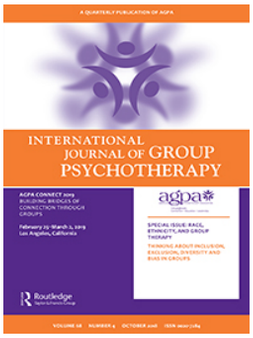

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Group Psychotherapy in Specialty Clinics for Substance Use Disorder Treatment: The Challenge of Ethnoracially Diverse Clients

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ABSTRACT

Minimal research has explored how clinicians address race and ethnicity considerations in the context of group psychotherapy within substance use disorder (SUD) specialty treatment settings. This article is an exploratory qualitative study in an effort to narrow this gap, using data from semistructured interviews with 13 group clinicians at three outpatient SUD specialty clinics in the United States. Results are drawn from the portion of coded material pertaining to ethnoracial considerations. A predominant theme from the interviews was the importance of individualized care in terms of "meeting clients where they are at." However, minimal attention appears to have been given to addressing clients' demographic diversity. Overall, ethnoracial considerations were minimally addressed in groups, with clinicians framing such primarily in terms of "cultural" factors relevant to clinics' treatment philosophies. Moreover, limited attention was reportedly given to acknowledgment of social inequities faced by ethnoracial minority clients (e.g., racial discrimination), even though a few

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clinicians reported concern that minority clients were less engaged in treatment. Clinical implications of these findings and recommendations for future research are discussed.

As treatment settings around the world become more ethnoracially diverse in their clientele, a greater integration of multicultural considerations within group psychotherapy is imperative. Although attention to this integration has increased within the psychotherapy literature generally, most of this research has focused on individual psychotherapy (Chen, Kakkad, & Balzano, 2008; Stark-Rose, Livingston-Sacin, Merchant, & Finley, 2012). As several scholars have argued, the traditional group psychotherapy literature has been an inadequate guide, in that it has relied on assumptions that do not clearly reflect multicultural and social justice considerations (Brook, Gordon, & Meadow, 1998; Burnes & Ross, 2010; Chen et al., 2008; Green & Stiers, 2002; Okech & Rubel, 2007; Salvendy, 1999).

Within the past decade, best practices have been developed for integrating multicultural and social justice considerations into group psychotherapy, such as from the Association for Specialists in Group Work (Singh, Merchant, Skudrzyk, & Ingene, 2012; see also Hays, Arredondo, Gladding, & Toporek, 2010; Okech, Pimpleton, Vannatta, & Champe, 2015; Okech, Pimpleton-Gray, Vannatta, & Champe, 2016; Singh & Salazar, 2010). Other scholars have argued further that group settings, as microcosms of society, are uniquely situated for engaging in intercultural dialogue and providing healing associated with racism and discrimination (Brook et al., 1998; E. C. Chen, Thombs, & Costa, 2003; Fenster, 1996; Hays et al., 2010).

This article addresses race/ethnicity considerations within group psychotherapy for substance use disorder (SUD) specialty treatment. Recent research has demonstrated that sociocultural factors pertaining to race and ethnicity mediate pathways toward developing and recovering from SUDs (see, e.g., Chen, Balan, & Price, 2012; Frank, Moore, & Ames, 2000; Shih, Miles, Tucker, Zhou, & D'Amico, 2012; Straussner, 2012; Zapolski, Pedersen, McCarthy, & Smith, 2014). These factors include racism (Gibbons, Gerrard, Cleveland, Wills, & Brody, 2004), discrimination (McCabe, Bostwick, Hughes, West, & Boyd, 2010), poverty (Glass et al., 2017), and acculturative stress

(Gil, Wagner, & Vega, 2000), among many others. Furthermore, SUD treatment is unique in terms of its connection with criminal justice systems, for which ethnoracial minorities frequently have much higher rates of drug-related arrests, court-ordered treatment, and incarceration (Alexander, 2012; Khenti, 2014; Mitchell & Caudy, 2015).

In recent years, multicultural competencies for SUD treatment have received increased attention (Gainsbury, 2017; Guerrero, Campos, Urada, & Yang, 2012; Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013; Howard, 2003a, 2003b; Shorkey, Windsor, & Spence, 2009; Vandevelde, Vanderplasschen, & Broekaert, 2003). However, this literature has generally focused on individual psychotherapy or at least has not specifically addressed group psychotherapy. This gap in the literature is remarkable, considering that group psychotherapy is by far the predominant modality for SUD specialty treatment (Crits-Christoph, Johnson, Connolly Gibbons, & Gallop, 2013; Fletcher, 2013; Weiss, Jaffee, De Menil, & Cogley, 2004; Wendt & Gone, 2017). Furthermore, given that SUD treatment groups are generally open enrolling, there are limits in what clinicians can do to individualize treatment or anticipate group enrollment and dynamics. One approach is to offer single-race groups for SUD treatment; however, these groups are rarely offered (e.g., available in approximately 10% of SUD treatment settings in the United States) and are not feasible in most organizations (Campbell & Alexander, 2002; Howard, 2003b).

