CHAPTER 1

Guided Self-Change Treatment and Its Successful Extension to Group Therapy

> A persuasive body of outcome research has demonstrated unequivocally that group therapy is a highly effectively form of psychotherapy and that it is at least equal to individual psychotherapy in its power to provide meaningful benefit.
>
> —Yalom and Leszcz (2005, p. 1)

This chapter lays the foundation for the rest of this book by (1) reviewing the development of the Guided Self-Change (GSC) treatment model and the several lines of research that influenced the model; (2) comparing the GSC treatment model with other cognitive-behavioral interventions for substance use disorders; (3) discussing how the GSC treatment model was successfully disseminated throughout the community in which it was originally developed; and (4) presenting the results of the randomized controlled trial (RCT) that successfully extended the GSC treatment model developed as an individual treatment to a group therapy format.

The GSC treatment model was an outgrowth of our earlier research on outpatient treatment of problem drinkers. In comparison with more severely dependent drinkers, problem drinkers are not physiologically dependent on alcohol, tend to have had a problem for fewer years, are usually employed, have a supportive environment, and are very resistant to traditional labels such as *alcoholic* or *drug addict*. These differences are described in detail in our earlier book, *Problem Drinkers: Guided Self-Change Treatment* (M. B. Sobell & Sobell, 1993a). Although the GSC treatment model was developed for English-speaking problem drinkers, it has been extended to and evaluated with drug abusers whose problems are not severe (L. C. Sobell et al., 2009; L. C. Sobell, Wagner, Sobell, Agrawal, & Ellingstad, 2006) and to Spanish-speaking alcohol abusers (Ayala, Echeverría, Sobell, & Sobell, 1997, 1998; Ayala-Velazquez, Cardenas, Echeverría, & Gutierrez, 1995). The findings of our study comparing GSC delivered in a group versus an individual-treatment format and extending the GSC treatment model to drug abusers are presented in this chapter, as is a summary of a previous review of several studies that evaluated the GSC treatment model and adaptations of that model (M. B. Sobell & Sobell, 2005).

INFLUENCES ON THE DEVELOPMENT OF THE GSC TREATMENT MODEL

As reviewed elsewhere (M. B. Sobell & Sobell, 1993a, 2005), several lines of research influenced the development of the GSC treatment model. The first major influence derived from epidemiological research conducted in the 1970s showing that many individuals had alcohol problems that were not severe (e.g., Cahalan & Room, 1974; Schuckit, Smith, Danko, Bucholz, & Reich, 2001; M. B. Sobell & Sobell, 1993b). Consistent with other health problems, it seemed reasonable to think such individuals might benefit from a less intense, briefer intervention compared with individuals with more severe alcohol problems. Related to this was research on problem drinkers' preferences for moderation goals (Heather & Robertson, 1981; Marlatt et al., 1985; Miller, 1986–1987).

Another important influence on the development of the GSC treatment model was a study by Edwards and his colleagues (1977) that found that one session of advice or counseling produced the same outcomes as a comprehensive treatment. Furthermore, individuals randomly assigned to either condition generally showed considerable improvement. Although the majority of cognitive-behavioral studies until that time had emphasized skills training, improvement following a single session could not be explained by skills training. Rather, the most likely explanation was that many individuals have the capacity to change their substance abuse problem if sufficiently motivated and that the single session catalyzed their motivation. Such thinking is supported by research on the phenomenon of self-change (i.e., natural recovery) that has shown that many people with alcohol and drug problems can successfully change on their own (reviewed in Klingemann & Sobell, 2007).

Bandura's (1977, 1986) social cognitive theory was another influence on the development of the GSC treatment model, as it suggested that self-efficacy, outcome expectations, and goal choice might be important determinants of motivation. Many individuals with substance use disorders (SUDs), especially those whose problems are not severe, are ambivalent about the need to change. In this regard, another influence was the development of motivational interviewing, a therapeutic approach put forth by Miller and his colleagues to minimize resistance and increase clients' motivation to change (Miller, 1983; Miller & Rollnick, 1991, 2002). The motivational interviewing approach was consistent with Prochaska and DiClemente's (1984) transtheoretical model of change that conceptualized motivation as a state and targeted increasing motivation for change as a focus of therapy. For these reasons, motivational interviewing has become the recommended counseling style for developing a therapeutic alliance with clients (Kazdin, 2007; Meier, Barrowclough, & Donmall, 2005; Moyers, Miller, & Hendrickson, 2005).

THE GSC TREATMENT MODEL COMPARED WITH OTHER COGNITIVE-BEHAVIORAL INTERVENTIONS FOR SUDs

The GSC intervention reflects a synergy of time-tested cognitive-behavioral strategies that are delivered using motivational interviewing techniques (e.g., rolling with resistance, decisional balance exercise, readiness ruler). Although the GSC treatment model has several unique features, it also shares many features with other cognitive-behavioral interventions, including the use of functional analysis (M. B. Sobell, Sobell, & Sheahan, 1976); self-monitoring of alcohol and drug use (L. C. Sobell & Sobell, 1973); problem-solving skills to develop alternative responses to

drinking or drug use situations (D'Zurilla & Goldfried, 1971); and homework assignments, including a decisional balance exercise (Janis & Mann, 1977; Kazantzis, Deane, & Ronan, 2000).

Table 1.1 highlights the major differences between the GSC treatment model and other cognitive-behavioral interventions for SUDs. Factors unique to the GSC treatment model include (1) incorporating cognitive elements of the relapse prevention model (Marlatt & Donovan, 2005; Marlatt & Gordon, 1985; M. B. Sobell & Sobell, 1993a); (2) allowing alcohol clients to self-select their treatment goals (i.e., moderation or abstinence; M. B. Sobell & Sobell, 1995); (3) using the Timeline Followback (TLFB) to provide clients with feedback about their pretreatment alcohol or drug use and related risks (Agrawal, Sobell, & Sobell, 2008; L. C. Sobell & Sobell, 2003); (4) allowing clients to request additional sessions after the four semistructured GSC sessions (M. B. Sobell & Sobell, 1993a); and (5) using a motivational interviewing style throughout the delivery of the intervention.

Before we further describe the GSC treatment model and its extension to group therapy, it is important to briefly review the findings of studies that compared the same treatment delivered in individual and group formats with substance abusers. As will be apparent, such studies are few in number.

BRIEF REVIEW OF STUDIES COMPARING GROUP AND INDIVIDUAL TREATMENTS FOR SUDs

With a long and rich history (Bernard & MacKenzie, 1994; Scheidlinger, 1994; Yalom & Leszcz, 2005), group therapy is a popular form of treatment across many clinical disciplines (e.g., psychology, psychiatry, social work) and across a wide range of clinical problems (e.g., anxiety and mood disorders, posttraumatic stress disorder, obesity) (Barlow, Burlingame, Nebeker, & Ander-

TABLE 1.1. Major Ways the GSC Treatment Model Differs from Other Cognitive-Behavioral Interventions for SUDs

- Provides goal choice that includes low-risk drinking and accepts harm-reduction alternatives for clients not willing to seek abstinence.
- Clients functionally analyze their own substance use (i.e., identify high-risk trigger situations and associated consequences for use) and develop their own treatment plans.
- Emphasizes the application of problem-solving skills.
- Incorporates cognitive elements of the relapse prevention model into the treatment. Rather than providing skills training, a relapse management approach is used to generate a dialogue about taking a realistic perspective on change and to discuss the need to construe slips as learning experiences.
- Uses the Timeline Followback to gather pretreatment substance use data that are then used to generate personalized feedback for clients about their level of substance use, risks, and consequences.
- Incorporates flexibility in scheduling, explicitly soliciting client input as the main determinant for additional sessions.
- As a brief intervention, it includes an aftercare telephone call 1 month after the last scheduled session that is intended to provide support for clients' functioning and to facilitate resumption of treatment if needed.
- Uses motivational interviewing as a communication style throughout the intervention, in addition to incorporating various motivational interviewing strategies and techniques (e.g., readiness ruler, advice feedback, decisional balancing).

son, 2000; Guimon, 2004; Humphreys et al., 2004; Panas, Caspi, Fournier, & McCarty, 2003; Satterfield, 1994; Scheidlinger, 1994; Weiss, Jaffee, deMenil, & Cogley, 2004). In the substance abuse field it is the "most common treatment modality" (Weiss et al., 2004, p. 339). The popularity of groups relates in large part to two factors: (1) the provision of social support to clients and (2) the ability to treat multiple clients concurrently and at a lower cost than individual therapy.

