



# Complexities with group therapy facilitation in substance use disorder specialty treatment settings

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## ABSTRACT

In spite of increased attention to research-based interventions for substance use disorders (SUDs), a formidable research-practice gap impedes the implementation of evidence-based treatments (EBTs). An underappreciated dimension of this gap is a mismatch in treatment modality: Whereas clinical trial and implementation research has focused primarily on individual therapy, the majority of SUD specialty treatment is in group format, with open-enrolling groups being most common. This study aims to narrow this research-practice gap by exploring clinicians' perspectives on complexities with group therapy facilitation in SUD specialty treatment settings. Semi-structured interviews were conducted with 13 group clinicians from among three outpatient SUD specialty clinics—diverse in their operational structures, treatment philosophies, 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. Clinicians emphasized the importance of having flexibility in facilitating groups, through built-in group processes and clinicians' own adaptations and accommodations; this flexibility was especially emphasized for the use of EBTs or manualized interventions. Clinicians also had difficulties with group facilitation generally, as evidenced by their reported difficulty in managing complex group dynamics, their limited group therapy experience and training, and their reliance on educational groups. We discuss specific strategies for improved innovation and implementation of EBTs for SUD group therapy.

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## 1. Introduction

Although several psychosocial interventions for substance use disorders (SUDs) have been validated through randomized clinical trials, a deeply entrenched gap remains between science and practice (Carroll & Rounsaville, 2007; Glasner-Edwards & Rawson, 2010; Manuel, Hagedorn, & Finney, 2011; Miller, Sorensen, Selzer, & Brigham, 2006). Evidence-based treatments (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). Identified reasons for this gap include organizational barriers (Carroll et al., 2011; Carroll & Rounsaville, 2007), the complexity of SUD treatment (Aarons, Miller, Green, Perrott, & Bradway, 2012; Lash, Timko, Curran, McKay, & Burden, 2011; Wells, Saxon, Calsyn, Jackson, & Donovan, 2010), and clinician attitudes (Knudsen, Ducharme, & Roman, 2007; Manuel et al., 2011).

An underappreciated aspect of this research-practice gap is a mismatch in treatment modality: Whereas clinical trials have focused

primarily on individual therapy, most SUD specialty treatment is provided in group format (Wendt & Gone, 2017). 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 organizations it is the overwhelming focus (Fletcher, 2013). In addition to cost considerations, 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). Potential benefits of group therapy 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 (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012; Yalom & Leszcz, 2005).

In spite of the high prevalence of group therapy for SUDs in real world settings, research efforts have focused primarily on individual therapy. Some group SUD treatment studies, particularly for motivational interviewing (MI) and cognitive behavioral therapy (CBT), have been conducted (e.g., Crits-Christoph et al., 2013; D'Amico, Houck, Tucker, Ewing, & Pedersen, 2017; Hogue, Henderson, Ozechowski, &

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Robbins, 2014; Santa Ana, Wulfert, & Nietert, 2007; Watkins et al., 2011). However, the vast majority of EBTs and major treatment research studies have been designed for individual treatment modalities (Anton et al., 2006; Connors, DiClemente, Velasquez, & Donovan, 2013; Sobell & Sobell, 2011; 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 (Wendt & Gone, 2017; Connors et al., 2013). This research focus on individual therapy is understandable, in that groups with interdependent members are more difficult to study in clinical trials (see Baldwin, Murray, & Shadish, 2005; Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004). Nonetheless, this focus is clearly a mismatch for SUD specialty treatment settings. Such a mismatch has clinical implications, in that clinical skills required for quality group facilitation are not obviously transferable from individual service delivery. These skills include building group cohesion, managing confrontation and conflict, redirecting clients who monopolize group discussion or stray off topic, managing unhelpful advice given from one member to another, and eliciting client participation rather than lecturing (American Group Psychotherapy Association, 2007; Center for Substance Abuse Treatment, 2005; Sobell & Sobell, 2011; Yalom & Leszcz, 2005).

