern with providing

individualized care, views about how group therapy uniquely facilitates this care, and the importance of facilitating client engagement in groups. (See Figure IV.1 for a concept map depicting the relationship between these themes.)

"Meeting Clients Where They Are At"

A predominant theme from the interviews, reflected by all clinicians, was the importance of providing individualized care, with the recognition that clients differ greatly and no one-size-fits-all treatment approach exists. This theme was frequently expressed by reference to "meeting clients where they are at." In fact, a variation of this phrase was used (often repeatedly) by 10 of the 13 participants. This "meeting" of clients typically referred to the importance of recognizing varying stages in readiness to change, differing levels of motivation, and varying treatment goals, as exemplified in these vignettes from each clinic:

> It all depends on meeting the person where they are at: What abstinence means, what the idea of recovery means to them, the idea of spirituality. (Taylor, ND)
>
> We try to deliver to individuals depending on where they are in their process of treatment. (Brett, RS)
>
> We try to just meet people where they are at. And we are very mindful of the stages of change. We talk about that constantly as a team. (Becky, SUDIC)

To be sure, the bounds of this "meeting" were limited, especially in light of the clinics' agendas of promoting abstinence, as expressed by one clinician:

> I think that the mission and the purpose [of the clinic] is to meet people where they are at. You know, while working towards a goal of abstinence. (Becky, SUDIC)

Nonetheless, clinicians endorsed the importance of playing a lighter hand with "meeting" clients who were not committed to abstinence, with most clinicians endorsing the use of motivational interviewing principles such as empathy and promoting client autonomy.

> All the therapists here, we do a really good job of meeting clients where they are. So even if a person comes in and doesn't want to stop drinking, we can empathize with them. . . . "Hey, we get that you don't want to stop drinking, right?" (Lina, ND)
>
> We can do motivational interviewing. We can work with them. We are open to meeting them where they are at. . . . If there is an ambivalence, if they are just like, "No, I don't want treatment," that is their choice, too. (Karlie, SUDIC)

Underscoring each of these statements is the recognition of tailoring treatment to unique individuals, rather than imposing a unitary standard on all clients.

Unique Benefits of Group Therapy in Facilitating Individualized Care

Given this emphasis on individualized care, it may seem inconsistent that the predominant treatment modality—by far—for the three clinics was group therapy, as discussed above (see "Settings" sub-section in Method section). Although clinicians acknowledged the role of cost-effectiveness and efficiency in their clinics' widespread use of group therapy, they universally extolled the therapeutic benefits of group therapy for each client, especially in terms of mutual positive peer support that groups uniquely provide.

> It is usually being reported that [group therapy] was a very good experience and very encouraging and motivating—something that people don't often say when they leave individual therapy, at least in my experience. Because of the peer relationships. (Rosemary, RS)
>
> With you as my [individual] client, I can build a certain kind of rapport with you . . . that

> maybe you want to show up to appointments because you feel like you could get something out of it, and I am helpful to you as clinician. That is different than, "I said I was going to give John a ride to wherever on Thursday after group." Or, "Man, you know, Tom was having a really bad day. I wonder if he got through that thing with his wife." I'm invested in those relationships . . . *and* we are in the same place and we "get it." And there is something about that mutual support. (Becky, SUDIC)

As reflected in the above vignettes, clinicians contrasted the more expansive role of mutual peer support from the more limited and less community-engaged support available through a professional. This mutual peer support was also cited as reducing stigma due to exposure to others with similar problems, or instilling hope from clients witnessing others' successes.

> One of the benefits of regularly being in groups is . . . to know that you are not in this alone. And it is seeing people struggle in the same way that you have struggled, hearing their stories, getting strategies. (Brett, RS)

> Even when [clients] don't have a lot of self-efficacy, [they] can be like, "Well, if Joe over there is doing it—and Joe is kind of an idiot—then I can probably do it too," you know? (Riley, ND)

Peer support also was reported to provide a broader sense of accountability to individual recovery, which was seen as particularly important to SUD clients.

> When people are living in an addiction, they are living the way that they want, how they want, regardless of how it affects other people, often. And they really have lost the ability to engage in healthy relationships. And they have lost the ability to be accountable. . . . Group therapy offers accountability. . . . And it is accountability with other people. It is accountability to their peers. (Becky, SUDIC)

This peer accountability was seen as extending to outside the therapy room as well.

> We don't see and hear everything that goes on in their lives. *They* see and they hear and they communicate with each other all the time. So if we have got a person that is working a really strong recovery program, and there is another [client] that is really struggling—they might be going out smoking pot on the weekends—and they happened to see each other. . . . The other person could decide that they want to step up and help them and say, "Hey dude, I saw you smoking on the weekend. Let's talk about it. What's going on?" So the group process really helps develop that. (Maddy, ND)

Finally, mutual peer support was viewed by participants as providing opportunities for building interpersonal skills or social learning.

> A therapist is not like a real person. . . . It's really with their peers and stuff. If they can really do it there, then they've faced it for sure. . . . It's designed to be like a social laboratory. . . . At least some of the same things that they would have out in the real world they're going to experience in group. The same fears, hesitations, hang-ups, defenses, all that kind of stuff. So it gives them a chance to change it. (Lane, RS)

Overall, clinicians' comments about mutual peer support implied a belief that group therapy enhances rather than diminishes the ability for clients' individual needs to be met, in terms of providing care that is more expansive, relevant, and personable.

Role of Client Engagement in Groups

A major indicator—discussed explicitly by 11 respondents—of whether groups adequately met individual clients' needs was the extent to which clients were thoroughly "engaged" in group sessions. Clinicians' appraisals of effective vs. ineffective group sessions hinged predominantly on whether clients were perceived to be adequately engaged. These

appraisals were especially made near the end of group sessions, in terms of whether clients appeared to be excited about what they experienced or learned.

> My determination of success is participation, activity, and engagement. . . . We think that the sign of success is we have done less of the participation. They have actually generated the ideas. They are flowing with the group. And they come out with, "Yeah, this is what I am going to do. This is how I am going to apply it." (Brett, RS)
>
> At least half the group will say, "Oh my God, I learned so much! I had so much fun learning tonight!" You know, it's like—you ever walk out of class in school and just feel like, "Wow that was really amazing, that was powerful! I learned so much!" and you're excited about knowledge again? (Taylor, ND)

In contrast, participants' negative appraisals of groups hinged on clients being disengaged, either through their eyes "glazing over" or their being eager for the session to end.

> You can tell when you are losing them. And when their eyes are glazing over. And so, if I feel like they are. . . engaging in conversation about the material, that feels like a really good session. . . . If it is crickets, that is always hard for me to deal with. (Karlie, SUDIC)
>
> If I have had an unsuccessful group, I mean, it is really evident. People are looking at the clock constantly. They are writing their feedback sheets as soon as they are halfway through the group, so they are already kind of evaluating the group like it is over. . . . People are getting a flatter affect. . . . I know I am not connecting with them, or they are not connecting with each other. (Riley, ND)

In fact, the concern for disengaged clients prompted at least one group at New Day to provide coloring pages and crayons to keep clients' minds occupied.

Necessity of Flexibility for Group Facilitation

In order to provide individualized and engaging care, clinicians universally expressed the necessity of being flexible in their group therapy facilitation. In certain ways, this flexibility was embedded into clinics' existing group programming; in other ways, clinicians needed to make adaptations and accommodations based on individual and group needs. Clinicians also discussed problems with the inflexibility of some manualized/structured therapies in the context of group therapy. (See Figure IV.2 for a concept map depicting the relationship between themes pertaining to flexible group facilitation.)

Flexibility Embedded Into Existing Group Therapy Structure and Processes

The importance of flexible group facilitation, in the service of meeting clients where they are at, was evident from clinicians stressing the importance of incorporating multiple topics and activities, in order to reach the most individuals.

> I . . . just try to use different resources. Not just one thing, and this is the only perspective. . . . I don't think any one thing is going to work 100% for 100% of people. . . . There needs to be a plethora—not an overabundance, but just enough that they can find what works for them and just incorporate what they feel like is helpful. (Alex, ND)
>
> I do believe that [clients] are the world's best expert on themselves. They'll figure out a way and say, "This will work," or "This won't work." And it has to be up to them. How can I say, "Well, you have to do it this particular way"? I find that ludicrous, at best. So I'm going to try to use whatever I think might work. (Lane, RS)
>
> I guess it just comes to my beliefs in learning—that maybe something is not going to resonate for another person. . . . Especially like the acceptance-based therapies, I think are harder sometimes for maybe lower functioning people to grasp, whereas the CBT is definitely something that they can understand easier. So sort of the [client] then is able to

glean, “OK, this isn’t my favorite group but I get something from another one.” (Meagan, SUDIC)

As reflected in the above vignettes, clinicians and their clinics balanced group therapy with individualized attention by attempting to provide multiple approaches, allowing individual clients to “glean” from the various approaches and “find what works for them.”

This flexibility was evident in participants’ commonly reported group therapy processes and activities. These included a range of processes across clinics, including psychoeducational topics and lectures, skills training, experiential activities, group discussions, and homework assignments. In addition, for New Day and Recovery Services, flexibility was integrated into group structure through brief “check-in” periods at the beginning of each session, in which each client would briefly report their emotional state and recent relapses, cravings, stressors, and/or victories. These “check in” periods, reported by all 10 clinicians for New Day and Recovery Services, would last from a few minutes to 15-20 minutes of a 90-minute group. In like manner, a common practice (reported by seven clinicians) was individualized planning at the end of groups, in which clients would briefly discuss their goals and activities from now until the next session; these plans were reported to be especially important prior to weekends and holidays.

Flexible, individualized treatment also was discussed through various ways in which one-on-one encounters with clients intersected with group therapy. The most frequently reported intersection was ad-hoc one-on-one conversations (usually immediately after sessions), when clients expressed individualized needs that were determined by the clinician to be inappropriate or difficult to address in group format. These ad-hoc conversations were reported across clinics (by eight clinicians) but were especially prevalent for New Day. Recovery Services provided individual therapy for certain clients, especially for clients with more severe addiction or

comorbid psychiatric disorders; however, individual and group therapy were not typically integrated or coordinated in a formal way. SUD Intensive Clinic utilized individual case management for each client, and clinicians sometimes attempted to integrate case management with group therapy (e.g., by discussing homework assigned in groups).

Flexibility also was built into groups in order to address complexities for open groups (the only type of group offered by each clinic), in light of group membership continually changing. The major difficulty in this regard was the inability for content to build on itself conceptually:

> The thing with rolling admissions is, obviously, you are having people coming in all stages, so, unfortunately, we cannot have the kind of groups that the knowledge would build on itself, which puts us in a weird place. (Karlie, SUDIC)

This complexity was typically addressed by clinicians briefly reviewing with clients what happened in previous sessions, often with the assistance of returning clients.

> Even if they miss part one last week . . . we are going to review part one. "OK, what did we talk about last week? What is distress tolerance? What was the skill?" And the group can then share with the newcomer what it is. Which helps them learn it better, too. (Kris, ND)

SUD Intensive Clinic's manualized protocol allowed for this process in the most systematic way, in terms of each session being adapted to stand on its own, with the first 5 minutes (of 50-minute sessions) being devoted to briefly summarizing the therapy's theoretical model (e.g., by briefly reviewing at the start of CBT sessions the interdependent roles of thoughts, feelings, behavior, and environment). In addition, a practice reported across clinics was having each group member introduce themselves when new members were in attendance.

Flexibility Emphasized for Using Manualized Therapies

Importantly, client engagement was discussed extensively in terms of limitations of manualized or more structured therapies in the context of group therapy. Most clinicians stressed the importance of finding a "middle ground" between standardization and individualized care.

> Meeting people where they are at and meeting the needs of the group, I think, sometimes is compromised by doing manualized [therapy]. . . . There is a middle ground between being some fluffy therapist who just does everything by their gut and being a hardened, manualized, "You have to stick to the manual." (Becky, SUDIC)
>
> I think there has got to be some room for personalities. . . . Structure is really good, but I think there's got to be some flexibility in there too. . . . The person that wrote [a treatment manual] doesn't know the people in front of me. (Alex, ND)

Other clinicians described the importance of this flexibility, using phrases such as doing "my little twists and turns" (Brett, RS) or putting "my own spin" on the material (Karlie, SUDIC).

Clinicians also expressed that flexibility was important in order to promote group engagement and build group cohesion. In this regard, several clinicians expressed concern that rigidity with manualized treatments could impede potential benefits from the group milieu.

> If we were just to kind of follow CBT or do a manualized treatment, there would be no time creating this thing that happens amongst people. . . . Every time I make an effort at focusing on, you know, structure and form, they don't want it. And it does not work. And what seems to work is . . . here are all these strangers in the worst positions they are in in their lives, but they start helping each other. (Rosemary, RS)

This vignette implies the importance of not only discovering from practice what "works," but also learning from clients what they "want." In this regard, several clinicians reported the

importance of promoting the group's autonomy in influencing the direction of groups, especially as clients progress in their recovery. This process necessarily involved seeking regular feedback from group members.

> I read their feedback sheets that they give after every group. And one of the common things that they identify is having the ability to take it in a direction or subject where they need to address something at that time. (Taylor, ND)
>
> We are always asking for input. You know, "How can we make the group better? Did you like this activity?" or whatever. . . . And we have learned there that sometimes we may have to have a group where we just don't come with our agenda. Don't come with a set topic. Just say, "OK, what do you all want to talk about?" (Brett, RS)

As suggested in these vignettes, considerable flexibility with manualized/structured group therapies is required in order for clients to feel like therapy is engaging and valued.

Necessity of Clinician Accommodations and Adaptations in Group Settings

Finally, clinicians reported several ways in which flexible group facilitation sometimes required departing from planned material. One form of departure (reported by eight clinicians, including five New Day clinicians) was through impromptu accommodations, with clinicians changing course based on what is happening in the current session.