The term *group therapy* has been used to describe a wide variety of therapeutic activities (e.g., educational, didactic, interactional, process, support, aftercare, codependency), including self-help groups. Although self-help groups, a widely used group format in the substance abuse field, incorporate and resemble some aspects of group therapy, there are several major differences, the most significant being that leaders need no professional training (Scheidlinger, 1994; Yalom & Leszcz, 2005). Consequently, self-help groups are not included in this review.

Group therapy has a long tradition in the treatment of SUDs (Center for Substance Abuse Treatment, 2005; Institute of Medicine, 1990; Panas et al., 2003; Vannicelli, 1992; Weiss et al., 2004), especially with adolescents (D'Amico et al., 2011; Kaminer, 2005). Given this history, one might expect to find considerable research supporting the efficacy of group therapy with SUDs. To the contrary, RCTs of group versus individual treatment are sparse and lack appropriate controls (Institute of Medicine, 1990; Weiss et al., 2004).

In one of the first reviews of the group therapy literature with alcohol abusers, Brandsma and Pattison (1985) found 30 studies. Based on their review, they concluded that it was impossible to evaluate the efficacy of group therapy, as the research was plagued with multiple problems (e.g., inadequate designs, inadequate specification of procedures, lack of controls, poor measures, lack of replications), including that most of the group treatments had been combined with other program components (e.g., individual therapy, aftercare, self-help meetings). Despite these problems, the studies reported abstinence or improvement rates ranging from 15 to 53%, comparable to those for individual treatments.

A similar review conducted two decades later (Weiss et al., 2004) found that little has changed from the Brandsma and Pattison (1985) review. In this recent review, 24 comparative trials of group therapy with SUDs were found. The authors classified these studies into six distinct categories: (1) group therapy versus no group therapy (e.g., Stephens, Roffman, & Curtin, 2000); (2) group therapy versus individual therapy (e.g., Marques & Formigoni, 2001); (3) group therapy plus individual therapy versus group therapy alone (e.g., Linehan et al., 1999); (4) group therapy plus individual therapy versus individual therapy alone (e.g., McKay et al., 1997); (5) group therapy versus another group therapy with different content or theoretical orientation (e.g., Kadden, Cooney, Getter, & Litt, 1989); and (6) more group therapy versus less group therapy (e.g., Coviello et al., 2001). The two major conclusions from this review were that no significant outcome differences existed between group and individual treatments and that no single type of group therapy was superior.

RCTs of the Same Treatment Delivered in a Group versus Individual Format for SUDs

Because the RCT of the GSC treatment model involved an evaluation of the same treatment in an individual versus a group format (L. C. Sobell et al., 2009), the following review includes only RCTs that compare the same treatment delivered in a group versus an individual format. Consequently, studies comparing different types of groups (e.g., Abrams & Wilson, 1979; Miller & Taylor, 1980; Oei & Jackson, 1980) or different group and individual treatments (e.g., McKay

et al., 1997; Stephens et al., 2000) are not included. In addition, family and marital studies are excluded, as they have no individual-treatment component.

Of the 24 studies in the Weiss and colleagues (2004) review, only 3 (12.5%) addressed the efficacy of group compared with individual therapy for SUDs (Graham, Annis, Brett, & Venesoen, 1996; Marques & Formigoni, 2001; Schmitz et al., 1997). Although not in the Weiss and colleagues review, a fourth study (Duckert, Johnsen, & Amundsen, 1992) using an RCT compared the same treatment in group and individual formats for alcohol abusers. To facilitate comparisons among these four RCTs, the major characteristics of each study are listed in Table 1.2. Thus only details not in Table 1.2 are discussed subsequently.

In the Graham and colleagues (1996) study, alcohol and drug abusers were randomized to 12 sessions of relapse prevention aftercare treatment delivered in either a group or an individual format. At the follow-up, there were no significant differences between the two treatment conditions on any alcohol or drug use outcome measures. However, prior to randomization, all clients had participated in one of two treatment programs for SUDs (12-step 26-day residential program or 1-year outpatient eclectic group). Because other interventions (mainly groups) immediately preceded this study's comparison of group and individual aftercare, it does not allow a true comparison of the efficacy of the two aftercare treatment modalities.

TABLE 1.2. RCTs of the Same Treatment Delivered in Group versus Individual Formats for SUDs

	Author (year)			
Study characteristic	Duckert et al. (1992)	Graham et al. (1996)	Marques & Formigoni (2001)	Schmitz et al. (1997)
Country	Norway	Canada	Brazil	United States
Sample size	135	192	155	32
% Male	60.0	66.9	92.0	50.0
Type of substance abuse problem	Alcohol	Alcohol and other drugs	Alcohol and other drugs	Cocaine
Treatment type	Cognitive-behavioral	Relapse prevention aftercare	Cognitive-behavioral	Cognitive-behavioral relapse prevention aftercare
No. of scheduled sessions	12	12	17	12
Length (min) of group sessions	90	60–90	—	60
Follow-up period (mo)	21	12	15	6
% Found for follow-up	57.7	74.0	68.4	84.0
Self-reports confirmed	Yes	No	Yes	Yes
Significant outcome differences				
Pre- versus posttreatment	Yes	Yes	Yes	Yes
Group versus individual	No	No	No	No

Note. Dash indicates that data were not reported.

In the Schmitz and colleagues (1997) study, cocaine-dependent clients who had recently completed an inpatient chemical dependency treatment program were subsequently randomly assigned (by cohorts) to a 12-session manualized cognitive-behavioral relapse prevention treatment delivered in either a group or individual format. At the follow-up, there were no significant differences between the two conditions. As with the Graham and colleagues (1996) study, because all participants had received other substance abuse treatment before the RCT, a pure test of the efficacy of the two aftercare treatments is not possible.

In the Marques and Formigoni (2001) study, alcohol and drug abusers were randomly assigned to a 17-session cognitive-behavioral treatment delivered in either a group or an individual format. The first treatment session, which was conducted individually for both conditions, consisted of reviewing assessment data and presenting educational information about alcohol and drugs. Abstinence was required of all participants for the first 3 months, after which alcohol clients could select a moderation goal. Although the two conditions did not have significantly different outcomes at the follow-up, 7% of participants had dropped out after the first session, and only 54% completed 8 of the 17 sessions. Although there were no significant differences in dropout rates between the group and individual conditions, drug clients attended significantly fewer sessions than did alcohol clients.

In the Duckert and colleagues (1992) study, alcohol abusers were recruited through newspaper advertisements, matched pairwise, and then randomly assigned to a 12-session cognitive-behavioral treatment delivered in either a group or an individual format. Groups were of a single gender, and all participants were allowed to select an abstinence or moderation drinking goal. Besides the format, the two conditions differed in the number of hours spent in sessions (individual: 7 hours; group: 25 hours). At follow-up no significant differences were found between the group and individual conditions on a number of outcome variables, including alcohol consumption. When asked at the follow-up, a larger number of group than individual participants reported that they wanted more contact with their therapists. This may reflect the feeling that group participants had received proportionately less personal attention from their therapists than they would have if they had been assigned to individual therapy.