In addition, certain enduring financial and clinical factors within SUD specialty treatment may further complicate the implementation and use of existing EBTs. In order to maximize clinic resources and minimize client wait times, SUD specialty treatment settings rely heavily on open-enrolling groups (Wendt & Gone, 2017; Morgan-Lopez & Fals-Stewart, 2008). In a recent survey of group therapy SUD specialty clinicians in the United States, 69% reported that all of their facilitated groups were open-enrolling groups, with only 10% reporting that none of their groups were open (Wendt & Gone, 2017). However, open-enrolling groups are rarely studied in clinical trials, due at least in part to difficulties in controlling for equivalent group comparisons and in analyzing data (Morgan-Lopez & Fals-Stewart, 2008; Weiss et al., 2004).

What should be done about this treatment modality mismatch between research and clinical contexts? Some might propose that the burden is on clinicians to adapt existing EBTs into group formats. Such would likely be a daunting task, however, especially in light of limited resources and training for doing so. At any rate, remarkably little research exists concerning what SUD clinicians do in group therapy, and thus the extent to which a treatment modality mismatch is a barrier in EBT implementation is unknown. A first step, then, would be to explore clinicians' perspectives on complexities with group therapy facilitation in SUD specialty treatment settings. How do clinicians balance treatment structure (including use of treatment manuals) with group process? What practices are most likely to be used? How are open-enrolling 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 exploratory qualitative study. This exploration may be helpful in bridging the gap between research and practice, by informing researchers about clinical complexities that may be neglected in SUD treatment research focusing on individual interventions.

## 2. Material and methods

### 2.1. 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 considered for inclusion; 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 (identified

here by pseudonyms) were diverse in their operational structures, treatment philosophies, interventions, and types of clientele. The first clinic, New Day, was part of a large non-profit SUD treatment organization, with a primary focus on twelve-step principles and community reintegration. Services were reimbursed through sliding-scale payments, government contracts, and donations; more than half of clients were court-ordered. The second clinic, Recovery Services, was operated by a state medical school, and included an intensive outpatient track and a standard outpatient track; its treatment approach was eclectic, with therapeutic orientations varying per clinician. Services were reimbursed primarily through private health insurance. The third clinic, SUD Intensive Clinic, was an intensive outpatient clinic operating within a U.S. Veterans Affairs medical center; its treatment approach was predominantly rooted in CBT and MI. 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. Group size ranged from 5 to over 20 clients, with most groups having between 12 and 18 clients. Second, Recovery Services had a five-week intensive outpatient program as well as standard weekly outpatient groups. Intensive groups met for 3 h (half process-oriented and half educational) three times weekly; standard outpatient group sessions lasted 90 min and these groups did not have a fixed duration for a given client. Group size generally ranged from 6 to 12 clients, with intensive groups being on the higher end. 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 CBT and motivational enhancement therapy. Group size generally ranged from 8 to 12 clients.

### 2.2. 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 outpatient group therapy for SUDs in the past two years; physicians and non-licensed trainees were excluded, in order to ensure that participants were 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 1. The sample was diverse in gender (67% women), age (range from 25 to 65 years; mean of 39 years), years providing SUD services (range from 1 to 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).

### 2.3. Measure

The primary measure consisted of a 32-item semi-structured interview (1.5–2 h) with each participant, completed between October 2013 and June 2014. The interview protocol was piloted with a volunteer student clinician. The first author asked each participant about their clinic's mission, treatment philosophy, goals, and strengths and weaknesses (4 items); its group therapy curriculum (6 items; e.g., "Could you briefly describe the different kinds of groups that are offered here?"); and its approach to EBT and manualized therapies (5 items, as applicable; e.g., "How often and in what ways do you consult scientific research to guide practice here?"). Participants also were

**Table 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																	
Non-Hispanic White	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 for SUDs																	
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			
Years treating SUDs			3.7	4.6			23.0	14.8			3.0	1.7			9.5	12.3	