> When you dive into a topic, if you really start to explore and people are really trying to get something out of it, and then it triggers something, I feel that it's somewhat detrimental to not only the person who needs to address that stuff, but also to the group as a whole. . . . And so again, it's meeting the clients where they are at. (Taylor, ND)
>
> Sometimes you do have to talk about what is going on in a client's life. They had a relapse. So you want to talk about that and not what you had on the agenda. (Kris, ND)

In other cases, clinicians from all three clinics discussed decisions to depart from what was planned at the outset, in light of last-minute appraisals of group needs.

> If there is something that I feel like they really cannot hear today, based on where the group is at, I will skip ahead to the next one and then come back and do that one. (Karlie, SUDIC)

> A lot of what happens in the group is really based upon where the [clients] are at. So if we have got [clients] that are really struggling, then we are going to tap into that need on that day, as opposed to something else that we might have planned, you know? (Maddy, ND)

> I may have a plan . . . in my mind, and then I gauge it on the group and their level of how alert they are and awake. . . . If it is a rainy, gloomy day like this, I would not show a video. I might stand up and do an interactive lecture. So it really is based on the group and their level of functioning. And will this engage them or will this put them asleep today? (Rosemary, RS)

These vignettes suggest that clinicians do not simply attempt to meet individual clients where they are at, but also appraise the state of entire groups—"where the group is at"—and adjust accordingly.

Complex Group Dynamics

Although clinicians clearly valued "meeting clients where they are at" in the context of flexible and engaging group therapy, achieving this result was frequently a challenge in light of complex group dynamics. As explained by one clinician, each client is "bringing something different" to the therapy room:

> I think group therapy is far more challenging than individual. I have done an even amount

> of both, and I think that navigating group therapy is much more difficult because there is a lot of personalities. . . . Every person who walks into the room is bringing something different. (Becky, SUDIC)

These group dynamics were sometimes complicated by frequent changes in group enrollment, beyond the clinician's control, that influenced or impaired group cohesion.

> Once people do kind of get used to group and comfortable in group and trust the group members, . . . a lot of times, a couple weeks later they are moving on to a totally new group—which makes establishing both a therapeutic bond with me in the group, and with the group members, a challenge. (Riley, ND)

In particular, clinicians expounded on the difficulties of facilitating groups with clients who vary in their level of engagement, as well as with clients who are diverse in addiction severity or motivation to change. (See Figure IV.3 for a concept map depicting the relationship between these themes.)

Clients with Varying Levels of Engagement

In terms of varying levels of group engagement (discussed by 12 participants), a common problem was groups consisting of both over-engaged and under-engaged clients.

> In a large group, one person can kind of take over, and the rest of the group members can kind of hide. (Rosemary, RS)

> Sometimes there is a guy that's been in the Friday group that tends to kind of go off on weird tangents. And he is using a lot of circular talk and sometimes it doesn't really make sense. And so I'll have to kind of, "OK, OK, thanks! Let's get somebody else's input." Not that it's not important, but I can kind of see people zoning out. . . . If given the chance, I mean, he'll talk for 10 minutes or more. (Alex, ND)

This dynamic reportedly resulted in more quiet or withdrawn clients receiving considerably less attention and care than they would have through individual therapy.

> People that maybe do not feel as open or willing to share in front of other people . . . can just sit sort of in the shadows. . . . You always have someone, right, that is willing to speak up. And then you have people that are not willing to speak up, won't give you eye contact, maybe just sort of nod their head. Whereas if you are in individual therapy, you could really engage them more and open them up and hear what they are learning. (Meagan, SUDIC)

> One really big drawback [with group therapy] is . . . sometimes not being able to spend enough individual time with someone who is particularly struggling. . . . If they are in a place where they still want to isolate, or they do not feel comfortable enough, a lot of times they will kind of bolt out of group the second the group is over, and my interactions with them are really limited. (Riley, ND)

Barriers for providing individualized care through groups were compromised further for clients with social anxiety and other comorbid problems. Less commonly reported problems with individual clients included disruptive, aggressive, intoxicated, or sleepy clients.

Clients with Varying Levels of Readiness to Change

In addition to challenges with having clients with varying levels of engagement, eight clinicians discussed challenges with working with clients having differing levels of severity or readiness to change.

> You have [some clients] talking about ecstasy and talking about shrooms. And someone is just like, "All I have ever done is marijuana." . . . You have to be cautious; that can create a lot of different dynamics. (Brett, RS)

> There are a couple people that I've been working with recently in there that I think have probably 9 to 12 months [of sobriety]. And then we have got a couple people that relapsed within the last month. So just trying to find information that is relevant to everybody has been challenging. (Alex, ND)

Although one potential solution is to develop tracks for differing levels of readiness to change (as attempted by New Day), clients may still have *intra*personal variation in motivation:

> You could be in a group where all of the people are in one stage of change, and it all makes sense to them. The next time you run the group, you have three people who are in different stage of change, and they are like falling asleep. . . . Those stages of change waver. (Becky, SUDIC)

The difficulty of navigating differing and shifting stages of change also pertained to clinicians' reported difficulties with utilizing motivational interviewing principles in groups. Although most clinicians endorsed the use of motivational interviewing (especially for New Day and SUD Intensive Clinic), six clinicians expressed difficulties with facilitating motivational interviewing in groups, in terms of limited experience or difficulty balancing the needs of individuals with groups.

> We ask a lot of open-ended questions. Not so much motivational interviewing or those sort of techniques, because it is a group. . . . I think sometimes those techniques work better individually. (Lina, ND)

> It is much easier . . . to adhere to the MI [motivational interviewing] principles . . . in an individual session. I think it is easier for me in a session to say, "So, I hear that you are really on the fence about twelve-step programming. I have some information about that. Would it be OK for me to share it?" Than for me to be in a group and ask for permission.

> Well, what if three people say yes and four say no? For the sake of making a group go, I am probably not going to do that. I am just going to offer the education as being psychoeducational, and people can take it or leave it, I guess. (Becky, SUDIC)

As reflected in the above vignettes, clinicians expressed an inability to facilitate motivational interviewing in groups or even a belief that it was not appropriate or possible to do so, which clearly limited their ability to address client motivation among a diverse group of clients.

Clinician and Organizational Challenges and Barriers

The preceding set of challenges—pertaining to complex group dynamics—is likely endemic to any attempt at group therapy. Other challenges, however, pertain to organizational deficits and barriers, each of which pose a threat to clinicians' narratives of providing individualized and flexible care. First, some clinicians reported having limited or inadequate experience with group therapy facilitation. Second, psychoeducational approaches were predominant, reflective of a narrow range of potential group therapy options. Finally, limited attention was given to clients' demographic diversity (e.g., gender, race, ethnicity, and culture). (See Figure IV.4 for a concept map depicting these themes.)

Limited Clinician Experience and Organizational Training

A critical challenge for group therapy facilitation was limited clinician experience with group facilitation, along with limited organizational efforts to ensure quality control of groups. Several participants, especially clinicians from New Day and SUD Intensive Clinic, had minimal group therapy training and experience at the time they were hired.

> I've never run a substance abuse group before [being hired]. And I'm brand-new out of school. [My university] doesn't have a substance abuse track. (Kris, ND)

> I only did seven months of SUD groups in my internship . . . and so, I had minimal experience there. . . . I would say groups are my weakest point. (Karlie, SUDIC)

Other clinicians discussed perceived deficiencies in other clinicians at their clinic.

> I think a lot of people who run groups end up doing some version of individual therapy in that setting. If you don't really know or have [not] had a lot of experience with group, that is what you will end up doing. . . . It is not the same group experience as if you do more of an experiential group process. (Morgan, RS)

Participants also reported minimal on-the-job training in facilitating groups. Clinicians typically learned through observing groups at the clinic, and then transitioned to facilitating groups on their own. In some cases this process involved co-facilitation or being observed by a supervisor, particularly for clinicians being initially trained while students.

> During my practicum experience I was paired with the therapist that facilitated the group, and so I would sit in and watch her do the group . . . . After about four or five weeks of watching . . . I started facilitating the group with her observing. (Lina, ND)
>
> I would observe my field instructor doing it, and then I did it. I co-facilitated with her for a while. And then I did it on my own, but she would observe and provide feedback. (Karlie, SUDIC)

In other cases, however, clinicians had minimal training and felt unprepared when they were expected to facilitate groups on their own.

> I think I observed five or six groups and then a therapist . . . observed me do one group. And then I was on my own. . . . I felt unprepared. Completely. (Kris, ND)
>
> I had no experience in [a particular group], and was just thrown into it. . . . I need to sit in and see someone, and so the fact that I have not really gotten a chance to do that, and

> instead I have just been thrown in, in a way, has made me more uncomfortable. (Karlie, SUDIC)

In addition, limited attention was given to group therapy quality control efforts. Although New Day routinely had clients complete feedback forms at the end of each group session, formalized or systematic quality control efforts were absent for each clinic. Clinicians from each clinic reported that their clinics would like to begin instituting formal outcome monitoring but that they had not yet done so. One clinician was especially critical about the lack of quality control efforts in the clinic:

> What do I think that this place does to ensure that group sessions are high in quality? Nothing. They hire people with group experience sometimes. With good group skills sometimes. But my supervisor has never sat in my group. (Morgan, RS)

Apart from observing student clinicians, supervisory observation was reported to be minimal across the clinics. Most participants reported, though, that their group therapy facilitation skills were sharpened through co-facilitating groups or consulting with other clinicians in the clinic.

Predominance of Psychoeducation

Another complexity is the predominant role of psychoeducation in group settings. Given limitations in clinicians' experience and skill with group therapy delivery, combined with complexities of and limited resources for group facilitation, it is perhaps not surprising that participants reported frequent utilization of psychoeducational groups, whether through lectures, didactic presentations, worksheets, or videos. Occasional experiential activities were reported, such as hands-on activities, team-building exercises, or interactive games—even then, the predominant goal was typically education. (In some cases, enhancing peer support was an explicit goal for group tasks, especially for New Day and Recovery Services.) In contrast, active

skills practice was reported to be infrequent, primarily limited to mindfulness exercises in some group sessions in New Day and SUD Intensive Clinic, and minimal role playing at SUD Intensive Clinic.

The predominance and importance of psychoeducation was also implicitly communicated by participants in the interviews. For example, three clinicians gauged the success of group sessions in terms of whether clients were learning and retaining educational content.

> You can tell you have had an unsuccessful group when [clients] have no idea what you have been talking about. When you are asking people to engage, and they are not understanding the content enough. (Becky, SUDIC)
>
> If they remember next week what we talked about, that's a good indicator, too, of how engaged they were. If they can tell the newcomer what we talked about. (Kris, ND)

One clinician had some satisfaction even if clients could only "mimic" content.

> [Clients] will say, "I know we talked about it in the group. AA says not to do it." And so, if they are able to even mimic that stuff, even if they don't think it applies, then at least I know they are hearing it. . . . Might apply it at some point. Some part of their mind, it will stick at some point. (Karlie, SUDIC)

According to this same clinician, socialization through education was viewed as important not only through learning theoretical content but through the use of specific terminology: "Hearing them actually use the buzzwords, it is just so exciting!" (Karlie, SUDIC). The implication here is that clients are best helped when they understand the theoretical models that are being utilized and they are able to describe or at least label those models.

Participants varied in whether they were concerned about the amount of psychoeducation in groups. For at least three clinicians at New Day and Recovery Services, a focus on

psychoeducation appeared to stem from a belief in the necessity of promoting a disease model of addiction.

> So we are basically telling them in those education pieces how to not use, what to do instead. Or also teaching them about the illness that they have so they can best understand it and then work with it. . . . So I think to me that is why [psychoeducation] is so helpful, especially when we are describing what is wrong, why they have this problem. And especially reviewing that whole disease concept with them. (Rosemary, RS)

This education was seen as a prerequisite to other activities—such as sharing experiences or developing insight about comorbid mental health problems—to clients in early recovery.

> People aren't sober a good amount of time. . . . So then there's really not a lot of experiences in recovery to share. So . . . it is more about me presenting information. So usually I do the majority of the talking, and then they get to ask questions. (Lina, ND)

The above vignette suggests that clients in early recovery do not already have experiences and knowledge that are worthwhile to draw from in therapy; rather, they first need to be filled with new "information." Or, alternatively, clients need to be reminded of this information, in light of "addicts" being especially forgetful, as discussed in the following vignette:

> Addiction is a disease where you forget. You know, "You have a built-in forgetter," is the joke in the recovery community. So repetition, much like how you became an addict by using substances every day on a repetitive basis, is sort of the same concept. I mean, case in point, you could have someone who has been in and out of AA for 10 years, and then be sitting in a group and they say, "You know, I was at work today and someone said something to me that pissed me off and I didn't know what to do." And I was like, "What have you been hearing for 10 years? You call your sponsor, you might say a prayer, you

> might do meditation, you might get a book and read, go take a timeout, or whatever." So why is it they forget that? Well, it's sort of a part of the disease. (Taylor, ND)

As implied in the above vignette, even if clients have been "hearing" what to do for many years, they still may be prone to forget and in this case the course of action is to remind them of what they already know. Although some clients may complain about this repetition, one clinician said that such complaints are usually a sign of "resistance":

> Folks can find a way to relate, even if it is with material they had heard before. And sometimes they will say, "That really helped me when I heard this, and it is great to hear it again." But when there is some, "I have got this down," or "You are not understanding this," usually that is some kind of resistance, or, you know, to try to . . . distance themselves from the process. (Rosemary, RS)

In contrast, five clinicians (all at New Day and SUD Intensive Clinic) expressed concern about the amount of psychoeducation in their clinics.

> A lot of it is . . . psychoeducational stuff. And it's like, "OK, well, you are going to learn about Bill Wilson." But if you don't care who Bill Wilson is, then what is the point? (Riley, ND)

> I have been in groups . . . that were just psychoeducational, and someone just standing up there and explaining it to you for 45 minutes. And it is so hard to keep them engaged when you see their eyes glaze over, when that is all you are doing. (Karlie, SUDIC)

> I have sat in on some . . . groups, and it is not a lot of back-and-forth between who is talking. And I think it is easier in that way to . . . become disengaged and sort of just like mind drift off. . . . They are not practicing enough . . . in a lot of the groups. . . . Like simple exposures to not using, or things like that. I think we could definitely be doing

> more of that. I think [clients] would enjoy it more, instead of necessarily just sitting there and just talking again and again about the negative consequences of their substance use. (Meagan, SUDIC)

These vignettes suggest that educational approaches may contradict clinicians' aspirations for meeting clients where they are at. That is, these approaches were criticized for giving information that was simply not relevant to many clients and in a manner that was not engaging.