In summary, RCTs comparing the same treatment delivered in a group versus an individual format for clients with SUDs are rare. Of the four published studies, two (Graham et al., 1996; Schmitz et al., 1997) were not pure comparisons, as clients had received other treatment immediately prior to being randomized. The most striking and consistent finding across all four studies, however, was that, although clients demonstrated significant improvements in their substance use, there were no differences between the group- and individual-treatment formats. Last, none of the four studies reported any cost-effectiveness evaluations of group versus individual treatment.

Research Issues in Conducting RCTs of Group versus Individual Therapy

Several issues make it difficult to conduct research studies comparing group with individual therapy. One serious problem that can threaten the validity of such treatment comparisons is differential attrition (Piper, 1993; Piper & Joyce, 1996). In this regard, studies have shown that a greater number of clients drop out when assigned to group than to individual therapy (Budman et al., 1988; Hofmann & Suvak, 2006). The Budman and colleagues (1988) study, an RCT of group versus individual therapy with psychiatric clients, illustrates the importance of implementing strategies to minimize dropouts. The great majority of the 29 patients who dropped

out after being informed of their assignment had been assigned to group rather than individual therapy (89.7%, $n = 26$; 10.3%, $n = 3$, respectively). Therefore, although significant improvements occurred in both conditions, it was impossible to draw firm conclusions about the relative efficacy of group versus individual therapy because of differential attrition. Another issue concerns recruiting a sufficient number of participants to randomize to group and individual treatment, particularly in closed groups (i.e., those to which no new members are added after the first session), which can be difficult. Other complicating factors involve group characteristics (e.g., gender composition) and different session lengths for group and individual therapy. Last, a critical issue that must be addressed in any comparative evaluation of group versus individual treatment is whether the study is a pure comparison in which there are no other concurrent or preceding treatment components (e.g., treatments preceding aftercare, self-help groups, pharmacotherapy) that could provide alternative explanations for the findings.

Several conclusions about the role and utility of group therapy can be drawn based on this chapter: (1) group processes play an important role in the efficacy of groups; (2) because of their inherent structure, groups offer important advantages that do not exist in an individual therapy setting; (3) groups that incorporate group processes have reported comparable outcomes to individual therapy; and (4) groups can treat multiple patients at one time, thereby reducing the financial burden on the payer. Given the widespread use of group therapy in clinical practice with SUDs, the only curious issue is why there is a paucity of research (particularly RCTs) evaluating the *same type of treatment* (e.g., theoretical orientation, procedures, number of sessions) delivered in a group versus an individual setting. With these caveats in mind, we now return to a consideration of GSC and how it was adapted to a group format.

GENERAL FRAMEWORK OF THE GSC TREATMENT MODEL

The general framework for the GSC treatment model is an assessment and four semistructured sessions, with additional sessions available as needed. The major components of a GSC assessment and four-session treatment program for substance abusers, whether delivered in an individual or a group format, are described in detail in Chapters 4 and 5, respectively. These chapters include therapist handouts for each individual therapy (4.1–4.4) and each group therapy (5.1–5.4) session. Each handout contains detailed session guidelines, objectives, procedures, and homework exercises. In addition, each group therapist handout contains guidelines on how to conduct several round-robin discussions, which is the format used to conduct the clinical intervention in a group format. Round-robin discussions were designed so that support, feedback, and advice emanate primarily from group members rather than from the group leaders.

EXTENDING THE GSC TREATMENT MODEL TO A GROUP FORMAT

The primary empirical support for the cognitive-behavioral, motivational interviewing group therapy approach that is the subject of this book derives from an RCT that compared a GSC intervention delivered in a group versus an individual format (L. C. Sobell et al., 2009). For two decades starting in the mid-1970s, our clinical research focused on developing and validating individual therapies for those with SUDs. However, by the early 1990s the substance abuse field as well as the agency where we were then employed, the Addiction Research Foundation

in Toronto, Canada, had developed waiting lists for clients requesting individual therapy. At this same time, both in the United States and in Canada, there were serious concerns about health care cost containment as well as cost-effective treatments (Rosenberg & Zimet, 1995; Spitz, 2001; Steenberger & Budman, 1996). Consequently, we decided to extend and validate the GSC treatment model in a group format. The group-versus-individual study, also known as *GRIN* (*GR*oup vs. *IN*dividual), was an RCT that evaluated the GSC treatment model delivered in a group versus an individual format with 264 alcohol and drug abusers voluntarily seeking treatment. This was also the first study to evaluate the GSC treatment model with drug abusers whose problems were not severe (e.g., no intravenous drug users participated). Although discussion of the group treatment procedures and details occupies much of this book, it will be helpful to first discuss how the GRIN study evolved and to present the results of the RCT of GSC used in group and individual therapy.

All of the therapists who participated in the GRIN study were trained in conducting GSC treatment, a time-limited cognitive-behavioral motivational intervention (M. B. Sobell & Sobell, 1993a, 2005), with individual clients, and most had some, albeit limited, experience in conducting groups. However, early during a pilot study intended to precede the formal study, it became clear that the integration of cognitive-behavioral procedures (e.g., homework, self-monitoring, functional analyses of behaviors, relapse prevention) and motivational interviewing techniques, vital elements of the GSC individual treatment model, would require careful thought and attention if they were to be successfully incorporated into a group setting. The major concern was addressing the needs and problems of multiple clients while capitalizing on group processes without a loss of therapeutic effectiveness. To address this concern, we stopped the pilot study and spent several months reviewing the group psychotherapy literature to determine how to best integrate the GSC intervention into a group format. Our goal was to retain the curative elements of the GSC intervention delivered individually while addressing the constraints and opportunities intrinsic to group therapy.

After stopping the initial pilot study and providing the GSC staff with training in group skills and how to integrate them with their cognitive-behavioral and motivational interviewing skills, a second pilot study was conducted, followed by the completion of the GRIN study. We believe that the success of the GRIN study, and especially the high level of group cohesion achieved, demonstrates that we were able to successfully integrate cognitive-behavioral and motivational interviewing principles and techniques with group processes.

HOW WELL DOES GSC WORK?

As reviewed elsewhere (M. B. Sobell & Sobell, 2005), the GSC treatment model has been evaluated in multiple settings (e.g., outpatient alcohol treatment programs, primary care centers), with different populations (adults, adolescents, alcohol and drug abusers, gamblers), and with both English and Spanish speakers. A summary of the main findings of studies evaluating the GSC treatment model for clients with alcohol problems that also had 1 year or more of follow-up appears in Table 1.3. This table lists the outcome variables assessed in each study and shows the percentage change for those variables from pretreatment to posttreatment. For proportion of days abstinent, a positive change indicates improvement, whereas for mean drinks per drinking day (or mean drinks per week), a negative change indicates improvement. The amount of change demonstrated in these studies is similar to that shown in other studies of brief interven-

tions (Babor et al., 2006) and primary care interventions (Fleming, Barry, Manwell, Johnson, & London, 1997).

There are two additional published studies, involving adolescents, that used the GSC treatment model, but because they did not meet the 1-year follow-up criterion, they are not listed in Table 1.3. In one study (Breslin, Li, Sdao-Jarvie, Tupker, & Ittig-Deland, 2002), at the 6-month follow-up, 50 adolescent substance users treated with an adaptation of GSC were found to have reduced their substance use by about 44%. The second study, also an adaptation of GSC, involved 213 African American and Hispanic adolescents. Preliminary follow-up results around 11 weeks found that clients' self-reported marijuana and alcohol use had decreased about 55% and 47%, respectively (Gil, Wagner, & Tubman, 2004). The findings from these two studies are consistent with those in Table 1.3 that have a 1-year follow-up, but they showed greater change scores, possibly because of their shorter follow-up intervals. Although studies using motivational interviewing in groups with adolescents are few in number, D'Amico and her colleagues have offered compelling arguments (D'Amico et al., 2011) and support (D'Amico, Osilla, & Hunter, in press) for motivational interviewing is particularly suited (e.g., taking a collaborative approach, addressing ambivalence about changing, avoiding labels, allowing youths to give voice to the need to change rather than being told what to do) for at-risk youths and particularly those from disadvantaged/marginalized or cultural minority backgrounds.