In an effort to narrow this research-practice gap, this study is an initial exploration of group psychotherapy content and dynamics related to client race and ethnicity within SUD specialty treatment. Data are drawn from a broader mixed-methods study that explored commonly reported group practices used by SUD specialty clinicians in the United States (see Wendt & Gone, 2017, 2018). This study included a question about clinicians' perspectives on how race and ethnicity are addressed within the groups they facilitate. Through qualitative analysis of clinicians' answers to this question, we present and discuss some complexities for meeting ethnoracial clients "where they are at" within the context of group SUD specialty treatment.

METHOD

Setting

The study consisted of interviews with 13 clinicians from three SUD specialty outpatient clinics located in the same metropolitan area in the midwestern United States. The participating clinics (identified by pseudonyms), each of which provided open-enrolling groups as their predominant treatment modality, were diverse in their treatment approaches, types of clientele (as estimated by clinic directors), and funding: (1) New Day was part of a nonprofit 12-Step SUD treatment organization; approximately 30% of clients were ethnoracial minorities (primarily African Americans), 54% of all clients were court ordered, and services were covered through Medicaid and sliding-scale fees. (2) Recovery Services was operated by a state medical school and had an eclectic treatment orientation (primarily 12-Step and cognitive behavioral); 5% to 15% of clients were ethnoracial minorities, and most clients' services were reimbursed by private health insurance. (3) SUD Intensive Clinic was a Veterans Affairs intensive outpatient SUD clinic with a cognitive-behavioral/motivational enhancement approach; 35% of clients were ethnoracial minorities, 20% to 25% of which were African Americans. Across clinics, most clients were male (60%–70% at New Day and Recovery Services; 90%–95% at SUD Intensive Clinic) and adults (though New Day and Recovery Services also provided groups for adolescents). For more information about these clinics and their group therapy programming, see Wendt and Gone (2018).

Participants

Inclusion criteria consisted of being a full- or part-time licensed provider at one of the three clinics who has facilitated outpatient SUD group psychotherapy in the past two years. Of 17 eligible clinicians, 13 (81%) participated: nine women and four men—10 non-Hispanic Whites, two African Americans, and one Asian American. Ten were social workers, two were addiction counselors, and one was a recovery support specialist. A master's was the highest degree for all but one participant (whose highest degree was an associate's). Participants had a mean of 9.5 years treating SUDs (SD = 12.3).

Measure

The primary measure for the original study was a semistructured interview (1.5–2 hours) with each participant, completed between October 2013 and June 2014. Participants were asked a variety of questions about their clinic's treatment program and their own approaches and perspectives to group psychotherapy. Of particular relevance for this article, interviews included the following question, "In what ways are race or ethnicity addressed in your groups?" Follow-up questions were asked, as needed, for clarification and additional information.

Procedure

After full review, this study was designated as exempt from regulatory oversight by the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board. After receiving permission from clinical directors at each of the three clinics, the first author recruited all eligible clinicians through staff meeting announcements and/or e-mail solicitations. Participants were interviewed privately by the first author, either at their respective clinics or at a university office, and were reimbursed at a rate of $30 per hour. Interviews were audio recorded, transcribed verbatim, and analyzed using conventional thematic content analysis—a constructive, iterative, and interpretive process of coding text and identifying themes within and between interviews (Braun & Clarke, 2006; Hsieh & Shannon, 2005). NVivo qualitative data analysis software (version 10) was used to code textual material and interpret hierarchical relationships between identified themes. The results reported in this article are drawn from a portion of the coded and analyzed material: answers to questions related to how ethnoracial considerations were addressed in groups, as well as any other text that was coded as pertaining to race/ethnicity from the interview. In addition, to provide context, a theme pertaining to clinicians' general concern with providing individualized treatment is reported at the beginning of the Results section. Selected vignettes are included throughout the Results section to enlist the reader in data interpretation, illustrate themes in richer detail, and give voice to research participants. In some cases, the interviewer's (I) questions are included in vignettes for context, along with respondents' (R) answers. Participants are identified by pseudonyms.