These concerned clinicians described their attempts at providing a more therapeutic as opposed to classroom feel for their groups, through sitting at the table with clients rather than standing at a chalkboard.

> I started having people say, "I really enjoy your class." And I was like, OK, what am I doing wrong that people are saying "I am enjoying your class"? And I was like, OK, I am standing at the board like a teacher; that is one thing I can change real quick. So I started sitting at the table with them. (Riley, ND)

> What I have noticed, depending on the clinician, they will stand either in the front of the room or the back of the room, at one end of the table with a whiteboard. And sort of it does look like a classroom. . . . When I am in group, like sitting in the middle of them as a circle . . . and sitting as much as possible instead of standing and sort of directing. (Meagan, SUDIC)

These clinicians described these efforts as reducing the notion that the therapist is the "expert" with all of the information.

> I am uncomfortable with them feeling like, "Oh, [Meagan] is the facilitator of this group, she knows more than I do about what is going on, I need to listen to her." . . . I do not like the idea of there being this hierarchy. I am more comfortable in this sort of "social

worky" concept of, "We are collaborating. This is a horizontal relationship." (Meagan, SUDIC)

I sit at the table with the group. So I try to portray more of a partnership thing and not, "I am the authoritative figure and you do what I say." (Lina, ND)

These efforts of cultivating more of a "partnership" and "collaboration" with clients—ostensibly more in the spirit of "meeting clients where they are at"—appear to be in contrast with didactic approaches in which the focus is on disseminating information as a necessary step for healing for all clients.

Limited Attention to Clients' Demographic Diversity

Another inconsistency with the stated ideal of providing individualized care was the limited attention given to the demographic diversity of clients. With the exception of Recovery Services' three specialty groups (one each for opioid addiction, health professionals, and dually-diagnosed clients) and adolescent programming for New Day and Recovery Services, the clinics did not offer specialized groups for particular demographics (e.g., gender-specific groups). The roles of gender, race, ethnicity, and culture were particularly explored in each of the interviews. In terms of gender, the primary reported way that gender issues were incorporated into groups was through behavioral norms, such as group members being expected to avoid sexist remarks and being discouraged from forming sexual/romantic relationships with other group members. In terms of substantive content concerns, sex and gender issues were rarely reported, other than occasional psychoeducation about different biological responses to alcohol and drugs, or when issues were brought up by clients.

> Where we talk about different physical and psychological effects of alcohol and other drugs, we do talk about how it affects different genders—so like reproductive systems and stuff like that. So we touch on that. (Lina, ND)

> Gender comes up from time to time. And we just talk about it openly . . . like, "I wonder if that is a women's only"—like we'll say, "Well, what do the men think? . . . Would you deal with that any differently?" (Morgan, RS)

Beyond this limited attention, gender issues were not formally built into the group therapy curricula at any of the clinics, and only two participants expressed concerns with this absence. One was concerned that the clinic's twelve-step focus was sometimes not adequately tailored to women.

> Something . . . I admittedly do not address. . . . Often times we . . . talk about "surrendering." And when you read women's focused recovery stuff, they want to get away from the idea of surrendering. And I agree that it definitely has a different connotation for someone that maybe has a trauma history, or has been in these kinds of problematic relationships. So having a recovery thing where it is like, "Oh, you have to surrender," could be incredibly not empowering for them. (Riley, ND)

The other participant was concerned about men's issues not being more formally integrated, especially given gender-related barriers for the clinic's predominantly male veteran population.

> There is a greater stigma with men with mental health [treatment]. There is a greater stigma of mentioning their emotions. There is a greater stigma of them appearing weak in that way. . . . I think that the fact that we have all those barriers against us, we . . . should be addressing them in a way. (Karlie, SUDIC)

Issues pertaining to race, ethnicity, and culture were addressed even less frequently in groups. As with gender issues, group members were expected to avoid racist or prejudiced remarks, and issues were discussed as they were raised by clients. In terms of substantive content, issues pertaining to race and ethnicity were very rarely reported, with slightly more attention given to cultural aspects (especially the role of spirituality).

> We talk about how our value system is shaped based on cultural influences and traditions in society, and things like that. . . . And we touch on spirituality as well, and how a lot of times that impacts our value systems. (Lina, ND)

Otherwise, race and ethnicity issues were not formally built into the group therapy curricula at any of the clinics, nor were they very frequently discussed in sessions. One clinician explained that there was less need for addressing these issues given the nature of addiction:

> [For] African American persons in group, unless that person brings it up, it is just not addressed. . . . I think maybe it has to do with that whole addiction model of treatment. Everybody is kind of presenting with the same symptoms. (Rosemary, RS)

Another clinician explained that although race and ethnicity issues were assessed individually at intake, they were not incorporated into groups:

> In all the paperwork, we assess like, "What do you identify with ethnicity? Do you anticipate this affecting your treatment?" And so, it is a question that we are asking, but then we don't really do a lot with it, and we don't talk about what that means or how that might be a barrier. So it is something we are assessing for but not necessarily incorporating. (Karlie, SUDIC)

These last two vignettes suggest difficulties in providing individualized care; the former suggests that individualization is not really needed, whereas the latter indicates that individualization has

not been carried through to the group therapy level. Clinicians generally did not report concerns with this limited attention to race, ethnicity, and culture—the only exception being one clinician who discussed issues with court-ordered Muslim clients of Middle Eastern descent who were not comfortable being in a mixed-gender group but had no alternatives.

> They do not participate, even when prompted. They will kind of give one, two-word closed answers to their questions, and it is really challenging to address that in group. And then, . . . we're still talking about something that has 12 steps because there are 12 apostles. . . . It is very much in Judeo-Christian belief systems. (Riley, ND)

This example demonstrates how intersecting aspects of client identity—ethnicity, religion, gender, nationality, and legal status—may result in clients being greatly disenfranchised from group therapy.

Discussion

This article describes real-world complexities for SUD group therapy facilitation, especially as they intersect with utilizing EBTs or more structured, manualized treatment protocols. As presented above, although clinician participants emphasized the importance of providing individualized, flexible, and engaging treatment, several challenges and obstacles were evident in providing such in group format. Some of these challenges pertain to the burden of facilitating dynamics in groups with highly diverse clients, especially in terms of clients with differing motivation to change. Other challenges revealed clinician and organizational deficits and barriers, such as clinicians having inadequate group therapy facilitation experience and training, a predominant role for psychoeducational groups rather than skills-based groups, and limited attention given to clients' diversity in terms of gender, race, ethnicity, and culture. In this

section, I discuss these themes and their implications for bridging the gap between research and practice, including general recommendations for researchers, clinicians, and administrators.

Prior to this discussion, two basic limitations of this study should be addressed. First, due to the case-base nature of this study, caution should be exercised about the extent to which clinicians' reported experiences generalize more broadly to other SUD specialty treatment clinics and clinicians. However, as described elsewhere, the three clinics have many commonalities with what is known about SUD specialty clinics nationally (with one notable difference being that the majority of clinicians in this study are social workers, whereas addiction counselors/therapists are more predominant nationally; see Chapter II). Moreover, this study included a wide range of EBT implementation, including one clinic (SUD Intensive Clinic) with very extensive use of manualized treatments adapted from EBTs. This range makes it likely that themes reported in this article will be at least somewhat generalizable at a broad level, especially in terms of complexities with implementing EBTs and manualized therapies in group format. Second, this study did not include direct observation of SUD treatment, as such was not feasible in my role as a researcher. Observation of course would have helped to provide a fuller picture of group therapy facilitation, especially in ways that do not match respondents' accounts. To compensate, for this study care was taken to elicit detailed accounts of group therapy facilitation, including in-depth discussion of a recent session the clinician facilitated, along with questions aimed at what is actually done in sessions rather than what is theoretically or ideally done. I recommend for observation to be utilized in future studies of SUD group therapy facilitation.

Balancing Flexibility and Structure

A major implication from this study is the wide chasm between real-world group facilitation and the utilization of EBTs or manualized therapies. Clinicians' expressed needs for

flexibly implemented therapy—especially in light of open groups and challenging group dynamics—were universally shared and emphasized. Importantly, most clinicians expressed positive attitudes towards EBTs or manualized therapies (especially to guide new clinicians), but only if sufficient flexibility was permitted. This finding converges with research that clinicians are more likely to have positive attitudes about and utilize EBTs when sufficient flexibility is built into the protocol (see, e.g., Palinkas et al., 2008). On one hand, this level of flexibility appears to be quite reasonable, both for addressing the complex nature of addiction as well as for capitalizing on unique benefits of group therapy. Although some attention has been given to incorporating unique group therapy principles—such as group cohesion and interpersonal learning (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Yalom & Leszcz, 2005)—these principles have not been addressed in most EBTs. Rather, the assumption seems to have been that existing EBTs—designed for and tested on individual therapy—simply need to be adapted into group format. Although limited, some researchers have published group therapy protocols in which they aim to balance flexibility, group therapy principles, and evidence-based principles (e.g., Donovan et al., 2013; Sobell & Sobell, 2011; Wenzel et al., 2012).

On the other hand, it is possible for clinicians to overemphasize the importance of flexibility, leading to clinical decisions that may not be best for individual clients. Considerable research demonstrates the limitations of clinical wisdom used to depart from established protocols (Ægisdóttir et al., 2006; Dawes, Faust, & Meehl, 1989). Moreover, clinicians may have widely varying sensibilities about when and whether to deviate. This tension raises the importance of decision-making guidelines for knowing when to deviate and why. Such is an especially difficult task in terms of appraising the status of entire groups; these appraisals are

likely ripe for errors, in that certain individuals may not fit the group appraisal. To be sure, making clinical decisions on the status of an entire group (e.g., group cohesion) would be consistent with a systems approach to treatment that typically underlies group therapy theory (American Group Psychotherapy Association, 2007). However, in the case of open-enrolling, short-term therapies (where the composition of the group is constantly in flux), it would be difficult for clinicians to know how much to emphasize group-level appraisals in order to "meet clients where they are at."

One general recommendation is for greater recognition of the value of flexibility in SUD treatment delivery. Although clinical researchers have acknowledged that EBTs are intended to be flexibly implemented, the need for flexibility perhaps reaches a new level for SUD treatment, given its reliance on open groups and the chronic, frequently relapsing nature of addiction. Moreover, this study suggests that clinicians need more than to be encouraged to be flexible with treatment protocols; greater training, supervision, and resources are needed. To this end, I encourage researchers and clinicians to develop and make more widely accessible EBTs that can be flexibly utilized in open groups. At a minimum, this study suggests the importance of group protocols allowing for individualized check-in periods and safety planning, the ability to depart from what was planned in order to address crises and relapses, and ample time for peer support and group discussion. In this regard, clinicians might benefit from consulting treatment manuals that have been adapted for use with open groups (e.g., Donovan et al., 2013; Wenzel et al., 2012.)

Limited Training, Supervision, and Quality Control

A second implication is that the ability for clinicians to balance flexibility and structure in group therapy may be quite difficult inasmuch as clinicians have not received sufficient training

in group therapy facilitation. In this study, several clinicians reported having limited experience prior to being hired, as well as minimal oversight and supervision on the job, typically limited to observing a few group sessions facilitated by other clinicians. One possible consequence of these limitations is an overemphasis on content (e.g., a psychoeducational approach) rather than group process. Others have discussed the problem of assuming that group therapy can be easily conducted by clinicians without adequate training, including clinicians whose primary training is with individual clients (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Yalom & Leszcz, 2005). An assumption that seemed to be commonly reflected by clinicians in this study is that group therapy experience comes by observing other clinicians' groups and then facilitating one's own groups, perhaps with co-facilitation and/or supervisory observation in between. Such an approach certainly makes sense for a developmental training process, but only if observed clinicians and supervisors are themselves skilled in group therapy facilitation. Moreover, some clinicians in this study reported inadequate training and supervision prior to being expected to facilitate groups. Furthermore, limited quality control efforts were instituted to ensure groups were high in quality.

As a general recommendation, more attention should be given to training and quality control for group therapy. As discussed above, group therapy skills are not automatically transferrable from clinicians trained to work with individuals—a realization that dawned on several clinicians from this study as they began facilitating groups. In particular, administrators and supervisors ought to recognize that the practice of learning through observation is effective only to the extent that the observed therapy is high in quality. Therefore, clinics would benefit from having clinicians' readiness for group therapy be based on mastered competences rather than mere experience. In particular, effective group therapy facilitation requires greater

knowledge about and experience with *process* rather than mere mastery of content (American Group Psychotherapy Association, 2007). Experience with group process might also be enhanced through discussion or, better yet, practice during clinical meetings and/or between co-facilitators. An obstacle, of course, is time, considering that many clinicians are already burdened with clinical concerns; it is worth stressing, nonetheless, that quality group therapy ought to require considerably more time for preparation, practice, documentation, and debriefing than does individual therapy. Finally, clinicians may need greater guidance for making decisions about balancing content and process, including knowing when to deviate from a treatment manual or agenda. It is recommended for clinics to develop clear guidelines for decision-making processes about whether and how often to deviate, with major decisions being made on a team basis rather than by solitary clinicians. In this regard, clinicians may benefit from supervisory or peer feedback about whether they are too quick to deviate or alternatively too rigid.

Therapy vs. Classes

A third implication for group therapy facilitation from this study is the predominance of psychoeducation in group therapy. Although psychoeducational groups are not an inherent problem, this study suggests that group therapy is frequently utilized as a vehicle for content delivery (a traditional classroom model) rather than as a distinctive modality in which interpersonal group relations are part of the treatment (see American Group Psychotherapy Association, 2007; Yalom & Leszcz, 2005). Perhaps psychoeducational approaches will be determined to be adequate by researchers and practitioners, but it should not be assumed at the outset that these approaches are optimal, even when adapted from EBTs. Not only is a psychoeducational focus limited in its ability to draw on unique aspects of group therapy—including those touted by participants in this study (e.g., peer support and accountability)—but

research indicates that psychoeducational approaches are limited in effectiveness (see Gifford et al., 2012).