Because this book is intended as a clinical guide, the studies in Table 1.3 are not further discussed. The evidence, however, shows that the GSC treatment model has consistently been associated with substantial and significant gains over the course of treatment and that these changes are maintained following treatment.

How Well Does GSC Work in Groups?

Findings from the GRIN study are briefly summarized here, as they have been reported in detail elsewhere (L. C. Sobell et al., 2009). The participants had voluntarily sought treatment for an alcohol or drug problem at the Addiction Research Foundation in Toronto, Ontario, Canada. When the study was conducted, the Addiction Research Foundation was the largest outpatient service provider in the province of Ontario. The GRIN study was designed for problem drinkers and for drug abusers voluntarily seeking treatment (drug abusers who used drugs intravenously or who used heroin were excluded). The major procedural details of the GRIN study (i.e., session dialogues, forms, exercises, round-robin discussions) are described in other places throughout this book. Chapter 3 discusses assessment measures and materials used in both the GSC individual and group sessions and Chapters 4 and 5 present the GSC treatment model in terms of its application to the conduct of the individual and group therapy, respectively. Also included in these chapters are the therapist and client handouts, clinical examples, and sample therapist and client dialogues. The details of the statistical analyses of the GRIN are reported elsewhere (L. C. Sobell et al., 2009). What follows is a summary of the important findings and also some insights into the study that go beyond what can be communicated in journal articles.

The most important result of the GRIN study was that participants in both the individual- and group-treatment conditions showed sizeable and significant improvement across treatment and follow-up. There were, however, no significant differences between the two treatment formats. That is, although clients in both treatment conditions significantly reduced their alcohol or drug use, it did not matter whether they were in individual or group therapy.

TABLE 1.3. Summary of Outcome Studies Evaluating the GSC Treatment Model for Clients with Alcohol Problems

Study and group	Variable	Pretreatment	Posttreatment	Change
Andréasson, Hansagi, & Oesterlund (2002)				
4GSCS (n = 30)	Mean drinks/DD	5.2	4.5	–13%
1GSCS (n = 29)	Mean drinks/DD	6.3	4.7	–25%
Ayala et al. (1998)				
INDIV (n = 177)	Prop abstinent	0.73	0.82	+9%
INDIV (n = 177)	Mean drinks/DD	9.2	6.5	–29%
Breslin et al. (1998)				
SC (n = 33)	Prop abstinent	0.28	0.45	+17%
NSC (n = 36)	Prop abstinent	0.24	0.37	+13%
M. B. Sobell, Sobell, & Gavin (1995)				
BC (n = 36)	Prop abstinent	0.32	0.61	+29%
RP (n = 33)	Prop abstinent	0.33	0.50	+17%
BC (n = 36)	Mean drinks/DD	6.7	4.2	–37%
RP (n = 33)	Mean drinks/DD	5.1	3.6	–29%
M. B. Sobell, Sobell, & Leo (2000)				
DSS (n = 19)	Prop abstinent	0.23	0.47	+24%
NSS (n = 24)	Prop abstinent	0.21	0.44	+23%
DSS (n = 19)	Mean drinks/DD	6.3	4.3	–21%
NSS (n = 24)	Mean drinks/DD	5.8	4.6	–20%
L. C. Sobell et al. (2009)				
INDIV (n = 107)	Prop abstinent	0.30	0.58	+28%
GRP (n = 105)	Prop abstinent	0.30	0.53	+23%
INDIV (n = 107)	Mean drinks/DD	6.4	4.1	–36%
GRP (n = 105)	Mean drinks/DD	6.7	4.6	–31%
L. C. Sobell et al. (2002)				
ME/PF (n = 321)	Prop abstinent	0.21	0.35	+14%
B/DG (n = 336)	Prop abstinent	0.23	0.34	+11%
ME/PF (n = 321)	Mean drinks/DD	5.9	4.7	+20%
B/DG (n = 336)	Mean drinks/DD	5.9	4.7	+20%

Note. All studies had to have a minimum of 1 year of follow-up. Study and group designations: 4GSCS, 4 GSC sessions; 1GSCS, 1 GSC session; INDIV, individual treatment; SC, supplemental care; NSC, no supplemental care; BC, behavioral counseling; RP, behavioral counseling plus cognitive relapse prevention; DSS, directed social support; NSS, natural social support; GRP, group treatment; ME/PF, motivational enhancement/personalized feedback; B/DG, bibliotherapy/drinking guidelines. Prop abstinent, proportion of days abstinent; Mean drinks/DD, mean number of drinks consumed per drinking day. Change is defined as the percentage of change pretreatment to posttreatment. From M. B. Sobell and L. C. Sobell (2005, p. 205). Copyright 2005 by the Springer Publishing Company. Reprinted by permission.

Validity of Self-Reports and Treatment Integrity Checks

As part of the study, each participant provided the name of a collateral informant who could be contacted to corroborate the participant's self-reports of posttreatment alcohol or drug use. Results showed that collaterals confirmed participants' self-reports of alcohol and drug use (L. C. Sobell et al., 2009). A treatment integrity check on therapists' compliance with the study protocol found that compliance was uniformly high for both the individual and group treatment conditions (L. C. Sobell et al., 2009).

Outcomes for Alcohol Clients

Figure 1.1 shows that for clients who had a primary alcohol problem, the percentage of abstinent days for those in the individual and group treatment conditions were similar at all three time points. Furthermore, for clients in both conditions, the percentage of abstinent days showed a large increase over treatment that was sustained over the 12-month follow-up. Figure 1.2 shows similar results but for mean number of standard drinks consumed per drinking day. Again, the data for clients in both treatment conditions were very similar. Because some reports in the alcohol literature have noted that females have shown better outcomes than males in brief cognitive-behavioral interventions (Sanchez-Craig, Leigh, Spivak, & Lei, 1989; Sanchez-Craig, Spivak, & Davila, 1991), we explored whether there were any gender differences. However, no significant differences related to gender or relating gender to treatment conditions were found for this study.

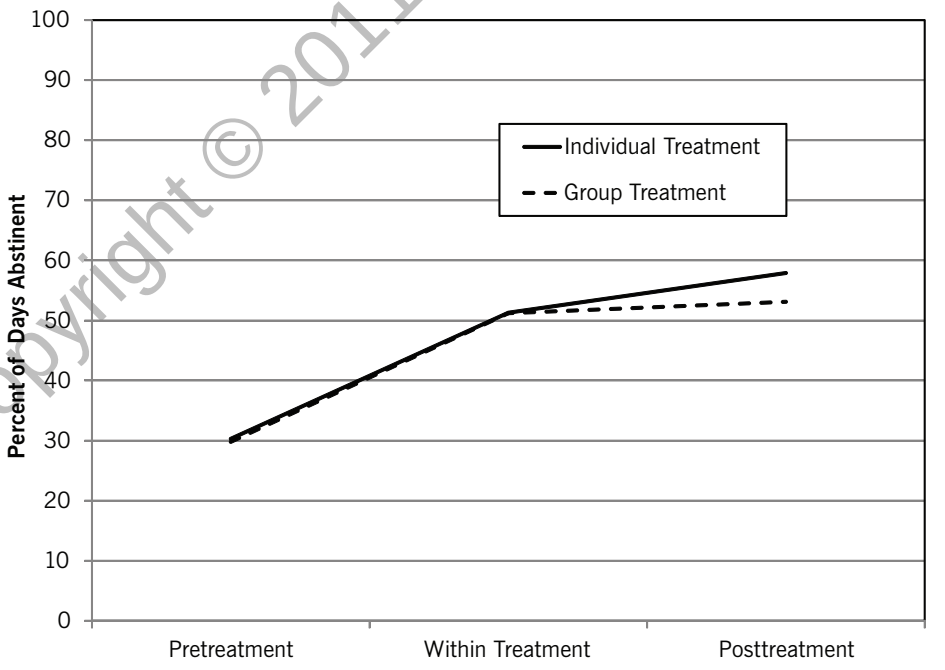

FIGURE 1.1. Percent of days abstinent during pretreatment, within treatment, and posttreatment for problem drinkers assigned to individual- and group-treatment conditions.