RESULTS

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

However, when it came to describing the role of groups in addressing clients' demographic diversity, it appeared that relatively limited attention was given to such. With the exception of a group at Recovery Services for health professionals, the clinics did not offer specialized groups for specific demographic groups. Moreover, when asked about how ethnoracial diversity was addressed in their groups, clinicians had much less to say in comparison to addressing addiction-specific needs. The remainder of this section describes major themes concerning how ethnoracial considerations were reportedly addressed in groups. Overall, these considerations were minimally addressed in groups, with clinicians framing such primarily in terms of "cultural" factors relevant to clinic treatment philosophies (e.g., values, spirituality, and environmental factors). Moreover, limited attention was reportedly given to acknowledgement of social inequities faced by ethnoracial minority clients (e.g., racial discrimination), even though a few clinicians reported concern that minority clients were less engaged in treatment.

Minimal Consideration of Race/Ethnicity in Groups

The most consistent point—shared explicitly by at least two clinicians per clinic—in regards to ethnoracial considerations is that they were not formally or routinely incorporated into group processes or curricula and assumed to be irrelevant unless raised by clients. Rather—perhaps contrary to the slogan "meeting clients where they are at"—these considerations were seen to be peripheral to each of the clinics' treatment approaches:

> I: Are race and ethnicity addressed in groups?
>
> R: I don't think so. I don't think that much. I think that sometimes they are. I think they are more than before…. In all the paperwork, we assess like, "What do you identify with [in terms of] ethnicity? Do you anticipate this affecting your treatment?" And so, it is a question that we are asking, but then we don't really do a lot with it, and we don't talk about what that means or how that might be a barrier. So it is something we are assessing for but not necessarily incorporating. (Karlie, SUD Intensive Clinic)

This response suggests the clinic had attempted to assess for ethnic identity and how it might affect treatment, but practically speaking, groups were not tailored to such. According to another clinician, ethnoracial factors were addressed infrequently due to the nature of addiction treatment:

> I: Does anything stand out about how race or ethnicity comes out in groups? Are there any things that come to mind about that?
>
> R: It does not typically. And again, I think because it is not our population. If there is someone—again, like I can mostly say African American persons in group [as racial minorities], unless that person brings it up, it is just not addressed because—I think maybe it has to do with that whole addiction model of treatment. Everybody is kind of presenting with the same symptoms. (Rosemary, Recovery Services)

The assumption in this vignette appears to be that the nature of addiction treatment ("that whole addiction model of treatment") involves a focus on shared symptoms, with ethnoracial considerations being ancillary. Another clinician similarly shared that ethnoracial factors are a "nonissue" unless raised by clients:

> I: Are issues pertaining to race or ethnicity brought up in group, by group members?
>
> R: If they are, then we address it. The expectation is it's a nonissue unless you have some past problems, or some prejudice, or whatever, which then will come out and we need to address. (Lane, Recovery Services)

This vignette also reflects two assumptions expressed by others, namely, that ethnoracial considerations were expected to be raised by clients during group, and that these were primarily viewed as an issue to be

resolved for the sake of group process, such as in terms of policing biased and disrespectful communication among group members.

Framing of Ethnoracial Factors as "Cultural" Elements

In several instances, when participants were asked during the interviews about ethnoracial considerations, they focused on "cultural" aspects for promoting clients' recovery in a pragmatic manner consistent with their clinic's treatment approaches. Such was the case, for example, with clinicians at New Day, the 12-Step focused clinic, in terms of their framing ethnoracial considerations in terms of cultural and spiritual values that are relevant to all clients:

> I: What about race and ethnicity? How do those come into the curriculum?
>
> R: A lot of times we go over that when we are talking about the decisional balance, values, things like that. Because we talk about how our value system is shaped based on cultural influences and traditions in society and things like that.… And we touch on spirituality as well, and how a lot of times that impacts our value systems and things like that. (Lina, New Day)

Here race and ethnicity appear to be a proxy for differing "cultural influences" and "value systems." Similarly, another clinician immediately framed ethnoracial considerations in terms of "culture":

> I: What about race or ethnicity? How might those things be addressed in groups?
>
> R: We talk about culture a lot. We have got people that identify as Jewish. We have got African-American people in the group right now, we have got White people in the group right now. We have got Hispanic/Latino people in the group right now. You know, so we have got a really cool diverse group. And some of the [clients] are open to talking about their own like spiritual beliefs, for example. And others would be prompted to say, "How does that work out in your culture? Or in your home? You know, what are your views? What are your family's views on spirituality?" (Maddy, New Day)

Although this clinician mentioned ethnoracial categories in describing the group's diversity, the focus was on cultural differences—varying "beliefs" and "views" reflecting subgroup norms and orientations—that all group members can readily consider and discuss.