A focus on psychoeducation is likely not idiosyncratic to this study, as others have critiqued the tendency for SUD groups to be more like "classes" than therapy (see, e.g., Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel et al., 2012). Why such a focus on psychoeducation? There likely are several contributors. First, an educational approach naturally follows from a disease model of addiction, in that prior to receiving skills-based or insight-oriented therapy, "alcoholics" and "addicts" need to be firmly taught that they have a chronic illness rendering them qualitatively different from "non-alcoholics" and "non-addicts." As was discussed by some clinicians in this study, part of this illness is "forgetting," and so an educational focus may be presumed to be necessary even for clients who have been in treatment many times previously. Second, a psychoeducational group may be the natural outcome for clinicians with limited group therapy training and experience. Given that the predominant mode of training is observing other clinicians, inasmuch as observed groups are psychoeducational clinicians may assume that this is simply the way that groups are run. Moreover, lecturing to clients likely requires considerably less skill than orchestrating discussion with diverse clients with varying levels of motivation, drawing out the "music" from the group (Sobell & Sobell, 2011, p. 191). Finally, a psychoeducational approach may be assumed to be the natural adaptation of existing EBTs for SUDs. Because these EBTs are designed and evaluated for use with individual clients—and thus lack attention to group *process*—clinicians may be prone to simply port the *content* from these treatments into group format. For example, it is simpler for clinicians to teach *about* CBT principles than to have clients actively practice these principles in the group itself (e.g., through role playing)—especially in large groups.

Clinicians, researchers, and administrators ought to be uncomfortable about the predominant role that psychoeducational approaches play for SUD group therapy, especially given its relatively low clinical effectiveness (see Gifford et al., 2012). One recommendation is for greater innovation in creating, investigating, and implementing therapies that rely at the outset on group therapy processes. Such an effort may help clinicians to be more concerned about group process rather than mere content dissemination. Moreover, broad empirical support has been documented for principles of group therapy (e.g., group cohesion; American Group Psychotherapy Association, 2007; Yalom & Leszcz, 2005), suggesting the importance of fully capitalizing on those principles if group therapy is to be utilized. As discussed above, clinical researchers have largely resisted conducting clinical trials in group format, due to less experimental control and statistical complexities inherent in group designs. However understandable this practice may be from a research standpoint, a strong case can be made that the practice of adapting EBTs designed for individuals into group settings is in fact backwards, and that a more ecological approach would prioritize the design and testing of open group therapies that then could be adapted into other formats as needed. Of course, this approach has logistical and methodological challenges, but it is time for these challenges to be reckoned with and met by the clinical research community and their funders. For an industry to heavily treat clients in group format without this treatment being thoroughly grounded in group therapy principles ought to be seen as an obvious problem in need of an intervention.

However, even in the absence of innovative group therapy protocols, clinicians and administrators could make efforts for incorporating more skills practice and interaction within group sessions. (For an excellent example, see Wenzel et al., 2012.) For example, as discussed by several participants in this study, clinicians can make efforts to create more of a therapy room

rather than a classroom environment (e.g., by sitting in a circle with clients rather than standing at a chalkboard). One obstacle in this regard is group size, as a more therapeutic approach would be more difficult with larger groups. For non-psychoeducational groups, a group size of five to eight clients has been recommended as optimal, in light of research demonstrating that group interaction markedly drops with groups of nine clients or more (Yalom & Leszcz, 2005). However, even when educational approaches are desired or inevitable, clinicians might consider utilizing greater use of active learning educational strategies—for which there is a voluminous evidence-based literature in educational psychology (see Svinicki & McKeachie, 2013). Consistent with this literature, the Center for Substance Abuse Treatment (2005) has outlined four considerations for facilitating active learning in psychoeducational groups: (a) facilitating group discussion with limited lecturing, (b) encouraging groups to take ownership of their own learning (including de-emphasizing the leader role), (c) utilizing a variety of methods to accommodate for diverse learning styles, and (d) being mindful of potential neurocognitive impairment among clients.

Difficulty of Meeting Highly Diverse Clients Where They Are At

Finally, this study sheds some light on the difficulties with providing individualized therapy in a group format. Clinicians universally extolled the importance of "meeting clients where they are at," which typically had reference to working with clients regardless of their level of motivation to attempt to abstain from drugs and alcohol. In practice, however, this aspiration was fraught with difficulties, in terms of groups being composed of clients with widely varying levels of motivation and group engagement. Moreover, motivational interviewing principles—though otherwise reportedly valued by most clinicians—were seen as too difficult to utilize in groups. These challenges converge with the criticism about SUD clients receiving highly

individualized assessment but then being warehoused in groups that allow for very little individualization (see Fletcher, 2013). Each clinic attempted to bridge this individual-group gap in different ways through the use of one-on-one encounters (ad hoc sessions at New Day, individual therapy for some clients at Recovery Services, and individual case management at SUD Intensive Clinic), but with limited success.

In addition, questions can be raised about the extent to which clients' individual variation was addressed within the clinics' groups. Although efforts were made to acknowledge varying levels of motivation and severity, less engaged clients were difficult to reach in groups; moreover, attention to certain aspects of client diversity (e.g., gender, race, ethnicity, and culture) was noticeably absent. When attention was given to this diversity, it was generally in terms of behavior management (e.g., group norms for avoiding racist or discriminatory language) rather than substantive content or discussion. This problem is hardly unique to SUD treatment; criticisms are legion about the tendency for psychosocial interventions to give short shrift to important aspects of client identity, particularly in regard to ethnoracial minority clients (e.g., American Psychological Association, 2003; Ridley, 2005; Sue & Sue, 2007). Nonetheless, this observation problematizes the aspiration of "meeting clients where they are at," in that this aspiration may have little to do in actual practice with "meeting" diverse clients as racial, ethnic, cultural, and gendered beings. As reflected in a comment by one participant (Rosemary, at Recovery Services), this tendency may stem from a view of addiction in which "everybody is kind of presenting with the same symptoms." Although this homogeneity may be true to some extent (e.g., clients meeting diagnostic criteria for SUDs), pathways toward addiction and its treatment can be greatly mediated by diverse social factors pertaining to race, ethnicity, culture, and gender (see, e.g., Chen, Balan, & Price, 2012; Frank, Moore, & Ames, 2000; Greenfield et

al., 2007; Kissin, Tang, Campbell, Claus, & Orwin, 2014; Nelson-Zlupko, Kauffman, & Dore, 1995; Shih, Miles, Tucker, Zhou, & D'Amico, 2012; Straussner, 2012; Zapolski, Pedersen, McCarthy, & Smith, 2014).

One recommendation—particularly for administrators and clinicians—is for greater recognition of the ways that groups may not adequately facilitate, or may even hinder, "meeting clients where they are at." Future innovations and research are also strongly recommended concerning how to best integrate group therapy with individualized assessment and treatment. (For one example, which combines intensive outpatient twelve-step facilitation open groups with individual care coordination, see Donovan et al., 2013). Cost considerations are surely an important obstacle here, but the point nonetheless remains that just because clients are being "seen" via group therapy does not mean they are receiving optimal care. In addition, greater attention to substantively addressing multiple aspects of client diversity—not just addiction severity and motivation to change—is strongly recommended. One recommendation is for the creation and utilization of group sessions that more actively address social dimensions underpinning addiction, especially in light of increased recognition of the roles of poverty and loneliness in perpetuating addiction cycles (see, e.g., Hari, 2015; Hart, 2014).

Conclusion

Although group therapy is the predominant form of psychosocial therapy for SUDs, research efforts have focused on individual therapies. For this study I aimed to narrow this gap, by exploring through in-depth interviews how real-world clinicians facilitate group therapy. Clinicians emphasized the importance of providing individualized and engaging treatment, necessitating considerable flexibility in treatment delivery in groups. However, they had serious challenges with group therapy facilitation, due to factors that are likely endemic to any attempt at

group therapy (complex, unpredictable group dynamics) as well as challenges that pertain to organizational deficits and barriers (e.g., clinicians with inadequate group therapy experience, limited quality control efforts, the predominance of psychoeducation, and limited attention to clients' demographic diversity). Assuming that group therapy facilitation will remain a major aspect of SUD specialty treatment for the foreseeable future, it would behoove researchers, clinicians, and administrators to address these challenges. Several recommendations have been provided in this article, including greater recognition of the importance of flexibility for EBT delivery in groups, more attention to clinician training and quality control, the creation and evaluation of SUD treatments that rely on group therapy principles at the outset, greater incorporation of skills practice alongside less didactic education, and greater integration of group therapy with individualized assessment and treatment.

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Table

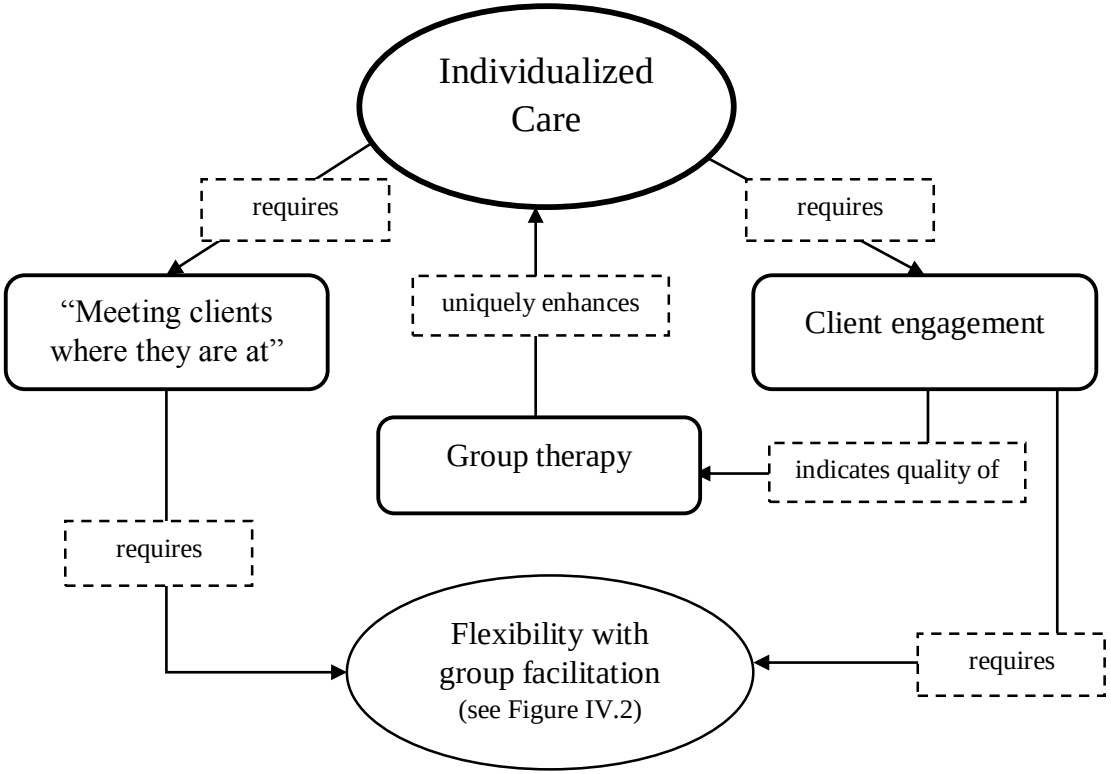
IV.1: Characteristics of Sample

Characteristic	New Day				Recovery Services				SUD Intensive Clinic				Total			
	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*	%	*N*	*M*	*SD*
Gender																
Women	67	4			50	2			100	3			69	9		
Men	33	2			50	2			0	0			31	4		
Age			35.8	3.8			51.3	8.3			26.7	1.5			38.5	10.8
Race/ethnicity																
White (non-Hispanic)	83	5			75	3			67	2			77	10		
Black	17	1			25	1			0	0			15	2		
Asian American	0	0			0	0			33	1			8	1		
Highest degree																
Master's	83	5			100	4			100	3			92	12		
Associate's	17	1			0	0			0	0			8	1		
Has been in recovery																
No	50	3			75	3			100	3			69	9		
Yes	50	3			25	1			0	0			31	4		
Profession																
Social worker	50	3			100	4			100	3			77	10		
Addiction counselor/therapist	33	2			0	0			0	0			15	2		
Recovery support specialist	17	1			0	0			0	0			8	1		
Yrs. treating substance use disorders			3.7	4.6			23.0	14.8			3.0	1.7			9.5	12.3