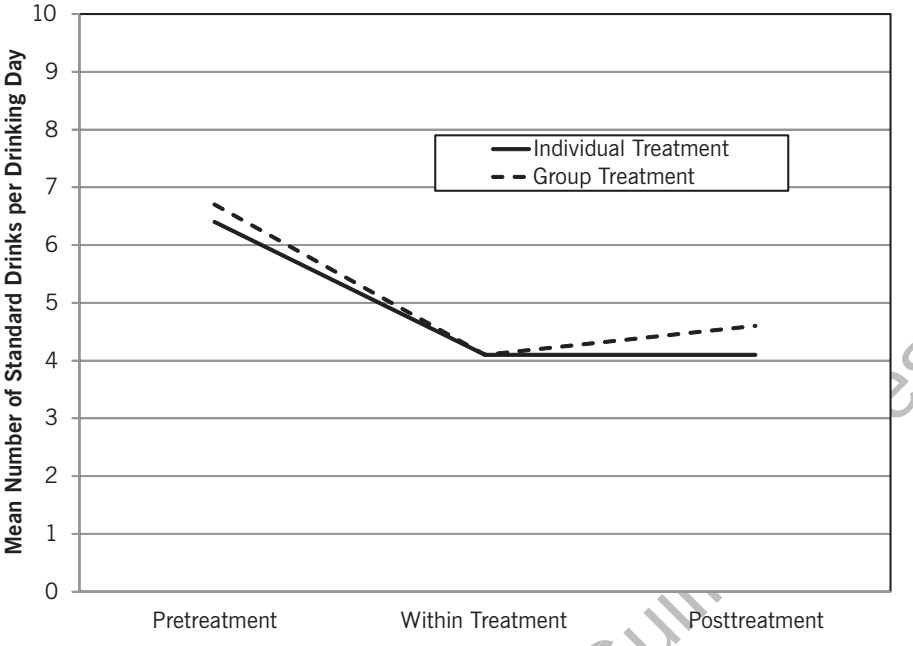

FIGURE 1.2. Mean number of standard drinks per drinking day during pretreatment, within treatment, and posttreatment for problem drinkers assigned to individual- and group-treatment conditions.

For clients with alcohol problems, an interesting pattern of improvement was observed. As in other studies involving problem drinkers, approximately three-quarters of the clients chose to work on reducing rather than stopping their drinking (Sanchez-Craig, Annis, Bornet, & MacDonald, 1984; M. B. Sobell, Sobell, & Gavin, 1995). However, in terms of drinking outcomes, as shown in Figure 1.3, the main change over the course of treatment and follow-up was that alcohol clients greatly reduced their percentage of heavy drinking days (i.e., five or more standard drinks), and concurrently increased their percentage of abstinent days. In contrast, their frequency of limited drinking days (i.e., one to four standard drinks) stayed almost constant from pre- to posttreatment. This phenomenon, in which clients chose a low-risk, limited-drinking goal but then increased their abstinent days, is consistent with another study (Sanchez-Craig, 1980) that found that those assigned to a low-risk drinking goal were significantly better able to abstain for the first 3 weeks of treatment (they were requested to do so putatively to facilitate the assessment) than those randomly assigned to an abstinence goal. These findings strongly suggest that the way clients view their ability to manage their drinking can be an important variable affecting their drinking decisions.

Outcomes for Cocaine and Cannabis Clients

In addition to providing a demonstration that the GSC intervention delivered in groups was as effective as the same intervention delivered individually, the GRIN study also extended the GSC treatment model to individuals with drug problems other than alcohol, most notably cocaine and cannabis. Figure 1.4 shows how the percentage of days abstinent from drug use changed from pretreatment through treatment and follow-up. Because there were no significant

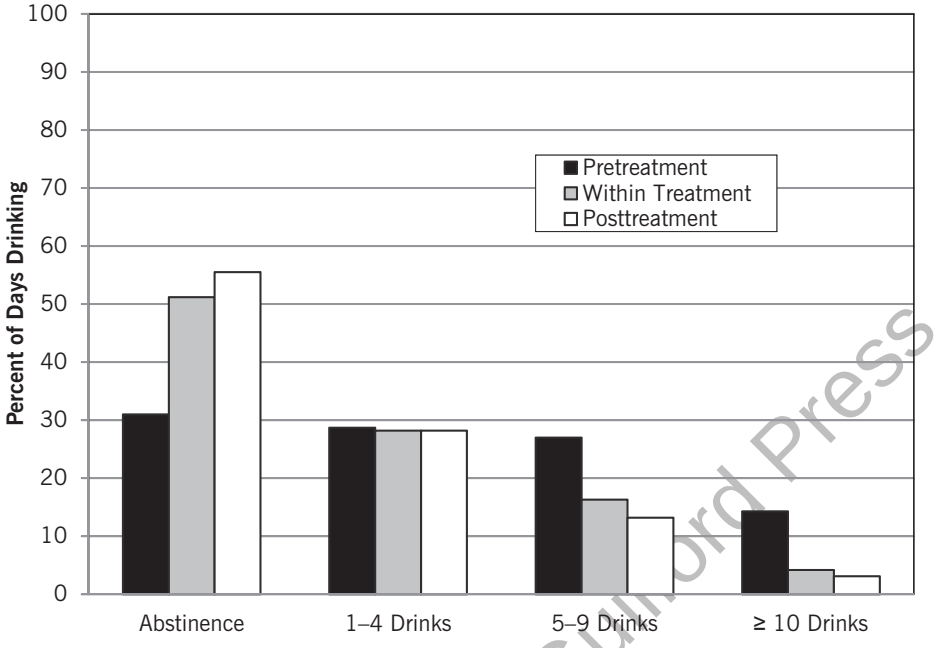

FIGURE 1.3. Percent of days drinking at different levels during pretreatment, within treatment, and posttreatment for problem drinkers. Because the individual- and group-treatment conditions did not differ significantly, they were combined.

differences at any point between clients in the group or individual conditions, data from both conditions were combined in Figure 1.4. As can be seen, clients with a primary cocaine problem improved considerably over treatment and continued to improve over follow-up. For clients for whom cannabis was the primary problem, although substantial gains over treatment were made, some regression over the follow-up year occurred. At the end of follow-up, however, they still were using far less than prior to treatment.

Therapist Time Ratio Analysis of GSC Group versus Individual Treatment

When treatments that require different amounts of resources are compared, the key question is not whether one treatment is as effective as another but whether a more expensive or demanding treatment (from the patient's perspective) produces sufficiently superior outcomes to warrant the added cost or personal investment. In evaluating the GSC treatment in a group versus an individual format, we calculated a therapist time ratio comparing the time spent providing group compared with individual treatment. This evaluation showed that there was a 41.4% savings in therapists' time when conducting group therapy (L. C. Sobell et al., 2009).