Note: Characteristics of clinician participants ( $N = 13$ ) from three outpatient SUD specialty clinics (with pseudonyms of New Day, Recovery Services, and SUD Intensive Clinic) in the same Midwestern metropolitan area of the United States, based on survey responses. SUD = substance use disorder.

asked about their SUD treatment background and experience (5 items; e.g., “What brought you to working here at [Name of Clinic]?”); details about a specific group they have facilitated recently (7 items; e.g., “What are the major processes, activities, and/or tasks of this group?”); and their SUD group facilitation practices generally (5 items; e.g., “How can you tell when you’ve had a very successful group session?”).

#### 2.4. 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. The first author contacted the clinical directors of the three clinics, 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 the first author, either on site at their clinics or at a university office. In most cases, interviews were completed in one visit (two participants required two visits). Participants were reimbursed \$30 per hour for the interview, and \$15 for completing a survey that included demographic information.

Interviews were audio recorded and transcribed verbatim according to conventional transcription standards. Transcripts (521 total pages) 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 type 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, with the exception of circumscribed themes reported elsewhere pertaining to racial/ethnic diversity within groups; see Wendt & Gone, *in press*).

Several processes were used to ensure rigor of data analysis. First, 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. Second, we 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, we adhered to a 32-item checklist for reporting information from qualitative studies (Tong, Sainsbury, & Craig, 2007).

### 3. Results

The following results include a presentation of major interpretive themes—limited to those that cut across the three clinics—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. Results are divided into two major categories: the necessity of flexibility for group facilitation and challenges/barriers for group facilitation.

#### 3.1. 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.

### 3.1.1. Flexibility embedded into existing structures and processes

The importance of flexible group facilitation 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, New Day)]

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, Recovery Services)]

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 clinicians' commonly reported group therapy processes and activities. These included a range of processes across clinics, including educational topics, skills training, experiential activities, group discussions, and homework assignments. For New Day and Recovery Services, flexibility was further integrated into group structure through "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 to 15–20 min 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, albeit limited, 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 with the group facilitator (usually immediately after sessions), when clients had individualized needs that were difficult to address in group format. These ad-hoc conversations were reported across clinics but were especially prevalent for New Day, which did not otherwise generally provide individual psychotherapy or case management sessions. The other two clinics provided individual sessions, with the group facilitators sharing the load of individual cases among themselves. Recovery Services provided individual psychotherapy to some clients (especially those with severe or comorbid psychiatric problems) and SUD Intensive Clinic provided weekly case management sessions to every client. However, individual and group therapy were not formally integrated or coordinated. Clinicians at the SUD Intensive Clinic did report some attempts to link group homework assignments with case management sessions (e.g., suggesting for clients to discuss group assignments with their case managers) but acknowledged that these efforts were idiosyncratic and with limited success.

Flexibility also was built into groups in order to address complexities for open-enrolling 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, SUD Intensive Clinic)]

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

### 3.1.2. Flexibility emphasized for using manualized therapies

Client engagement was discussed extensively in terms of limitations of manualized or more structured therapies in the context of group therapy. 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, SUD Intensive Clinic)]

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, New Day)]

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

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, Recovery Services)]

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, New Day)]

According to clinicians, considerable flexibility with manualized/structured group therapies is required in order for clients to feel like therapy is engaging and valued.

### 3.1.3. Necessity of clinician accommodations and adaptations

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, New Day)]

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, SUD Intensive Clinic)]

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, New Day)]

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, Recovery Services)]

These vignettes suggest that clinicians attempt to check the pulse of entire groups—"where the group is at"—and adjust accordingly.

## 3.2. Challenges and barriers

Clinicians discussed several challenges and barriers with providing group therapy in SUD treatment. These challenges and barriers are organized in the following three themes: First, management of complex group dynamics among diverse clients was a challenge with providing individualized care in group format. Second, some clinicians reported having limited or inadequate experience with or training in group therapy facilitation. Third, clinicians relied heavily on didactic educational groups, perhaps reflective of a narrow range of therapy options.