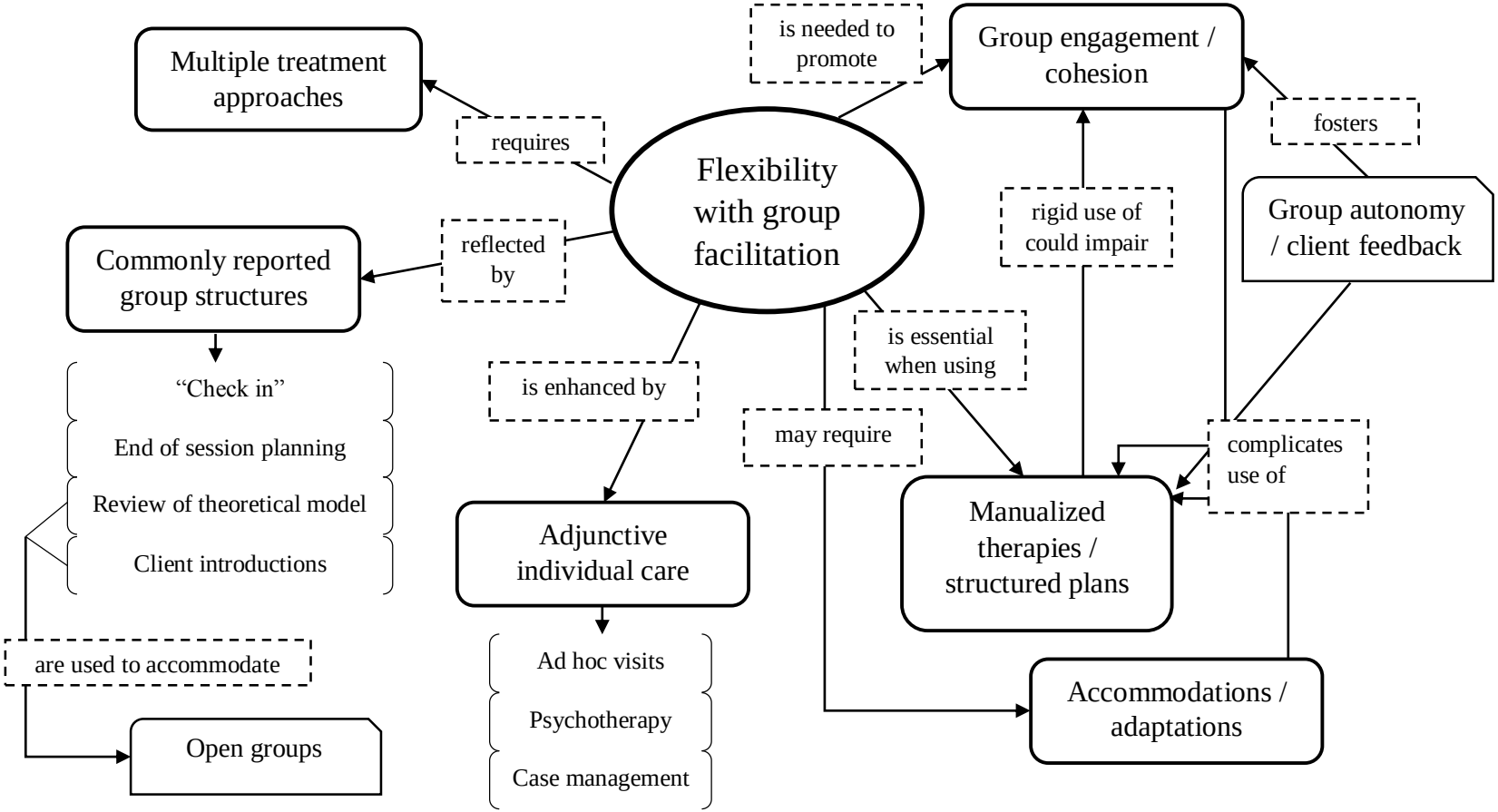
Note: Based on survey completed by each participant. Respondents were allowed to indicate only one response per item.

Figures

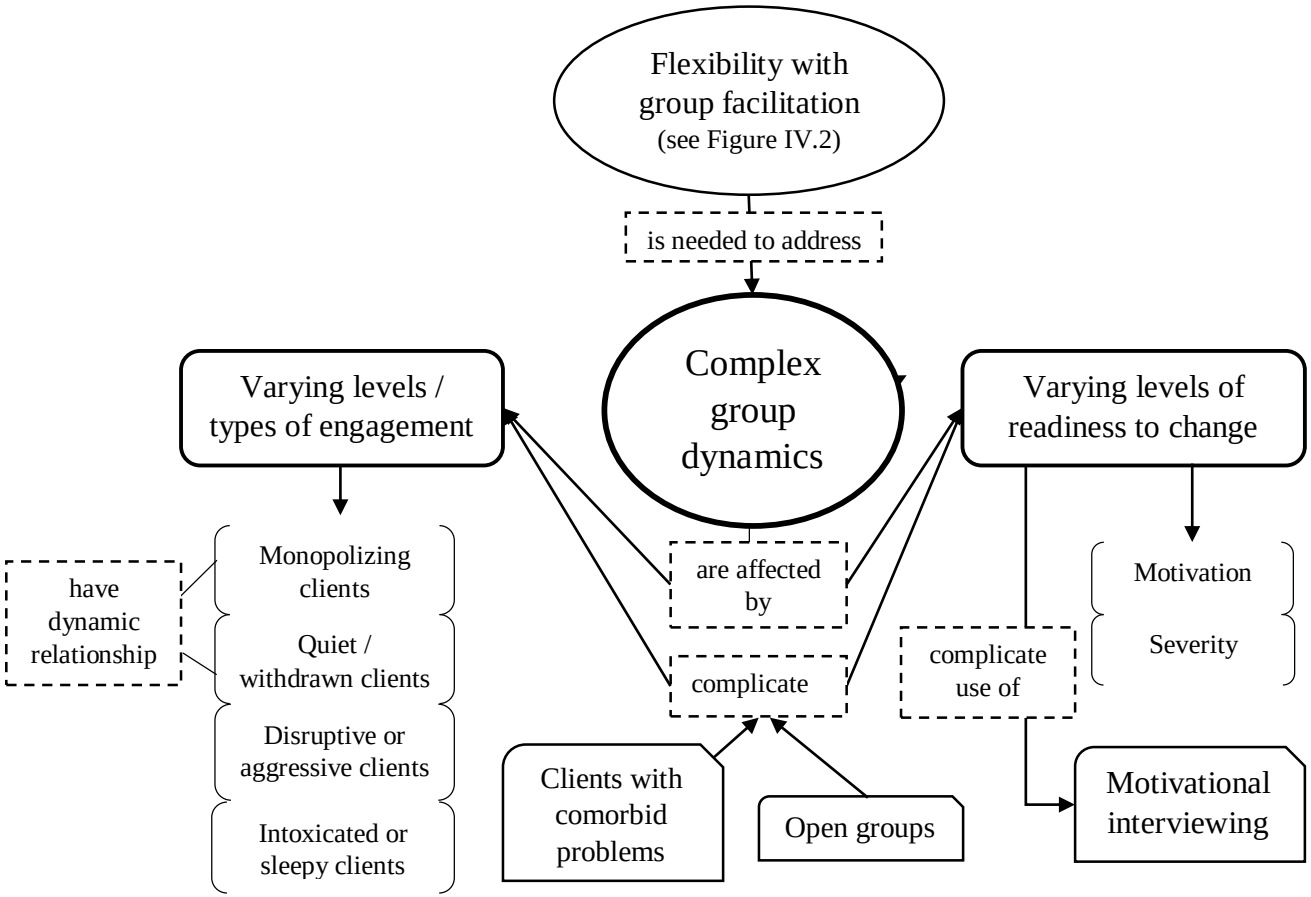
IV.1: Individualized Care: Concept Map



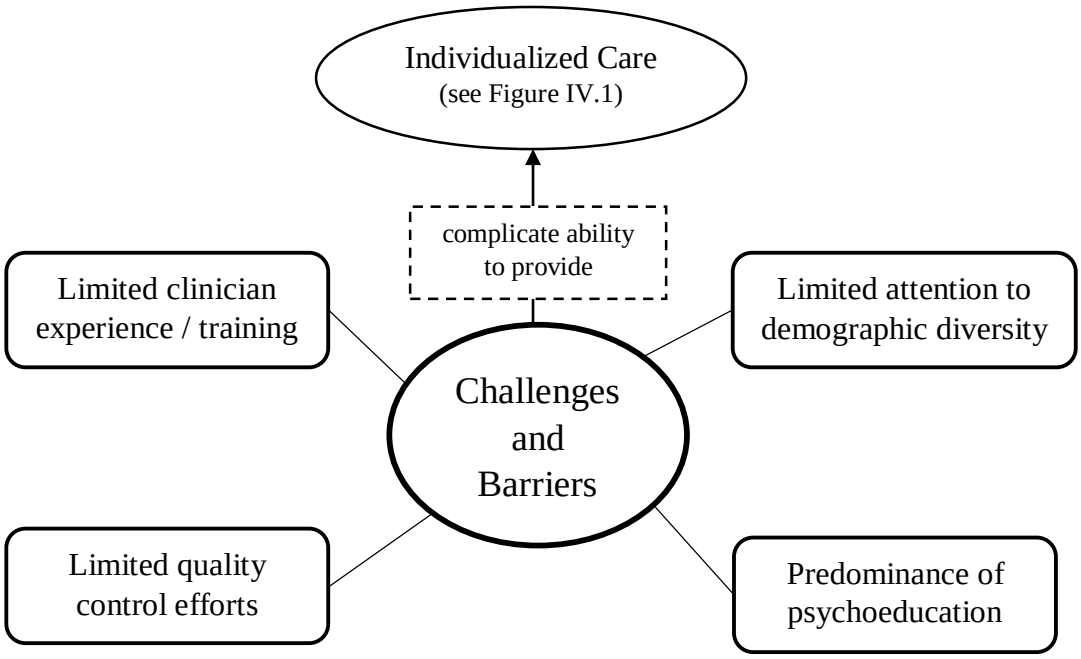
IV.2: Flexibility with Group Facilitation: Concept Map



IV.3: Complex Group Dynamics: Concept Map



IV.4: Challenges and Barriers: Concept Map



CHAPTER V

Conclusion

For this dissertation, I have sought to narrow the research-practice gap for substance use disorder (SUD) treatment through exploring how real-world clinicians facilitate group therapy. This exploration included a national online survey with 566 clinicians about the group practices they have utilized, as well as qualitative analysis of semi-structured interviews with 13 clinicians and three clinical directors at three diverse outpatient SUD specialty clinics located in the same Midwestern U.S. metropolitan area. For this brief concluding chapter, I review the major conclusions reported in each of the three studies and briefly reiterate broad recommendations for researchers, clinicians, and administrators.

The first study (Chapter II) confirmed the predominant use of group therapy in SUD treatment settings, including the predominant use of open groups. It also showed that clinicians highly report utilization of evidence-based treatment (EBT) components, especially for motivational interviewing and cognitive behavioral therapy, but with varying use of individual practices and continued frequent use of questionable/less effective practices (particularly didactic group education). The second study (Chapter III) reported considerable organizational challenges for integrating EBTs into the three clinics. These challenges generally centered on the predominance of open group therapy at each of the clinics. Considerable adaptations would be (or were) necessary to utilize EBTs in group format, especially for open groups; these adaptations would not be cosmetic and there is a general lack of resources to aid in this endeavor.

In the third study (Chapter IV), clinicians emphasized the importance of providing individualized and engaging treatment, necessitating considerable flexibility in treatment delivery in groups. However, clinicians also had serious challenges with group therapy facilitation, due to factors that are likely endemic to any attempt at group therapy (complex group dynamics) as well as challenges that pertain to organizational deficits and barriers (clinicians with inadequate group therapy experience, limited quality control efforts, the predominance of psychoeducation, and limited attention to clients' demographic diversity).

Several implications and recommendations can be made on the basis of this dissertation, which are discussed in more detail in the Discussion sections of each study. In general, the results of this dissertation suggest that it would behoove researchers, clinicians, and administrators to intensively and collaboratively address complexities with group therapy facilitation for SUD treatment. In terms of clinical research, a strong case can be made that the current state of affairs—clinicians being expected to adapt EBTs designed for individuals into group settings—is in fact backwards, and that a more ecological approach would prioritize the design and testing of open group therapies. Of course, this approach has logistical and methodological challenges, but it is time for these challenges to be reckoned with and met by the clinical research community and their funders. Moreover, researchers could be tremendously helpful by working with clinics and clinicians to adapt existing EBTs and best practices in a manner in which they could be more flexibly utilized and widely available, and with greater attention to group therapy as a distinctive modality rather than a mere vehicle for efficient and cost-effective treatment delivery.

For clinicians and administrators, greater recognition ought to be given that group therapy is a distinctive treatment modality requiring specialized training. The current state of

affairs, in which psychoeducational approaches are predominant, should be troubling, especially in light of limited evidence for these approaches. In general, greater attention to clinician training and quality control appears to be sorely needed. In particular, attention for balancing the needs of individuals with those of groups would be important, and a requirement for more successful integration of EBTs in group format (e.g., in providing individualized assignments and feedback). Where possible, clinics are recommended to adapt therapy structures (e.g., length and duration of groups) so that EBT principles can be utilized while at the same time providing adequate attention to group processes and unpredictable individual needs. Assuming that group therapy facilitation will remain a major aspect of SUD specialty treatment for the foreseeable future, it would behoove researchers, clinicians, and administrators to address these challenges.

APPENDICES

APPENDIX A

Clinical Practices Survey for Substance Use Disorders

(Adapted for Group Therapy)

Exploration of Therapy in Substance Use Disorder Treatment

I. ELIGIBILITY CRITERIA

The first several questions are simply to confirm that you are eligible to participate in this study.

1. Do you currently work at least 15 hours per week, providing direct clinical services for substance use disorders (SUDs) in the United States; or have you within the past two years?

- o Yes, currently
- o Yes, not currently but within past two years
- o No [*If no: not eligible*]

2. Have you spent any time facilitating group therapy for substance use disorders within the past two years?

- o Yes
- o No [*If no: not eligible*]

3. Are you licensed and/or certified for clinical practice for your profession in your state?

- o Yes (full license or certification)
- o Yes (temporary / limited license)
- o No [*If no: not eligible*]

4. Are you still a student?

> *Note: If you are licensed or certified to practice independently in your field but also are obtaining further training (e.g., you are an addictions counselor who is in the process of obtaining an MSW), then please answer "no" for this question.*

- Yes [*If yes: not eligible*]
- No

5. Are you a psychiatrist / other medical physician?

- Yes [*If yes: not eligible*]
- No

6. Are you at least 18 years old?

- Yes
- No [*If no: not eligible*]

II. DEMOGRAPHIC INFORMATION

Please answer the following demographic questions.

1. What is your primary profession? (*Select only one.*)

- Addiction therapist / counselor
- Clinical psychologist
- Counseling psychologist
- Marriage and family therapist
- Nurse
- Social worker
- Peer support specialist
- Other: *Please specify*: _____

2. What is the most advanced academic degree that you have obtained?

- High school (diploma, GED, or equivalent)
- Associate degree (for example, AA, AS)
- Bachelor's degree (for example, BA, BS, BSN)
- Master's degree (for example, MA, MS, MSN, MSW)
- Ph.D.
- Psy.D. or Ed.D.
- Other: *Please specify*: _____
- None (no high school diploma or equivalent)

3. In what year did you receive your most advanced degree? (*Please enter a four digit year; for example: 2003; if no degree, enter 0000*): _____

4. Approximately how many years have you been treating people for substance use disorders?

[Pull-down list including "Less than 1 year," each year between 2 and 29 years, and "30+ years."]