Clients' Evaluations of the GSC Intervention at the End of Treatment

Almost all of the participants (209 of 213: 106 individual treatment; 103 group treatment) who completed the fourth and last structured treatment session also completed an assessment of

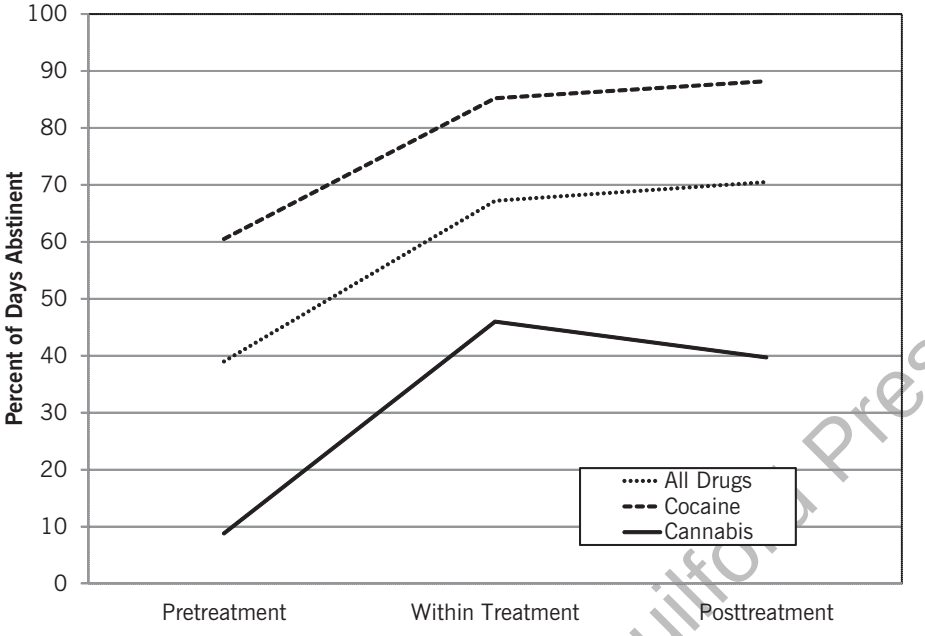

FIGURE 1.4. Percent of days abstinent from drugs during pretreatment, within treatment, and posttreatment for all drug abusers, and separately for cocaine and cannabis abusers.

treatment, rating several aspects of their treatment on 5-point scales (with lower scores reflecting more favorable ratings). Table 1.4 shows clients' end-of-treatment ratings for group and individual conditions and for clients with primary alcohol problems or primary drug problems. Some of the differences, as noted in Table 1.4, are statistically significant.

Overall, clients in both the individual- and the group-treatment conditions rated the program very positively, with mean ratings near the favorable end of the scale (1.42 and 1.56, respectively). Several other aspects of the intervention were also highly rated: quality of service, self-change component, therapists, self-monitoring logs, and the program atmosphere. In fact, with the exception of the length of the treatment and the difficulty of the homework, all mean ratings were positive. With regard to treatment length, group clients were more likely to rate the treatment as being "too little" (mean = 3.55) than individual clients (mean = 3.17), although the mean ratings for this variable suggested that clients in both conditions would have liked the treatment to be longer. Because this study was an RCT, the length of treatment was kept constant. However, in practice the GSC treatment model is flexible and allows for additional sessions. Clients in the group condition also rated the readings and the homework exercises as more useful than clients in the individual condition. One reason this may have occurred is that in the group condition the homework assignments formed the basis of round-robin discussions and, as such, received more attention and talk time because they were discussed by multiple clients. Last, and very important, clients were highly satisfied with being assigned to the group condition (mean = 1.55, with 1 = very satisfied). With regard to the statistically significant differences shown in Table 1.4, they were small in absolute magnitude, and there was no consistent direction of difference.

TABLE 1.4. Clients' End-of-Treatment Ratings of Treatment by Condition (Individual or Group) and by Primary Substance Problem (Alcohol or Drug)

Variable	Treatment condition	
	Individual (n = 107) Mean (SD)	Group (n = 106) Mean (SD)
Satisfied with treatment (1 = very, 5 = not at all)	1.42 (0.74)[a]	1.56 (0.76)[b]
Quality of service (1 = excellent, 5 = poor)*	1.23 (0.46)[a]	1.43 (0.59)[c]
Program length (1 = too much, 5 = too little)*	3.17 (0.64)[a]	3.55 (0.73)[d]
Satisfied with self-change component (1 = very, 5 = not at all)	1.91 (0.93)[a]	1.84 (0.97)[b]
Satisfied with therapist (1 = very, 5 = not at all)*	1.16 (0.44)[a]	1.42 (0.69)[b]
Readings useful (1 = very, 5 = not at all)*	2.25 (0.99)[e]	1.86 (0.93)[b]
Homework useful (1 = very, 5 = not at all)*	2.03 (0.96)[e]	1.68 (0.89)[d]
Homework difficulty (1 = too easy, 5 = too hard)	2.78 (0.62)[f]	2.86 (0.73)[d]
Self-monitoring useful (1 = very, 5 = not at all)	1.66 (0.83)[e]	1.65 (0.93)[b]
Decisional balance exercise useful (1 = very, 5 = not at all)*	2.23 (0.98)[e]	1.93 (0.89)[b]
Satisfied with program atmosphere (1 = very, 5 = not at all)	1.50 (0.75)[e]	1.69 (0.89)[b]
Program was helpful (1 = very much, 5 = not very much)	1.43 (0.66)[e]	1.52 (0.73)[d]
Recommend program to friend (1 = definitely, 5 = definitely not)	1.23 (0.50)[a]	1.27 (0.61)[g]
Satisfied with being in group (1 = very, 5 = not at all)		1.55 (0.76)[h]
	Primary substance problem	
Variable	Alcohol (n = 180) Mean (SD)	Drugs (n = 33) Mean (SD)
Satisfied with treatment (1 = very, 5 = not at all)	1.49 (0.76)[h]	1.53 (0.76)[i]
Quality of service (1 = excellent, 5 = poor)	1.34 (0.54)[j]	1.26 (0.51)[k]
Program length (1 = too much, 5 = too little)	3.34 (0.67)[j]	3.44 (0.91)[d]
Satisfied with self-change component (1 = very, 5 = not at all)	1.89 (0.98)[j]	1.81 (0.78)[i]
Satisfied with therapist (1 = very, 5 = not at all)	1.30 (0.60)[h]	1.22 (0.55)[i]
Readings useful (1 = very, 5 = not at all)	2.01 (0.99)[l]	2.34 (0.90)[i]
Homework useful (1 = very, 5 = not at all)	1.80 (0.94)[l]	2.16 (0.92)[i]
Homework difficulty (1 = too easy, 5 = too hard)	2.84 (0.68)[l]	2.71 (0.82)[k]
Self-monitoring useful (1 = very, 5 = not at all)*	1.58 (0.84)[j]	2.06 (0.98)[i]
Decisional balance exercise useful (1 = very, 5 = not at all)	2.09 (0.96)[j]	2.03 (0.90)[i]
Satisfied with program atmosphere (1 = very, 5 = not at all)	1.58 (0.81)[l]	1.66 (0.83)[j]
Program was helpful (1 = very much, 5 = not very much)	1.46 (0.68)[l]	1.53 (0.76)[i]
Recommend program to friend (1 = definitely, 5 = definitely not)	1.25 (0.55)[h]	1.25 (0.62)[i]
Satisfied with being in group (1 = very, 5 = not at all)	1.57 (0.76)[m]	1.47 (0.77)[n]

Note. Ratings made on 5-point scales (1–5) with end points shown for each variable.
[a]n, 106; [b]n, 103; [c]n, 101; [d]n, 102; [e]n, 105; [f]n, 104; [g]n, 100; [h]n, 177; [i]n, 32; [j]n, 176; [k]n, 31; [l]n, 175; [m]n, 81; [n]n, 19;
*$p < .05$, two-tailed independent sample t-tests.