### 3.2.1. Complex group dynamics

In contrast to individual therapy, clinicians discussed unique challenges with group therapy in terms of group dynamics. These group dynamics were sometimes complicated by frequent changes in enrollment, beyond the clinician's control, that influenced or impaired group cohesion. In particular, clinicians expounded on the difficulties of facilitating groups with clients who vary in their level of engagement and readiness to change.

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, Recovery Services)]

Sometimes there is a guy that's been in the Friday group that tends to kind of go off on weird tangents....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.

[(Alex, New Day)]

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 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, SUD Intensive Clinic)]

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

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.

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, New Day)]

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

It is much easier...to adhere to the MI 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?

[(Becky, SUD Intensive Clinic)]

As exemplified in the above vignette, clinicians expressed an inability to facilitate MI in groups or even a belief that it was not appropriate or possible to do so, which may have limited their ability to address client motivation among a diverse group of clients.

### 3.2.2. Limited clinician experience and training

A critical challenge for group therapy facilitation was limited clinician experience and training with groups, along with limited organizational efforts to ensure quality control. 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 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, SUD Intensive Clinic)]

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 who initially were student trainees at the clinics.

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, New Day)]

In other cases, clinicians had minimal training and then 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, New Day)]

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, based on participants' reports. 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 blunt 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, Recovery Services)]

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.

### 3.2.3. Reliance on didactic education

A final complexity is the predominant role of clinicians' providing didactic education 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 educational 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 contrast, active skills practice was reported to be infrequent, primarily limited to mindfulness exercises in some group sessions at New Day and SUD Intensive Clinic, and minimal role playing at SUD Intensive Clinic; these skills were especially utilized in groups based on CBT and third-wave behavioral principles.

The predominant role of didactic education 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.

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, New Day)]

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, SUD Intensive Clinic)]

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, SUD Intensive Clinic). 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 education in groups. For at least three clinicians at New Day and Recovery Services, a focus on education 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 [education] 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, Recovery Services)]

In contrast, five clinicians expressed concern about the amount of education in their clinics' groups.

A lot of [the curriculum] 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, New Day)]

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... 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, SUD Intensive Clinic)]

These vignettes suggest that educational approaches may limit clinicians' abilities for facilitating relevant and engaging group sessions.

## 4. Discussion

This article describes real-world complexities based on qualitatively assessed clinician perspectives 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 having flexibility in group therapy facilitation, several challenges and obstacles were evident in offering this 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, and a reliance on didactic educational groups rather than skills-based groups. In this section, we discuss these themes and their implications for bridging the gap between research and practice, including general recommendations for researchers, clinicians, and administrators. These recommendations are primarily geared for open-enrolling groups, in light of the prevalence of open-enrolling groups as well as the practical barriers in providing closed groups within SUD specialty clinics. This focus is not intended to discourage the use of closed groups when possible, as these have the advantage of drawing more intensively from group therapy principles such as fostering group cohesion (see *Yalom & Leszcz, 2005*). Still, it should be noted that open-enrolling groups have clinical (not just economic) advantages, in terms of new clients with urgent needs being able to initiate treatment more rapidly.

#### 4.1. Balancing flexibility and structure

A major conclusion from this study concerns the wide chasm between real-world group facilitation and the use of EBTs or manualized therapies. Clinicians consistently emphasized the need for flexibly implemented therapy. Importantly, most clinicians expressed positive attitudes toward EBTs or manualized therapies (especially to guide new clinicians) but only if sufficient flexibility is permitted. This finding converges with implementation research demonstrating that clinicians are more likely to sustainably use EBTs when sufficient flexibility is built into treatment manuals or protocols (see, e.g., *Palinkas et al., 2008*).