5. How do you identify your gender?

- o Man
- o Woman
- o Other: *Please specify*: _____

6. What is your age as of today?

[Pull-down list including each age between 18 and 99 years.]

7. How do you identify your race / ethnicity?

- o American Indian or Alaska Native
- o Asian / Pacific Islander
- o Black / African American
- o Latino/a or Hispanic
- o Multiracial
- o White / Caucasian
- o Other: *Please specify*: _____

8. Have you been or are you currently in recovery for a substance use disorder?

- o Yes, and my clients are typically aware of my recovery status
- o Yes, and my clients are typically <u>not</u> aware of my recovery status
- o No
- o Prefer not to answer

9. What kind of formal / informal training in SUD treatment have you received? (*Select <u>all</u> that apply*)

[Randomized order for responses.]

- _ Self-training (from book, videotape or other materials)
- _ Empirically-based treatment manuals
- _ Interactive computer / web-based training
- _ Clinical workshops
- _ Personal experience in receiving SUD treatment for yourself
- _ Training as part of your certification
- _ Direct supervision / ongoing coaching
- _ Formal coursework in graduate / professional school
- _ Other: *Please specify*: _____

III. INFORMATION ABOUT YOUR WORK SETTING

[Note displayed if respondent indicated past but not current provision of direct clinical services: *Because you indicated that you are not currently working at least 15 hours per week in treating*

SUDs in the United States, but you have within the past two years: Please pretend you are taking the rest of this survey during the last month when you were working at least 15 hours per week in treating SUDs in the United States.]

The following questions are about your work setting. *If you work in more than one clinic / program, then please answer the following questions for the one clinic / program in which you spend the most time treating clients with SUDs.*

1. Which of the following best describes the clinic / program in which you work?

- o Private practice
- o Outpatient SUD specialty clinic
- o Outpatient mental health agency
- o Intensive outpatient / day hospital SUD program
- o Inpatient / residential SUD rehabilitation
- o Halfway house
- o Other: *Please specify*: _____

2. What is the operational structure of this clinic / program?

- o Private non-profit
- o Private for-profit
- o City / county government
- o State government
- o VA or Department of Defense
- o Indian Health Service
- o Tribal government
- o Other: *Please specify*: _____

3. What is the geographic region of this clinic / program? *(Select corresponding region for your state.)*

- o Mid-Atlantic (DC, DE, MD, NJ, PA, VA, WV)
- o Mid-Central (IL, IN, KY, MI, OH, WI)
- o Mid-South (AR, LA, OK, TX)
- o North Central (IA, KS, MN, MO, NE, ND, SD)
- o Northeast (CT, ME, MA, NH, NY, RI, VT)
- o Northwest (AK, ID, OR, MT, WA, WY)
- o Southeast (AL, FL, GA, MS, NC, SC, TN)
- o Southwest (AZ, CA, CO, HI, NM, NV, UT)
- o U.S. territory (PR or other territory)

4. What is your primary role at this clinic / program? (*What do you do most frequently on a day-to-day basis? Select only one.*)

- o Provision of direct services to clients (not including assessment or case management)

- Assessment
- Case management and/or referral
- Supervision and/or administration
- Research and/or evaluation

5. Does this clinic / program include medication-assisted opioid treatment (e.g., methadone or buprenorphine treatment)? (*Please select the one answer that is most accurate.)*

- Yes, and this is a primary function of the clinic / program (provided for nearly all clients).
- Yes, and it is prescribed by physicians in the clinic / program / hospital for some clients.
- No, but it is encouraged for some clients, who can obtain prescriptions from elsewhere.
- No, and it is generally discouraged.
- No, and it is prohibited for all clients.

6. Does this clinic / program include formally advertised, long-term harm-reduction (non-abstinence) treatment options? *(For this survey, medication-assisted treatment is not sufficient to count as harm reduction.)*

- Yes
- No

7. Among SUD clients who have relapsed / resumed use while in treatment, what percentage are terminated from treatment in this clinic / program as a result (in a typical month)?

- None
- Between 1 and 25 percent
- Between 26 and 50 percent
- Between 51 and 75 percent
- Between 76 and 99 percent
- 100 percent

8. In a <u>typical month</u>, approximately how long are the <u>group</u> treatment sessions that you *personally* facilitate? (*Select all that apply*)

_ 30 minutes or less
_ 45-50 minutes
_ 60 minutes
_ 75 minutes
_ 90 minutes
_ Up to 2 hours
_ More than 2 hours

9. In a typical month, what percentage of group treatment sessions that you personally facilitate are "open-enrolling groups"? (For this survey, “open-enrolling groups” are defined as groups where new members routinely join at different times in the life of the group.)

- ○ None
- ○ Between 1 and 25 percent
- ○ Between 26 and 50 percent
- ○ Between 51 and 75 percent
- ○ Between 76 and 99 percent
- ○ 100 percent

IV. INFORMATION ABOUT YOUR CLIENTS

The following questions are about the clients that you *personally* treat in a *typical week* at the clinic / program for which you are working (or in which you spend the most time with SUD clients, if you work in more than one clinic / program). (Note: If you are a clinical supervisor, do not include clients for whom you do not provide direct clinical care, such as your supervisee’s clients.)

1. Which of the following categories of clients do you personally treat in this clinic / program? (*Select all that apply*.)

- _ Clients with alcohol use disorders (with or without another diagnosis)
- _ Clients with drug use disorders (with or without another diagnosis)
- _ Clients with “dual diagnoses” (having a drug / alcohol use disorder and another psychiatric disorder simultaneously)
- _ Clients with mental health / psychiatric problems without any substance use problems

2. What percentage of the clients that you personally treat in this clinic / program have substance use disorders?

- ○ None
- ○ Between 1 and 25 percent
- ○ Between 26 and 50 percent
- ○ Between 51 and 75 percent
- ○ Between 76 and 99 percent
- ○ 100 percent

3. Approximately how many different SUD clients do you personally treat at this clinic / program (in a typical week)?

- ○ None
- ○ 1-10
- ○ 11-20
- ○ 21-30
- ○ 31-40

- 41-50
- 50+

4. Are the SUD clients you personally treat adults, adolescents, or both? (*Do not count parents or children of SUD clients you might consult with or treat in a family modality*.)

- Adults only (all age 18 or older)
- Adolescents only (all age 17 or younger)
- Both adults and adolescents

5. Of the SUD clients you personally treat, approximately how many are . . .

SCALE: (*1* = None or Very Few; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

1	2	3	4	5	Actively using alcohol or illicit drugs and not interested in recovery
1	2	3	4	5	Ambivalent but considering abstinence
1	2	3	4	5	Stating their intention to become abstinent
1	2	3	4	5	Newly abstinent (for less than one month)
1	2	3	4	5	Abstinent for one to three months
1	2	3	4	5	Abstinent for over three months

V. INFORMATION ABOUT YOUR PRACTICE

For this section, please respond to each question as best as you can, referring to the treatment you provide for your SUD clients in a typical month.

Be sure to consider only treatment *you personally have provided* (not treatment others in your same clinic or organization have provided, even for your same clients, nor for treatment you have supervised).

Note: If you work with SUD clients in more than one clinic / program: For this section and the remainder of the survey, please answer on the basis of your clinical practice across work settings.

1. In a typical month, for approximately how many of your SUD clients do you *personally* deliver treatment in the following ways?

SCALE: (*1* = None or Very Few; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

1	2	3	4	5	Individual therapy (not including assessment or case management)
1	2	3	4	5	Group therapy

1 2 3 4 5 Family / couples therapy

2a. In a typical month, for approximately how many of your SUD clients do you *personally* use each of the following approaches?

(*If you are unfamiliar with a given approach, then please select* 1.)

SCALE: (*1* = None or Very Few; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

1 2 3 4 5	Behavioral (not including cognitive-behavioral)
1 2 3 4 5	Body therapies (relaxation, acupuncture)
1 2 3 4 5	Cognitive-behavioral (traditional)
1 2 3 4 5	Cognitive-behavioral ("third wave": for example, ACT, DBT, mindfulness based CBT)
1 2 3 4 5	Emotion-focused, gestalt, or experiential
1 2 3 4 5	Family or marital systems
1 2 3 4 5	Psychodynamic / psychoanalytic
1 2 3 4 5	Motivational interviewing / motivational enhancement therapy
1 2 3 4 5	Community reinforcement approach
1 2 3 4 5	12-step facilitation
1 2 3 4 5	Faith-based
1 2 3 4 5	Rogerian / humanistic
1 2 3 4 5	Supportive-expressive

2b. If applicable, indicate how many of your SUD clients for which you use any approach not listed above. (*If no other approaches, then please select N/A*.)

SCALE: (*1* = None or Very Few; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

1 2 3 4 5 N/A Other: *Please specify*: _____

3a. Which one of the following intervention approaches do you use the most often?

[Randomized order for items.]

- o Behavioral (not including cognitive-behavioral)
- o Body therapies (relaxation, acupuncture)
- o Cognitive-behavioral (traditional)
- o Cognitive-behavioral ("third wave": for example, ACT, DBT, mindfulness based CBT)

- o Emotion-focused, gestalt, or experiential
- o Family or marital systems
- o Psychodynamic / psychoanalytic
- o Motivational interviewing / motivational enhancement therapy
- o Community reinforcement approach
- o 12-step facilitation
- o Faith-based
- o Rogerian / humanistic
- o Supportive-expressive
- o Other: *Please specify*: _____

3b. How did you learn to do this approach? (*Select <u>all</u> that apply.*)

[Randomized order for items.]

- _ Self-training (from book, videotape or other materials)
- _ Empirically-based treatment manuals
- _ Interactive computer / web-based training
- _ Clinical workshops
- _ Personal experience in receiving SUD treatment for yourself
- _ Training as part of your certification
- _ Direct supervision / ongoing coaching
- _ Formal coursework in graduate/professional school
- _ Other: *Please specify*: _____

4a. Which one of the following intervention approaches, if any, do you use the <u>next</u> to most often?

[Randomized order for items.]

- o Behavioral (not including cognitive-behavioral)
- o Body therapies (relaxation, acupuncture)
- o Cognitive-behavioral (traditional)
- o Cognitive-behavioral ("third wave": for example, ACT, DBT, mindfulness based CBT)
- o Emotion-focused, gestalt, or experiential
- o Family or marital systems
- o Psychodynamic / psychoanalytic
- o Motivational interviewing / motivational enhancement therapy
- o Community reinforcement approach
- o 12-step facilitation
- o Faith-based
- o Rogerian / humanistic
- o Supportive-expressive
- o No additional intervention approach [*skip to Section VI*]
- o Other: *Please specify*: _____

4b. How did you learn to do this approach? (*Select all that apply.*)

_ Self-training (from book, videotape or other materials)
_ Empirically-based treatment manuals
_ Interactive computer / web-based training
_ Clinical workshops
_ Personal experience in receiving SUD treatment for yourself
_ Training as part of your certification
_ Direct supervision / ongoing coaching
_ Formal coursework in graduate / professional school
_ Other: *Please specify*: _____

5a. Intervention Approach #3: Which one of the following intervention approaches, if any, do you use the next to most often?

[Randomized order for items.]

- o Behavioral (not including cognitive-behavioral)
- o Body therapies (relaxation, acupuncture)
- o Cognitive-behavioral (traditional)
- o Cognitive-behavioral ("third wave": for example, ACT, DBT, mindfulness based CBT)
- o Emotion-focused, gestalt, or experiential
- o Family or marital systems
- o Psychodynamic / psychoanalytic
- o Motivational interviewing / motivational enhancement therapy
- o Community reinforcement approach
- o 12-step facilitation
- o Faith-based
- o Rogerian / humanistic
- o Supportive-expressive
- o No additional intervention approach [*skip to Section VI*]
- o Other: *Please specify*: _____

5b. How did you learn to do this approach? (*Select all that apply.*)

_ Self-training (from book, videotape or other materials)
_ Empirically-based treatment manuals
_ Interactive computer / web-based training
_ Clinical workshops
_ Personal experience in receiving SUD treatment for yourself
_ Training as part of your certification
_ Direct supervision / ongoing coaching
_ Formal coursework in graduate/professional school
_ Other: *Please specify*: _____

VI. GROUP THERAPY PRACTICES

For this section, we are interested in what you actually do when you provide ***group therapy*** for substance use disorders.

We have listed many techniques and clinical practices that you may have used for treating addiction in groups. You will be asked to indicate ***approximately how many of your total group sessions*** you have used each practice ***in a typical month***.

Please carefully review the following instructions for this set of questions:

- Determine ratings for the proportion of ***total sessions***, not for the proportion of types of different groups. (For example, if in a typical month, a clinician facilitates 15 sessions of cognitive-behavioral group therapy and 15 sessions of twelve-step facilitation group therapy, he/she would determine ratings on the proportion of all 30 sessions.)

- Consider only group sessions, ***not individual work*** (such as case management or assessment) you may also perform, even for the same clients who are in your groups.

- Consider only group sessions ***you personally facilitate*** (not those others in your same clinic or organization facilitate, even for your same clients, nor for group sessions you may supervise).

- Please do your best to honestly assess how often each activity is clearly done. We know no one could possibly use most or even half of the listed techniques and practices within a single group session.

- For each item, select one answer, using the provided scales. (If you have not used a given practice or are unsure about whether you use it, then please select "None/Almost None.")

Before proceeding, please indicate that you have carefully read the above instructions for this set of questions:

- o Yes

---

1. The following items refer to **within-session hands-on techniques.**

In a typical month**,** for how many of your total SUD group sessions do you personally:

SCALE: (*1* = None or Almost None; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

[Randomized order for items.]