Clients' Evaluations of the GSC Intervention at the 12-Month Follow-Up

At the end of the 12-month follow-up, clients again rated their treatment experiences. Table 1.5 shows clients' evaluations of treatment at the 12-month follow-up for both the group and individual conditions and for clients with primary alcohol and primary drug problems. A total of 230 clients completed the follow-up questionnaires. Similar to their evaluations at the end of treatment, clients' overall evaluations of their treatment at the follow-up were positive, with more than 90% suggesting that the GSC program should continue and over 80% reporting that their substance use was either no longer a problem or less of a problem than before they entered treatment. Interestingly, and consistent with the end-of-treatment evaluations, 42.1% felt that the GSC treatment was not long enough. In this regard, there is substantial evidence that many alcohol and drug abusers with less severe problems show great improvement in brief treatment (e.g., Marijuana Treatment Project Research Group, 2004; Moyer, Finney, Swearingen, & Vergun, 2002; Stephens et al., 2000; Stern, Meredith, Gholson, Gore, & D'Amico, 2007). For example, in a multicenter RCT that compared two 12-session treatments delivered over 12 weeks (12-Step Facilitation and Cognitive-Behavioral Coping Skills) with a 4-session treatment (Motivational Enhancement treatment) delivered over 12 weeks, there were no important differences in outcomes between the treatments (Project MATCH Research Group, 1998). This finding is consistent with other studies showing that a sizeable proportion of individuals with various psychiatric disorders achieve successful outcomes after a few treatment sessions (Wilson, 1999). Thus, although clients in the present study felt that they would have liked more treatment, whether a longer treatment would have yielded better outcomes remains an empirical question. Finally, at the end of follow-up, 82.5% of individual and 81.0% of group clients felt that treatment goals should be self-selected. In addition, 87.7% of individual and 87.1% of group clients said that choosing their own goals was a good thing.

Clients' Evaluations of Group Treatment at Follow-Up

As discussed earlier, the literature shows that when given a choice most clients say they would prefer individual over group therapy. Thus it was decided that at the end of the 12-month follow-up and after all the outcome data had been collected, clients would again be asked to rate their treatment experience, this time including what treatment condition they would have chosen if they had been given a choice at the start of the study. Although it was a retrospective evaluation, significantly more group (38.2%) than individual (5.8%) clients stated at their 12-month follow-up that if given their choice they would have selected group treatment. This suggests that there was a preexisting bias against group therapy that to some extent was lessened by the clients' experience in the groups. At the end of the follow-up, 59.2% of the group clients and 75.6% of all clients still said they would have chosen individual treatment if given a choice. Consistent with the literature, these findings suggest that if group therapy is to be offered, providers need to include pregroup induction procedures to explain the benefits of group therapy and to attend to questions that potential group members may have about group therapy and its effectiveness. Finally, 75.4% of the individual and 65.5% of the group clients said they would prefer to be given the choice between individual and group treatment rather than being assigned to a treatment condition.

TABLE 1.5. Clients' Evaluations of Treatment at the 12-Month Follow-Up by Condition (Individual or Group) and by Primary Substance Problem (Alcohol or Drug)

Question	Treatment condition	
	Individual (IT) (n = 114)	Group (GT) (n = 116)
Amount of treatment		
% too little	36.3[a]	47.8[b]
% sufficient	62.8	51.3
% too much	0.9	0.9
Drinking status		
% no longer a problem	30.7	31.0
% less of a problem	50.0	52.6
% unchanged	16.7	14.7
% more of a problem	2.6	1.7
Choose own goal		
% good thing	87.7	87.1
% bad thing	4.4	5.2
% no opinion	7.9	7.8
Who should select goal?		
% self-select	82.5	81.0
% therapist select	10.5	12.1
% no opinion	7.0	6.9
Program should continue		
% yes	90.4	93.9[b]
% no	2.6	0.9
% no opinion	7.0	5.2
If assigned to GT, would have participated		
% yes	61.4	
% no	33.3	
% do not know	5.3	
If assigned to IT, would have participated		
% yes		92.2
% no		6.0
% do not know		1.7
If given choice, would have chosen**		
% IT	91.9[c]	59.2[d]
% GT	5.8	38.2
% no opinion	2.3	2.6

(cont.)

TABLE 1.5. *(cont.)*

Question	Primary substance problem: Alcohol (n = 189)	Primary substance problem: Drugs (n = 41)
Amount of treatment		
% too little	40.1[e]	51.2
% sufficient	58.8	48.8
% too much	1.1	0.0
Drinking status		
% no longer a problem	31.2	29.3
% less of a problem	52.4	46.3
% unchanged	14.8	19.5
% more of a problem	1.6	4.9
Choose own goal		
% good thing	88.9	80.5
% bad thing	3.7	9.8
% no opinion	7.4	9.8
Who should select goal*		
% self-select	86.2	61.0
% therapist select	9.0	22.0
% no opinion	4.8	17.1
Program should continue		
% yes	92.1	92.5[f]
% no	1.6	2.5
% no opinion	6.3	5.0
If assigned to GT, would have participated		
% yes	60.4[g]	66.7[h]
% no	33.3	33.3
% do not know	6.3	0.0
If assigned to IT, would have participated		
% yes	91.4[i]	95.7[j]
% no	7.5	0.0
% do not know	1.1	4.3
If given choice, would have chosen		
% IT	74.4[k]	86.2[l]
% GT	22.6	13.8
% no opinion	3.0	0.0

Note. At the last follow-up (12 months), GT participants were asked, "If you had been assigned to individual treatment rather than group, would you have continued to participate in this study?" and IT clients were asked, "If you had been assigned to group treatment rather than individual, would you have continued to participate in this study?"

[a]n, 113; [b]n, 115; [c]n, 86; [d]n, 76; [e]n, 187; [f]n, 40; [g]n, 96; [h]n, 18; [i]n, 93; [j]n, 23; [k]n, 133; [l]n, 29.

*$p < .01$; **$p < .001$.

Therapists' Evaluation of Clients at the End of Treatment

Another unique aspect of this study was that at the end of the fourth treatment session therapists completed a form evaluating their clients' participation and progress in treatment. Table 1.6 displays therapists' evaluations of clients for group and individual conditions and for clients with primary alcohol and primary drug problems. There were no significant differences between treatment conditions. Only 1 of 13 differences between alcohol and drug clients was statistically significant, with therapists rating alcohol clients as more likely to be on time for sessions than drug clients. What is striking about these evaluations is that irrespective of clients' treatment condition (group vs. individual) or their primary substance abuse problem (alcohol or drug), the therapists' evaluations were uniformly high, reflecting their views that their clients were responsive to treatment, participated actively, and completed their homework assignments.

DISSEMINATION OF THE GSC TREATMENT MODEL: FROM BENCH TO BEDSIDE

We developed the GSC treatment model when we were at the Addiction Research Foundation in Toronto, Canada. As a government-funded agency in a country with government-funded universal health care, the dissemination of effective and efficient treatments was a priority. The story of how the GSC treatment mode was effectively disseminated throughout the province of Ontario, which is the largest province in Canada, has been described in detail elsewhere (Martin, Herie, Turner, & Cunningham, 1998; L. C. Sobell, 1996) but is summarized here as it provides an illustration of the challenges of going from bench to bedside. At the outset of the dissemination effort, we were struck by the fact that although the Addiction Research Foundation was a well-known and internationally respected center for addiction research, evidence-based treatment was not widely used in the community. It was clear that the usual methods of dissemination (e.g., workshops, publications) had not been particularly effective and that, if we wanted to successfully disseminate the GSC treatment model, we would have to think outside the box. In this case, the "box" was the traditional way of attempting to disseminate clinical science, and "outside the box" meant to learn from the experience of others (i.e., business organizations) for which successful dissemination is a matter of survival.

In business, establishing new products requires a substantial and long-term investment in resources (once the product is launched the company must be prepared to respond to demand if sales skyrocket). Failure to obtain buyers for a product can have dire economic consequences. Such research has been described in detail in *Diffusion of Innovations* by Rogers (1995), who is considered the father of dissemination research. Rogers's book was the starting point in developing our efforts to get community treatment providers to adopt the GSC approach.

As described elsewhere (L. C. Sobell, 1996), we successfully partnered with practitioners in the community to disseminate the GSC treatment model. One of the key factors was having a flexible and adaptable product that we could use to train practitioners in the province of Ontario. Before this project, our dissemination efforts typically would have involved offering practitioners a 1-day workshop and handing out treatment materials. In contrast, we engaged in a carefully planned effort that unfolded over time, involving gaining a buy-in from community providers, which brought with it a responsibility on our part to provide continued training and consultation.