The importance of flexibility for group therapy in SUD settings has complex implications relative to the use of EBTs. On one hand, a high degree of flexibility may be warranted for using EBTs in groups, 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 in the SUD treatment literature 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 explicitly incorporated in most EBTs for SUDs (but see *Martino & Santa Ana, 2012*, for suggestions on integrating MI with the group principle of universality for groups with dually-diagnosed clients). 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.

On the other hand, however, it is possible for SUD group clinicians to overemphasize the importance of flexibility. Considerable research has shown limitations of clinical wisdom used to depart from established protocols (*Ægisdóttir et al., 2006; Bamatter et al., 2010; Dawes, Faust, & Meehl, 1989; Martino, Ball, Nich, Frankforter, & Carroll, 2009*). Moreover, clinicians may have widely varying sensibilities about when and whether to deviate. This tension raises the importance of the development of group-based 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, as some 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 short-term open-enrolling groups (where membership is constantly in flux), clinicians may have difficulty knowing how much to emphasize group-level appraisals versus the individual needs of group members who are most at risk.

One general recommendation is for greater recognition of the value of flexibility in SUD treatment delivery. Although EBTs are generally intended to be flexibly implemented, the need for flexibility perhaps

reaches a new level when it comes to SUD group therapy, given the complexities with group facilitation reported in this article. Moreover, greater training, supervision, and resources clearly are needed for clinicians in delivering EBTs in group format. To this end, we encourage researchers and clinicians to develop and make widely accessible EBTs that can be flexibly utilized in open groups. Although limited, some researchers have published group therapy protocols in which they aim to balance flexibility, group therapy principles, and evidence-based principles (see, e.g., *Donovan et al., 2013; Sobell & Sobell, 2011; Wenzel et al., 2012*).

#### 4.2. 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 limited inasmuch as clinicians have not received sufficient group training. In this study, several clinicians reported having limited experience prior to being hired, as well as minimal oversight and supervision on the job. Previous researchers have discussed the problem of assuming that groups can be readily facilitated by clinicians without specific training in group therapy (*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. This approach makes sense for a developmental training process but only if observed clinicians and supervisors are themselves skilled in group facilitation.

We recommend, then, that considerably greater attention be given to training and quality control for SUD group therapy by researchers, administrators, and clinicians. 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, because learning through observation is effective only to the extent that the observed therapy is high in quality, 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* beyond mastery of content (*American Group Psychotherapy Association, 2007*). Experience with group process might also be enhanced through discussion or, better yet, role play during clinical meetings and/or between co-facilitators. In addition, clinicians may need greater guidance for making decisions about balancing content and process, including knowing when and how to deviate from a treatment manual or agenda.

Finally, we suggest that training efforts focused on group MI may be especially promising. Although SUD clinicians report a high use of MI components in group settings (*Wendt & Gone, 2017*), several clinicians in this study reported having difficulty with implementing MI processes in groups, or even wondering if such was possible. These results are not surprising, given that MI training efforts have focused primarily on individual therapy. However, in recent years there has been a burst of research on facilitating MI in groups in a variety of contexts, including SUD treatment settings (*Crits-Christoph et al., 2013; D'Amico et al., 2017; D'Amico, Hunter, Miles, Ewing, & Osilla, 2013; Santa Ana et al., 2007; Wagner & Ingersoll, 2012*). This research is not generally tailored for open-enrolling groups, though *Martino and Santa Ana (2012)* discuss adaptations for these groups and illustrate several activities that could be used in both open-enrolling and closed groups (see also *Wagner & Ingersoll, 2012, p. 99*). This research could form the foundation of group MI training efforts, but at the current time we are unaware of research that has examined best practices for MI supervision and training focused specifically on group therapy (but see *Osilla et al., 2015*, for a study with implications for group MI training).