1 2 3 4 5	Explore a variety of different mental and behavioral strategies for coping with feelings of temptation (for example, call a friend, think about different options, or engage in another activity)

1 2 3 4 5	Identify and provide training for specific skills group members lacked (such as communication, problem-solving or drink-refusal skills)
1 2 3 4 5	Attempt to enhance motivation and commitment to change
1 2 3 4 5	Help group members identify and prepare for possible triggers or situations that might lead to use
1 2 3 4 5	Help group members learn that they do not automatically have to use substances when experiencing cravings (or other feelings linked to using)
1 2 3 4 5	Discuss, teach, show, or rehearse how to cope with difficult situations without using alcohol / other drugs
1 2 3 4 5	Encourage group members to anticipate future high risk situations and to formulate appropriate ways to manage these situations

---

2. The following items refer to **exploring group members' thoughts and/or feelings.**

In a typical month**,** for how many of your total SUD group sessions do you personally:

[Randomized order for items.]

SCALE: (*1* = None or Almost None; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

1 2 3 4 5	Discuss that one use (a "slip") does not have to become a full relapse
1 2 3 4 5	Listen and then repeat or rephrase what group members had said
1 2 3 4 5	Assess how happy group members were in different areas of life (such as family, social, job, legal, etc.)
1 2 3 4 5	Explore group members' denial of their addiction
1 2 3 4 5	Help group members accept unavoidable cravings without resorting to substance use
1 2 3 4 5	Review group members' reactions to previously assigned tasks, including problems they may have encountered in carrying out these tasks
1 2 3 4 5	Ask open-ended questions with the purpose of getting group members to talk more
1 2 3 4 5	Suggest a different meaning for a group member's experience, placing it in a new light (for example, offering a positive

	interpretation of a group member's negative statement or a negative interpretation of a positive statement)
1 2 3 4 5	Discuss high risk situations group members encountered in the past and explore specific actions they took to avoid or cope with the situation
1 2 3 4 5	Help group members notice and change thoughts that lead to drinking / drug use (for example, "Drinking / using is the only thing that will make me feel better")
1 2 3 4 5	Discuss group members' resistance to participating in a 12-step recovery program
1 2 3 4 5	Examine thoughts and emotions that lead to use
1 2 3 4 5	Examine the positive consequences of using (short-term or long-term)
1 2 3 4 5	Examine the negative consequences of using (short-term or long-term)
1 2 3 4 5	Discuss that using only once will lead to a full-blown relapse

---

3. The following items refer to **therapeutic style.**

In a typical month**,** for how many of your total SUD group sessions do you personally:

SCALE: (*1* = None or Almost None; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

[Randomized order for items.]

1 2 3 4 5	Emphasize that group members are in control of their recovery
1 2 3 4 5	Describe your own life experiences or beliefs with the intent of providing suggestions for problem-solving or emotional support
1 2 3 4 5	Treat group members as partners, including allowing their perspectives to help guide treatment
1 2 3 4 5	Give a strong opinion about what individual group members should do
1 2 3 4 5	Discuss that group members' addiction is a disease
1 2 3 4 5	Remain silent throughout the entire session
1 2 3 4 5	Emphasize that group members are powerless with respect to substance use

1 2 3 4 5	Help group members accept his/her identity as an addict
1 2 3 4 5	Use a confrontational style for the majority of a session (for example, confronting group members if they minimize the harm their substance use causes themselves or others)
1 2 3 4 5	Provide group education on alcohol and/or drug use in a lecture or teaching format
1 2 3 4 5	Facilitate free-form discussion groups or groups without a structure

---

4. The following items refer to **client support.**

In a typical month**,** for how many of your total SUD group sessions do you personally:

SCALE: (*1* = None or Almost None; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

[Randomized order for items.]

1 2 3 4 5	Make comments conveying sympathy, compassion or understanding
1 2 3 4 5	Try to understand group members' perspectives
1 2 3 4 5	Support group members' use of prescribed medications for their substance use, such as Disulfiram (Antabuse), Naltrexone, Methadone, and Buprenorphine (Suboxone)
1 2 3 4 5	Explore the quality of group members' social support network (For example, find out whether they have abstinence-supportive relatives or close friends)
1 2 3 4 5	Promote group members' relationships with God or their Higher Power
1 2 3 4 5	Encourage individual group members by saying something positive or complimentary about their strengths or efforts
1 2 3 4 5	Convey your positive perception of each group member as a person, regardless of whether you agree with their behaviors
1 2 3 4 5	Discuss the 12 steps to recovery

---

5. The following items refer to **facilitating client assignments or behaviors to take place outside of therapy sessions.**

In a typical month**,** for how many of your total SUD group sessions do you personally:

SCALE: (*1* = None or Almost None; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

[Randomized order for items.]

1 2 3 4 5	Ask group members to do one or more specific tasks between sessions (such as practicing skills)
1 2 3 4 5	Encourage and assess group members' involvement with self-help groups (for example, AA, NA, etc.)
1 2 3 4 5	Encourage group members to develop substance-free recreational activities
1 2 3 4 5	Help group members develop a plan to try out a period of abstinence as an experiment
1 2 3 4 5	Encourage group members to practice doing something constructive when having cravings or other feelings that have previously led them to use substances
1 2 3 4 5	Assist group members in defining specific treatment goals in a variety of life areas (including family, social, job, legal, etc.)
1 2 3 4 5	Help group members improve the quality of their social support networks (for example, engage in activities with abstinent friends)

VII. INFLUENCES ON YOUR PRACTICE

The next set of questions is about influences on your clinical practice with substance use disorder (SUD) clients.

1. To what extent do the following resources influence your current practice?

SCALE: (*1* = Not at all; *2* = To a slight extent; *3* = To a moderate extent; *4* = To a great extent; *5* = To a very great extent)

[Randomized order for items.]

1 2 3 4 5	Local workshops / conferences
1 2 3 4 5	State or national workshops / conferences
1 2 3 4 5	In-service / on-site trainings
1 2 3 4 5	Clinical supervision / formal consultation
1 2 3 4 5	Treatment manuals
1 2 3 4 5	Research journal articles
1 2 3 4 5	Clinical journal articles or newsletters

1 2 3 4 5	Internet-based information not specified above (for example, websites)
1 2 3 4 5	Electronic network / list-serv
1 2 3 4 5	Informal discussions with colleagues
1 2 3 4 5	Books
1 2 3 4 5	Training videos

2a. To what extent do the following factors influence your current practice?

SCALE: (*1* = Not at all; *2* = To a slight extent; *3* = To a moderate extent; *4* = To a great extent; *5* = To a very great extent)

[Randomized order for items.]

1 2 3 4 5	Institutional restrictions on number of sessions
1 2 3 4 5	Institutional requirements on type of treatment provided
1 2 3 4 5	Your clients' financial limitations
1 2 3 4 5	Your training (or lack thereof) in a particular approach
1 2 3 4 5	Training in graduate or professional school
1 2 3 4 5	Significant mentor / role model
1 2 3 4 5	A central, national figure in your field

2b. To what extent does the following factor influence your current practice?

If not applicable, or if you prefer not to answer, please select "N/A"

SCALE: (*1* = Not at all; *2* = To a slight extent; *3* = To a moderate extent; *4* = To a great extent; *5* = To a very great extent)

1 2 3 4 5 N/A	Your experience with your own recovery

3. Since you began your first job providing SUD treatment, have you learned and tried out a treatment or technique that was new to you?

- o Yes
- o No [*Skip to Section VIII*]

4. To what extent did each of the following influence you to **learn and try out** a new treatment or technique?

SCALE: (*1* = Not at all; *2* = To a slight extent; *3* = To a moderate extent; *4* = To a great extent; *5* = To a very great extent)

[Randomized order for items.]

1 2 3 4 5	Clients claiming that the treatment changed their lives
1 2 3 4 5	Positive findings in a major research journal
1 2 3 4 5	Endorsement by your professional organization as an evidence-based practice
1 2 3 4 5	Endorsement by treatment providers you respect
1 2 3 4 5	The technique or treatment could be integrated with the treatment you already provide
1 2 3 4 5	Training was readily available
1 2 3 4 5	Your practice setting provided adequate time to learn different approaches
1 2 3 4 5	You perceived the treatment as better than what you were already doing (in terms of economics, social prestige, convenience, or satisfaction)
1 2 3 4 5	The treatment / technique seemed to fit with your existing values, experiences and needs
1 2 3 4 5	The technique / treatment seemed easy to understand and use
1 2 3 4 5	You had the opportunity to try out or experiment with the treatment or technique

4a. Do you <u>still</u> use any of the new treatments or techniques you learned / tried out?

- o Yes
- o No [*Skip to Section VIII*]

4b. To what extent did any of the following factors lead to your **continued use** of the new treatment or technique?

SCALE: (*1* = Not at all; *2* = To a slight extent; *3* = To a moderate extent; *4* = To a great extent; *5* = To a very great extent)

[Randomized order for items.]

1 2 3 4 5	Client(s) liked it and reported feeling better
1 2 3 4 5	The technique/treatment could be integrated with the treatment that you currently provide
1 2 3 4 5	Endorsements by your professional organization
1 2 3 4 5	Colleagues were enthusiastic about the approach
1 2 3 4 5	Your setting provided adequate amount of time with your clients to use the treatment
1 2 3 4 5	You found there was client demand for the treatment
1 2 3 4 5	You enjoyed conducting the treatment or using the technique
1 2 3 4 5	The treatment developers offered many ways to obtain additional training, materials, and decision support
1 2 3 4 5	You were able to obtain advanced training in the treatment
1 2 3 4 5	The technique/treatment was easy to understand and use
1 2 3 4 5	You found you were able to conduct the technique/treatment successfully and better help clients
1 2 3 4 5	You perceived the treatment as better than what you were already doing (in terms of economics, social prestige, convenience or satisfaction)
1 2 3 4 5	The treatment / technique was compatible with your existing values, experiences and needs

VIII. ASSESSMENT AND ASSOCIATED SERVICES

We are interested in the extent to which you provide certain services for substance use disorders (SUD).

For this section, these services could take place in any context or type of treatment (for example, case management, assessment, individual therapy, group therapy, or family therapy), as long as they are services that *you personally have performed* (not those that others in your same clinic or organization have performed, even for your same clients, nor for treatment that you have supervised).

Using the scale below, select one number for each statement. (If you do not use a given service or are unsure about whether you use it, then please select "None or Very Few".)

1. In a **typical month,** for **how many of your SUD clients** did you:

SCALE: (*1* = None or Very Few; *2* = Some; *3* = Half; *4* = Most; *5* = Almost All or All)

[Randomized order for items.]

1 2 3 4 5	Make housing arrangements or refer to housing services
1 2 3 4 5	Recommend or provide HIV testing and/or counseling
1 2 3 4 5	Recommend or provide Hepatitis C testing
1 2 3 4 5	Ask whether the client has a history of depression
1 2 3 4 5	Assess depression using a depression scale (such as the BDI)
1 2 3 4 5	Refer to continuing care groups and clinics
1 2 3 4 5	Refer to a continuing care appointment with a specific provider at a given date and time
1 2 3 4 5	Encourage to attend a mutual self-help group (for example, AA, NA, etc.)
1 2 3 4 5	Assess for PTSD or trauma history
1 2 3 4 5	Provide information about the medical services available to the client
1 2 3 4 5	Ensure that the client receives proper evaluation and, when necessary, psychiatric care
1 2 3 4 5	Assess for domestic violence and, when appropriate, recommend or offer treatment
1 2 3 4 5	Assess tobacco use and, when appropriate, refer to or provide smoking cessation treatment
1 2 3 4 5	Offer or refer the client for educational, vocational, or employment services
1 2 3 4 5	Offer or refer the client for social and independent living skills training
1 2 3 4 5	Encourage clients who smoke *not* to try to quit smoking while they are trying to change their alcohol or drug use

1 2 3 4 5	Refer to a physician / psychiatrist (externally or as part of your clinic) for the purpose of being prescribed medication for psychiatric/mental/emotional symptoms or disorders.
1 2 3 4 5	Refer to a physician / psychiatrist (externally or as part of your clinic) for the purpose of being prescribed medication to treat addiction, beyond detoxification (for example, Antabuse, Suboxone, Methadone, etc.)
1 2 3 4 5	Use or recommend acupuncture as the sole treatment
1 2 3 4 5	Use or recommend detoxification as the primary treatment
1 2 3 4 5	Engage the client in long-term psychodynamic treatment
1 2 3 4 5	Provide group education on alcohol and/or drug use in a lecture or teaching format
1 2 3 4 5	Use relaxation therapy as the principal treatment approach
1 2 3 4 5	Discuss the 12 steps to recovery
1 2 3 4 5	Facilitate free-form discussion groups or groups without a structure
1 2 3 4 5	Provide immediate rewards (such as vouchers redeemable for services or goods) for specific actions, including abstinence, taking medication, or treatment attendance
1 2 3 4 5	Focus primarily on substance use when setting treatment goals because functioning in other life areas will improve with sobriety
1 2 3 4 5	Involve clients' family members / partners in treatment

APPENDIX B

Semi-Structured Interview Guide: Clinical Director Participants

[Note: This interview guide is meant to facilitate open-ended responses from participants. For this reason, actual questions may be slightly different from what are presented here, as well as possibly presented in a different order. Although it is difficult to anticipate what kinds of additional / varying questions may be asked, this guide provides the spirit of the kinds of questions that will be asked.]

PRE-INTERVIEW

[Estimated time: 5-10 minutes]

a. [Express gratitude to participant.]
b. [Review informed consent document / remind of time expected for interview / ask if any questions.]
c. [Introductory prompt:] For this interview, I am interested in learning, from your perspective as a clinical director, overall information about the clinic and the services it provides, especially in terms of group sessions. As a reminder, this interview is confidential, including not disclosing the name of the clinic—as well as any characteristics that would obviously identify the clinic—in any published reports. Do you have any questions or concerns before we begin?
d. [Indicate that I will begin recording now; begin recording.]

I. OVERALL CHARACTERIZATION OF CLINIC

[Estimated time: 10-15 minutes]

I thought we could begin by talking about [Name of Clinic] generally, in terms of its purpose, its history, and its overall services.