TABLE 1.6. Therapists' Evaluations of Clients by Condition (Individual or Group) and by Primary Substance Problem (Alcohol or Drug)

Variable	Treatment condition	
	Individual (n = 109) Mean (*SD*)	Group (n = 106) Mean (*SD*)
Responsive to treatment	4.48 (0.73)[a]	4.38 (0.79)
Completed homework	4.61 (0.82)	4.67 (0.70)
Participated actively	4.70 (0.59)	4.52 (0.62)
Punctual for sessions	4.60 (0.81)	4.70 (0.57)
Appeared satisfied with sessions	4.53 (0.62)	4.50 (0.62)
Understood homework	4.54 (0.73)	4.72 (0.60)
Appeared ready to change	4.27 (0.93)	4.31 (0.94)
Read handouts	4.73 (0.63)	4.83 (0.47)
Resistant to the treatment program	1.40 (0.81)	1.39 (0.76)
Unresponsive to feedback	1.50 (0.89)	1.40 (0.71)
Worked on self-selected goals	4.63 (0.63)	4.58 (0.80)
Good rapport with therapist	4.60 (0.60)	4.50 (0.56)
	Primary substance problem	
Variable	Alcohol (n = 182) Mean (*SD*)	Drugs (n = 33) Mean (*SD*)
Responsive to treatment	4.43 (0.75)[b]	4.45 (0.79)
Completed homework	4.65 (0.73)	4.55 (0.91)
Participated actively	4.60 (0.62)	4.67 (0.54)
Got along with others in the group	4.65 (0.53)[c]	4.75 (0.55)[d]
Punctual for sessions*	4.72 (0.55)	4.24 (1.17)
Appeared satisfied with sessions	4.51 (0.62)	4.58 (0.61)
Understood homework	4.62 (0.69)	4.67 (0.60)
Appeared ready to change	4.29 (0.92)	4.27 (1.04)
Read handouts	4.80 (0.52)	4.67 (0.74)
Resistant to the treatment program	1.40 (0.79)	1.39 (0.75)
Unresponsive to feedback	1.48 (0.83)	1.27 (0.67)
Worked on self-selected goals	4.62 (0.69)	4.55 (0.91)
Good rapport with therapist	4.53 (0.59)	4.67 (0.48)

Note. Ratings were made on 5-point scales (1 = *never*, 5 = *always*).
[a]n, 108; [b]n, 181; [c]n, 85, group only; [d]n, 20, group only.
*$p < .01$.

Target systems for the treatment were carefully selected through a market analysis and community forums, with the first target system being assessment/referral centers (Martin et al., 1998). Ten workshops were conducted to train center staff in how to conduct GSC treatment in group and individual formats. Of the 42 total assessment/referral centers in the province of Ontario, 39 participated in the training, involving more than 200 staff members.

An important element in creating a favorable response to GSC treatment among community service providers was encouraging them to tailor the procedures to fit their needs. That is, they were encouraged to integrate aspects of the GSC treatment approach that they felt were effective into their existing practices rather than totally discarding one approach for another. Another important element was the provision of ongoing clinical support. A toll-free number was established from our GSC program in Toronto to provide consultation to the field sites. A training videotape demonstrating the GSC intervention was also produced (L. C. Sobell & Sobell, 1995). These efforts resulted in wide-scale adoption of the GSC treatment model throughout the province of Ontario (Martin et al., 1998; L. C. Sobell, 1996).

Our experience in disseminating the GSC treatment model in Ontario has had a lasting influence on our work, including how we have gone about preparing this book. Although we cannot approach the task of writing a book with the same resources, time commitment, or personal involvement that went into the community dissemination effort, we hope that the contents of this book demonstrate a sensitivity to clinicians' and clients' needs and to the context in which cognitive-behavioral group therapy using motivational interviewing is likely to successfully occur.

OVERVIEW OF THIS BOOK

In setting the stage for the remainder of this book, this chapter has reviewed the development of the GSC treatment model and research that influenced its development, compared the GSC treatment model with other cognitive-behavioral therapy for substance use disorders, reviewed the few published RCTs of group versus individual treatment for substance use disorders, and presented the results of the RCT that successfully extended the GSC individual treatment model to a group therapy format.

The remainder of this book presents the details of GSC treatment and how to integrate and implement it in a group setting. It also addresses a plethora of issues and challenges that face therapists who conduct groups (e. g., failure to systematically use group processes, failure to integrate cognitive-behavioral techniques with group processes). Chapter 2, a general overview of motivational interviewing, describes and presents examples of motivational interviewing strategies and techniques and their utility. The strategies and techniques reviewed in Chapter 2 have been an integral part of the GSC treatment model for many years, including the study that compared GSC treatment in a group versus an individual format.

Chapter 3 contains a detailed discussion of how to conduct the GSC assessment, which is the same whether the treatment is delivered in an individual or a group format. This chapter also describes the clinical utility of the assessment measures and instruments that are used in GSC sessions. The therapist dialogues included in Chapter 3 are presented as examples of how topics might be initiated and probed rather than as clinical scripts. Chapters 4 and 5 describe the detailed application of the GSC model to the conduct of individual and group therapy,

respectively. Descriptions of each of the four individual treatment sessions and each of the four group treatment sessions include (1) therapist and client handouts, (2) clinical examples, and (3) sample therapist–client dialogues. In addition, both chapters present session outlines for therapists (i.e., objectives, procedures, materials and handouts needed) for each of four individual sessions (Therapist Handouts 4.1–4.4) and each of the four group sessions (Group Therapist Handouts 5.1–5.4). The session outlines for group therapists also include sample round-robin discussions for each group session. Last, Chapter 5 contains a detailed discussion of how to integrate motivational interviewing and cognitive-behavioral strategies and techniques into group therapy using round-robin discussions.

Chapter 6 discusses the importance of group preparation and planning, managing the group, and building group cohesion. This chapter also presents specific examples of how to successfully conduct cognitive-behavioral motivational group therapy using group processes. In this chapter we use two phrases that we feel are key to understanding how to successfully manage groups. The first, *Think Group*, is intended to help group leaders remember that groups have multiple members and that the group itself should be the agent of change. The second phrase, *Music Comes from the Group*, is used to communicate that group therapists can be viewed as conductors and that to achieve high group cohesion, which is related to successful treatment outcomes, the majority of interactions within the group need to come from the members (i.e., the music comes from the group).

Chapters 7 and 8 discuss two central aspects of how to manage groups. Chapter 7 addresses a multitude of structural issues (e.g., composition, attendance, role of cotherapists, breaking eye contact) that are critical for therapists to understand when conducting group therapy. Also included is a brief discussion of the major advantages and disadvantages of conducting group therapy compared with individual therapy. Chapter 8 discusses how to deal with challenging clients and difficult situations in groups. Specific examples for dealing with such situations are provided throughout the chapter.

Chapter 9, the concluding chapter, presents a discussion of the likely place of group psychotherapy in the health care system of the future. This chapter suggests that, as interest in and popularity of group therapy continues to grow, a major challenge will be to ensure that practitioners are competently trained to provide group therapy.

Finally, because the inclusion of clinical materials that could be freely copied and used by clinicians was successfully received in our 1993 book, *Problem Drinkers: Guided Self-Change Treatment* (M. B. Sobel & Sobell, 1993), we have again included a variety of materials that can be reproduced and used by practitioners and, where appropriate, given to clients. These materials include individual and group session outlines, clinical assessment materials, questionnaires, therapist and client handouts, homework exercises, and motivational feedback materials used during both group and individual sessions. With the exception of the group session outlines, all of the assessment and clinical materials can be used when applying the GSC treatment model in either group or individual therapy.