### 4.3. Therapy vs. classes

A final implication for group facilitation pertains to clinicians' reliance on didactic education within groups. This study suggests that group therapy is frequently utilized as a vehicle for didactic 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*). This may be concerning, given that SUD treatment limited to didactic education is generally ineffective (see *Gifford et al., 2012; Power, Nishimi, & Kizer, 2005*). For example, in a review of clinical trials for alcohol use disorder treatment, didactic educational groups were the least effective of 48 treatment methods, including confrontational approaches (*Miller & Wilbourne, 2002; cf. Miller, Forchimes, Zweben, & McLellan, 2011, p. 315*). Therefore, clinicians ought to be wary about relying too heavily on educational groups, even when teaching content derived from EBTs.

Clinicians' reliance on didactic education is likely not idiosyncratic to this study, as other observers 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 reliance on education? There may be several contributors. First, an educational approach may naturally follow from a disease model of addiction, in that prior to receiving skills-based or insight-oriented therapy, clients are assumed to first need an understanding and acceptance of addiction as a chronic illness. Second, a reliance on didactic educational may be the natural outcome for clinicians with limited group training and experience. Inasmuch as clinician-observed groups are educational, 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 (see *Sobell & Sobell, 2011, p. 191*). Finally, an educational 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 explicit consideration of group process—clinicians may be prone to simply port *content* into group format. For example, it is simpler to teach *about* CBT principles than to facilitate active practice of these principles in the group itself (e.g., through role playing), especially in large groups.

As a correction to this reliance on didactic education, we recommend for greater innovation in creating, investigating, and implementing therapies that rely at the outset on group therapy processes. 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 these principles if group therapy is to be utilized. As discussed above, clinical researchers have generally resisted conducting clinical research in group format, due to less experimental control and statistical complexities inherent in group designs. Nonetheless, a more ecological approach would prioritize the design and testing of open-enrolling group therapies, which could then be adapted into other formats as needed. 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 (see *Wenzel et al., 2012*). Group size may be a barrier in this regard; for non-educational groups, a group size of five to eight clients has been recommended as optimal, in light of research indicating that group interaction markedly drops with groups of nine clients or more (*Yalom & Leszcz, 2005*). If larger groups are unavoidable, clinicians might consider greater use of empirically-based active learning strategies from the educational psychology literature (see *Center for Substance Abuse Treatment, 2005; Svinicki & McKeachie, 2013*).

### 4.4. Limitations

Two limitations of this study should be addressed. First, clinicians' reported experiences at the three clinics for this study may have limited

generalizability to other SUD treatment clinics and clinicians. For example, it is unclear to what extent these themes would be present in opioid treatment clinics. However, 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; *Wendt & Gone, 2017*). Moreover, because this study included a wide range of EBT utilization, including one clinic (SUD Intensive Clinic) with extensive use of manualized treatments adapted from EBTs, we expect for the themes reported in this article to apply to a variety of treatment settings. Second, direct observation of treatment, which was not feasible for this exploratory study, would help to provide a fuller picture of group therapy facilitation, especially in ways that might 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. We recommend for future research to evaluate recorded group sessions in SUD specialty settings, along with ratings of clinician fidelity to EBTs and group therapy processes.

## 5. Conclusions

Although group therapy is the predominant form of psychosocial therapy for SUDs, research efforts have focused primarily on individual therapies. For this study we aimed to narrow this gap, by exploring through in-depth interviews clinicians' perspectives on complexities with group therapy facilitation in SUD specialty treatment settings. Clinicians emphasized the importance of having considerable flexibility in facilitating groups, which has implications for incorporating EBTs or manualized interventions. However, clinicians also had challenges with group therapy facilitation, as evidenced by their reported difficulty in managing complex group dynamics, their limited group therapy experience and training, and their reliance on educational groups. Assuming that group therapy will remain a major aspect of SUD specialty treatment for the foreseeable future, it would behoove researchers, clinicians, and administrators to more explicitly and comprehensively address these challenges. Recommendations include 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, and greater incorporation of skills practice alongside less reliance on didactic education.

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