1. How would you describe the overall mission or purpose of [Name of Clinic]? (What is its treatment philosophy? What makes it distinctive? Are there particular theories that guide clinical practice here?)
2. To the extent that you are familiar, could you briefly summarize the history of [Name of Clinic]? How has it changed over time? (How are these changes evident in what happens today?)
3. [If not already addressed] What are the major goals of treatment here (today)?
4. Could you briefly summarize the various types of services that are provided at [Name of Clinic]? (e.g., assessment, detox, medication, individual therapy, group therapy, family therapy, social services, housing)
5. [If not already addressed] Is medication for dual diagnoses and/or addiction provided here? Harm reduction approaches? Contingency management? (Why or why not? Explore clinic's philosophy.)

II. SPECIFIC QUESTIONS ABOUT CLINIC

[Estimated time: 15-20 minutes]

Now I would like to ask you some specific questions about the clinic, in terms of its providers, its clients, and its practices. In the interest of time, these questions are generally meant to have somewhat brief responses.

6. What is the operational structure of [Name of Clinic]—is it private, public, etc.? (What are its major funding sources?) What kinds of patient payment / reimbursement are accepted? What are most typical?
7. What different kinds of providers / clinicians are employed here (including medical providers)? (Ask about training, professions, licensure, recovery status.) What criteria do you use to hire clinicians? How are clinicians trained? Supervised? Are student trainees utilized? Is clinician turnover a problem?
8. What other staff members are utilized here? Are peer support specialists utilized? (In what ways?)
9. What are the primary substance problems you see? (Ask for at least rough percentages if possible.) Roughly what percentage of clients is female? White? African American? Latino? Asian? American Indian? LGBT? Court ordered? From what major sources are clients referred?
10. How do clients typically get to the clinic? Is public transportation readily available and convenient? Do you provide transportation to those who need it? Is housing available to some clients? Is parking available / free? Is childcare available? Are services available at different times of day or on weekends? (Ask for details.) What other services are available to clients as part of their treatment here?

11. What assessment procedures are used at intake? (What domains are assessed?) Are clients assessed / treated for dual mental health conditions? (Ask for details, including about referral.)
12. What criteria are used to enroll clients? (How long are wait lists?) To place clients in different levels of care? (What clients would not be appropriate for one level of care vs. another?) To transfer clients from one type of care to another? To terminate clients?
13. Are mutual support groups encouraged or required as part of treatment here? (How frequently? How is this facilitated?) Are other kinds of community integration (e.g., employment, volunteer work, or church involvement) encouraged or required?
14. Is drug testing routinely conducted as part of treatment here? (How frequently? Ask for details.) What happens when clients report having used / drank while in treatment? Are clients ever terminated due to using / drinking?
15. How are family members involved in treatment?
16. All things considered, what do you think [Name of Clinic] does best? In what ways do you think [Name of Clinic] struggles or could use improvement? (What services would you like to see offered here, or offered more frequently?) What are the biggest barriers to individuals seeking treatment here or remaining in treatment?

III. GROUP SESSIONS AT CLINIC

[Estimated time: 15-25 minutes]

Now I would like to ask you about the different kinds of group therapy that are offered here. An important goal of mine is to make sure I understand very well the different kinds of groups with which clients might be involved here.

17. [If not already addressed] Could you briefly describe the different kinds of groups that are offered here? [Ask follow-up questions as needed about the following:]
    a. [Make sure all different kinds of group topics are addressed.]
    b. What groups are psychoeducational? Process groups? Skills-oriented groups? "Check-in" groups? Specialty topic groups?
    c. Is the structure of the group curriculum fixed, or might it vary depending on client needs or other circumstances? Are there different "tracks" of treatment (e.g., according to stages of change)?
    d. Are groups open-enrolling or closed? How long do groups run / how many sessions? How long are group sessions?
    e. How many clients are in each group? (What is the least, average, and most?)
    f. How many clinicians are utilized for each group? (Are some groups co-facilitated?)
    g. [If not already addressed] What different theoretical approaches are used to guide groups?
    h. [If respondent does not know all of these details, ask which staff members are most familiar about details of group sessions.]
18. What is a group that is exemplary of the kind of treatment that [Name of Clinic] cares most about or does best? What are the basic goals, processes, activities, etc. of this group?
19. How individualized and flexible are treatment plans in terms of group therapy (e.g., what groups a person attends, what tasks are done in sessions, etc.)? (Does group therapy intersect with individual case management in a substantive way?)

20. Could you describe some common trajectories that different kinds of clients might go through, in terms of progressing in treatment? (If applicable: ask about progression from one kind of treatment to another.)
21. What is the justification for having so much group therapy? (Beyond economic reasons, what do you see groups doing that cannot be done individually? What are drawbacks of groups relative to individual treatment?)

IV. QUESTIONS ABOUT GROUP FACILITATION

[Estimated time: 10-15 minutes]

I now have some questions about how clinicians facilitate group sessions.

22. How do clinicians learn how to facilitate group sessions? (Do they observe others?)
23. How much do clinicians speak vs. group members? How do they facilitate conversation?
24. How do clinicians prepare for groups in advance? (What materials, manuals, handouts, etc. do they use?)
25. What kinds of difficult, unpredictable things have happened in groups? [Ask for examples.]
26. In what ways is gender addressed in groups? Race / ethnicity / culture?
27. Are there major demographic differences between group facilitators and clients at [Name of Clinic]? How is this addressed in groups?
28. Are there particular ground rules for groups? How are these regulated / enforced? Received by clients?
29. What would you say are characteristics or behaviors of an effective group facilitator?

a. What kind of training / experience do you think is important for leading groups? (Have you received this level of training?)

b. How does [Name of Clinic] ensure that group sessions are high in quality?

V. EVIDENCE-BASED PRACTICE CONCERNS

[Estimated time: 10-15 minutes]

We are almost finished—just one final set of questions about evidence-based practice.

30. Would you consider the groups that are offered here to be evidence-based treatments? [Ask follow-up questions about how / why this is so.]
31. How often and in what ways do you consult scientific research to guide practice here?
32. How are staff trained in delivering specific evidence-based treatments? In supervising / implementing delivery of evidence-based treatments? (In evidence-based *group* treatments?)
33. [If clinic utilizes evidence-based treatments]:
    a. What do you like most about your organization using evidence-based treatments? What do you like least?
    b. How do you feel about clinicians working from a treatment manual for group therapy?
    c. In what ways do evidence-based treatments need to be adapted for your clinic? Your clients? How do you gauge whether clinicians have drifted from the way the intervention is intended to be delivered? (Is fidelity monitoring ever done?)
34. What is your sense of the importance of evidence-based treatments to clinicians here? What are the biggest barriers to implementing evidence-based treatments here? (Do you

feel like there are adequate resources / training / supervision? Does clinician burn out play a role?)

POST-INTERVIEW

[Estimated time: 5-10 minutes]

I believe we have touched on everything I've wanted to ask. Is there anything you would like to add?

a. [Indicate that I will end recording now; end recording.]

b. [Express gratitude.]

c. [Provide reimbursement.]

APPENDIX C

Semi-Structured Interview Guide: Clinician Participants

[Note: This interview guide is meant to facilitate open-ended responses from participants. For this reason, actual questions may be slightly different from what are presented here, as well as possibly presented in a different order. Although it is difficult to anticipate what kinds of additional / varying questions may be asked, this guide provides the spirit of the kinds of questions that will be asked.]

PRE-INTERVIEW

[Estimated time: 5-10 minutes]

e. [Express gratitude to participant.]

f. [Collect survey; ask if any questions about it; ensure all questions were answered.]

g. [Review informed consent document / remind of time expected for interview / ask if any questions.]

h. [Introductory prompt:] For this interview, I am interested in learning in more depth and detail the kinds of things you were asked about in the surveys—things like the kinds of group practices you are involved with and what specifically goes on in group sessions, as well as about your experience and your beliefs about addiction and treatment. I would encourage you to be as honest and candid as possible, with the understanding that there

are no right or wrong answers and that this interview is confidential. Do you have any questions or concerns before we begin?

i. [Indicate that I will begin recording now; begin recording.]

I. CLINICIAN BACKGROUND / EXPERIENCE / BELIEFS

[Estimated time: 5-10 minutes]

I thought we could begin by talking briefly about your background and experience, as well as your general orientation to clinical practice.

1. What brought you to working in substance use disorder treatment?
2. And what brought you to working here at [Name of Clinic]?
3. What do you believe are the most important purposes for substance abuse treatment?
4. How would you describe your theoretical orientation to clinical practice?
5. What are your primary roles here?

II. OVERALL CHARACTERIZATION OF CLINIC

[Estimated time: 5-10 minutes]

I'd like to now ask you a few brief questions about [Name of Clinic].

6. How would you describe the overall mission or purpose of [Name of Clinic]? (What is its treatment philosophy? Its major goals? What makes it distinctive?)
7. [If not already clear] Could you briefly summarize the various types of services that are provided at [Name of Clinic]? (e.g., assessment, detox, medication, individual therapy, group therapy, family therapy, social services, housing)

8. [If not already addressed and if not already clear] Is medication for dual diagnoses and/or addiction provided here? Harm reduction approaches? Contingency management? (Why or why not? Explore clinic's philosophy.)
9. All things considered, what do you think [Name of Clinic] does best? In what ways do you think [Name of Clinic] struggles or could use improvement? (What services would you like to see offered here, or offered more frequently?) What are the biggest barriers to individuals seeking treatment here or remaining in treatment?

III. GROUP SESSIONS AT CLINIC

[Estimated time: 10-25 minutes]

I want to make sure I understand very well the different kinds of groups with which clients might be involved here. I would like to first review with you what I have already learned from talking with others here, and then I'll invite you to share what I might be missing or what you think is not quite right. [Show and discuss document that shows different groups (topics and types), information on fixed vs. flexible nature of group curriculum, information on group structure (e.g., open-enrolling vs. closed, number of sessions, length of sessions, number of clients and clinicians per group), and information on different tracks for various clients. This document will be made on the basis of interviews with clinic directors, and will be revised if needed after each new interview with clinicians. I will not share with respondents who said what.]

10. Would you say this is an accurate description of the groups that are provided here? Anything you would add / clarify?

11. [If not already clear] What is a group that is exemplary of the kind of treatment that [Name of Clinic] cares most about or does best? What are the goals of this treatment? What are the major processes, activities, tasks, etc. of this group?
12. [If not already addressed] What groups have *you* personally facilitated recently? Which of these have you facilitated most frequently?
13. [If not already clear] How individualized and flexible are treatment plans in terms of group therapy (e.g., what groups a person attends, what tasks are done in sessions, etc.)? (Does group therapy intersect with individual case management in a substantive way?)
14. [If not already clear] Could you describe some common trajectories that different kinds of clients might go through, in terms of progressing in treatment? (If applicable: ask about progression from one kind of treatment to another.)
15. What is the justification for having so much group therapy? (Beyond economic reasons, what do you see groups doing that cannot be done individually? What are drawbacks of groups relative to individual treatment?)

IV. DETAILS OF SPECIFIC GROUP CLINICIAN HAS FACILITATED

[Estimated time: 15-25 minutes]

I would like to ask you some questions about [group the respondent has facilitated most frequently]. You are welcome to share thoughts from other groups as well, but the purpose is to discuss in detail a specific group you have experience with.

16. [If not already addressed] What are the goals of this treatment? What are the major processes, activities, tasks, etc. of this group?
17. [Ask follow-up questions as needed about the following:]

a. Is this group a psychoeducational group, process groups, kills-oriented group, “check-in” group, and/or specialty topic group? (Why?)
b. Is this group open-enrolling or closed? How many sessions? How long are group sessions?
c. How many clients are in each group? (What is the least, average, and most?)
d. Do you co-facilitate this group?
e. What theoretical approaches are used to guide this group?

18. How did you learn how to facilitate this type of session? (Did you observe others? Who?)
19. How much do you speak vs. group members? How do you facilitate conversation?
20. How do you prepare for this group in advance? (For example, what materials, manuals, handouts, etc., do you use?) When do you prepare? How much time on average do you take to prepare beforehand? (Do you always prepare?)
21. I would like to have a sense of what happens, from beginning to end, in a typical session of this group. Could you very briefly run through the process? [Get a sense of distinguishing between psychoeducation/lecturing, group discussion, skills practice, homework assignment, homework follow-up, and any other activities.]
22. Are there particular ground rules for this group? How are these encouraged or enforced? Received by clients?

V. FURTHER QUESTIONS ABOUT GROUP FACILITATION

[Estimated time: 20-30 minutes]

I now have some questions to ask you about your group facilitation generally—not simply for the group we have been discussing.

23. How can you tell when you've had a very successful group session? [Ask for an example.]
24. How can you tell when you've had a very unsuccessful group session? [Ask for an example.]
25. What kinds of difficult, unpredictable things have happened in your groups? [Ask for examples.]
26. In what ways is gender addressed in your groups? Race / ethnicity / culture?
27. What would you say are characteristics or behaviors of an effective group facilitator?
    a. What kind of training / experience do you think is important for leading groups? (Have you received this level of training?)
    b. How does [Name of Clinic] ensure that group sessions are high in quality?

VI. EVIDENCE-BASED PRACTICE CONCERNS

[Estimated time: 10-15 minutes]

We are almost finished—just one final set of questions in which I will ask you "step back" a bit and reflect on some broader treatment issues, particularly about evidence-based practice.

28. How do you feel about evidence-based treatments?
29. What do you like most about using evidence-based treatments? What do you like least?
30. How do you feel about working from a treatment manual for group therapy?
31. [If respondent has experience with working from treatment manuals] How do you decide whether to deviate from the treatment protocol? [Ask for examples—both structural and in vivo.] How do you gauge whether you have drifted from the way the intervention is intended to be delivered?

32. [Other follow-up questions about evidence-based practice, depending on previous answers and time.]

POST-INTERVIEW

[Estimated time: 5-10 minutes]

I believe we have touched on everything I've wanted to ask. Is there anything you'd like to add?

a. [Indicate that I will end recording now; end recording.]

b. [Express gratitude.]

c. [Provide reimbursement.]