In similar fashion, a clinician at SUD Intensive Clinic framed ethnoracial considerations in terms of "culture"; however, consistent with the behavioral orientation of the clinic, this framing was more in terms of environmental risks:

> Just a couple of days ago … we were talking about crack-cocaine, which is kind of stereotypical. We were talking about crack-cocaine in terms of living in [two regional cities]. And the guys were saying, "You know, the homeless program is trying to put me into a place in [one of the two cities], and that is where I used crack. And it was this environment—I was with other Black people, and this is how it was. Nobody asks for help." … And that is how they associated…. Race is … like a smaller piece of the cultural piece. Like, this was the culture, and the culture I was in happened to have people of my same race, or not. (Becky, SUD Intensive Clinic)

This vignette suggests that ethnoracial considerations are secondary and perhaps even superfluous—this client's environment simply "happened to have people of [his] same race" and is not materially different from other environments that other clients would associate with substance use.

Minimal Group Engagement Concerning Racial Discrimination

In contrast to a focus on practical "cultural" factors that all clients would share, clinicians generally did not readily mention social inequities faced by ethnoracial minorities when asked about ethnoracial considerations in groups. When asked directly about racial discrimination in follow-up questions, two clinicians discussed how they would facilitate clients' engagement on this topic, both focusing on African Americans. A clinician at Recovery Services viewed disclosure of racial discrimination as an opportunity for validating some group members while broadening perspectives of others:

> R: Racial profiling…. "Driving while black," those kinds of things. That does come up.
> I: And that's free game to discuss and to—
> R: Absolutely, absolutely. A number of people wouldn't necessarily know—they wouldn't know their experience, but they don't have that same kind of situation. It's a learning experience for them. So they can benefit from it as well. It challenges their own kind of expectation or perceptions. They have to say, "Okay, that is a reality. That does have impact." (Lane, Recovery Services)

This vignette suggests the importance of acknowledging the role of racial discrimination for some, while also opining—after what appears to be some hesitancy about how others would respond—that discussion of such could benefit all clients.

Another clinician also suggested the need to acknowledge clients' experiences of racial discrimination; however, this clinician said that racial discrimination is sometimes used as an excuse for using substances:

> So, I was doing a … group for a while and had a client in there who—though he had marijuana on him, he was pulled over because he was Black. He was racially profiled and that was his—he said that in almost every group. And I don't deny—that happens all the time. So, you know, my approach with him was, "That's true—like, that could very well be true. That happens. It's real. That doesn't change the fact that you had marijuana in your car." So acknowledging that that happens and yet still looking at "What's your part?" (Kris, New Day)

This clinician went on to explain how other group members—in fixating on race-related grievances—sometimes "aren't helpful" in advancing the clinic's goals of instilling personal responsibility:

> I: And how did group members respond to this—him bringing this up week after week?
>
> R: Sometimes you have group members who sort of—like, there's a sort of saying that people co-sign other people's bullshit. So it's kind of like other clients don't help the matter because they're like, "Oh yeah, that happened to my cousin," or "Oh yeah that—oh, did you see that case on the news?" or whatever. And so they go that route instead of, "Yes, that

> happens, *and* you had marijuana in your car." It's that *and* piece. Like, *and* you had—"Yeah, but I wouldn't have been arrested had they not … profiled me and pulled me over." So, sometimes the clients aren't helpful. (Kris, New Day)

These vignettes from Kris suggest a potential conflict, particularly in 12-Step settings, between group members helping each other to be accountable (i.e., to call out each other's "bullshit") and their being empathetic in acknowledging social inequities. The vignettes perhaps also reflect a societal tendency to emphasize personal culpability rather than societal inequities for the behavior of ethnoracial minorities in the context of SUDs—with a focus on legal culpability rather than on treatment factors.

Client Disengagement

Overall, clinicians did not report being concerned about their groups' limited attention to race and ethnicity. However, two clinicians expressed concerns with ethnoracial minority clients being less engaged in 12-Step related groups or meetings. One clinician stated, "The only issue that might come up, too, is … for our African American men having trouble going to AA meetings or to community supports, because they don't feel a sense of belonging or connectedness there" (Rosemary, Recovery Services). Another clinician was concerned with court-ordered Middle Eastern/Muslim clients who were not comfortable being in mixed-gender therapy and support groups but had no alternatives: "They do not participate, even when prompted. They will kind of give one, two-word closed answers to their questions, and it is really challenging to address that in group" (Riley, New Day). This clinician went on to say that although the local 12-Step recovery community was generally inclusive, 12-Step oriented therapy could be alienating for these clients:

> We're still talking about something that has 12 steps because there are 12 apostles…. It is very much in Judeo-Christian belief systems. And asking them to go to these outside mutual aid groups feels like—I personally have a problem with it…. It is something that is a real challenge to address…. And it is not something that I have a solution that sits well with me yet, honestly. (Riley, New Day)

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

DISCUSSION

This article describes perspectives of 13 clinicians in SUD specialty clinics regarding incorporating group psychotherapy content and processes related to clients' race and ethnicity. Although participants emphasized the aspiration of "meeting clients where they are at," limited attention was given to clients' ethnoracial diversity. This observation suggests that this aspiration may have little to do in actual practice with "meeting" diverse clients as ethnoracial beings (see also Weaver & Brave Heart, 1999). Of course, these challenges are not unique to SUD treatment, as criticisms are legion about the tendency for psychosocial interventions to give short shrift to important aspects of client identity, particularly in regard to ethnoracial minority clients (e.g., American Psychological Association, 2003; Ridley, 2005; Sue & Sue, 2012), and this shortcoming has especially been the case for group psychotherapy (as cited above).

This study sheds additional light, though, on unique aspects of SUD specialty treatment that further complicate the challenge of addressing ethnoracial dynamics and content within group settings. We briefly address these considerations here, followed by some clinical recommendations. First, structural aspects common to SUD specialty treatment may problematize common approaches for addressing ethnoracial considerations within group psychotherapy. Multicultural guidelines and recommendations frequently address group planning considerations, such as determining whether groups should be culture specific or intercultural, adapting group format and logistics for the cultural context of group members, and carefully selecting group members for multicultural groups (Singh et al., 2012). Pregroup planning, however, is typically a luxury in SUD specialty clinics, where open-enrolling groups are the norm due to economic and treatment necessities (Wendt & Gone, 2017). Moreover, in such an environment specific groups organized by shared ethnoracial status are not generally feasible. Therefore, ethnoracial considerations generally need to be addressed by SUD specialty

clinicians in continually changing groups with unpredictable demographics.

Second, the clinicians in this study frequently appeared to assume that ethnoracial considerations within their groups were of minimal importance unless they were introduced by clients or obvious group tensions arose. One possible reason for superficial attention to ethnoracial considerations is because deeper engagement with legacies of racism and associated societal inequities that give rise to differential vulnerability to addiction are much more difficult to manage in medical or quasimedical treatment settings. Clinicians also may be wary about their psychotherapy groups becoming flashpoints for racial animosity.

On the other hand, the tendency to minimize ethnoracial diversity may stem from reductionist models of addiction which themselves minimize social and contextual factors (e.g., the disease model or medical model; Deacon, 2013). This reductionism appeared to be reflected by the comments of one clinician (Rosemary at Recovery Services), who said that "everybody is kind of presenting with the same symptoms." This assumption of the symptomatic homogeneity of addiction is empirically flawed (Hasin et al., 2013) but reflects a clinical tendency to reduce addiction down to its essential attributes in some fashion—perhaps reflective of 12-Step discourse in which individual and shared identification as an "alcoholic" or "addict" is of primary importance (see Kellogg, 1993; Steffen, 1997).

Finally, the intersection of SUD treatment and criminal justice poses unique challenges for group clinicians, particularly in light of ethnoracial minorities being much more likely to be arrested and incarcerated for drug/alcohol-related concerns (see Alexander, 2012; Khenti, 2014). These challenges were evident with a clinician who struggled with balancing the validation of injustice with an emphasis on the client's own responsibility. They were also evident with clients being court mandated to attend treatment and/or support groups for which the only local alternatives were perceived as alienating.

Clinical Implications

These results suggest that greater attention to ethnoracial considerations for group psychotherapy in SUD specialty treatment settings may be in order. To this end, we provide four clinical

recommendations. First, we suggest that psychotherapy groups may be more relevant and engaging for ethnoracial minorities to the degree that they address social dimensions underpinning addiction. More focus on social dimensions is especially important in light of increased recognition of the roles of poverty, racial discrimination, and incarceration in perpetuating addiction cycles (see, e.g., Hari, 2015; Hart, 2014).

Second, we encourage SUD specialty clinicians to consider the therapeutic benefits of proactively anticipating and addressing ethnoracial considerations, rather than seeing such as problems to avoid or as unimportant unless raised by clients. As others have recommended, groups do not have to be organized by shared ethnoracial status or overtly focused on multicultural themes for ethnoracial considerations to be pertinent and worthy of discussion (Singh et al., 2012). To the contrary, ethnoracially mixed groups can become venues for intergroup dialogues on difficult topics that are relevant to clients' recovery (Hays et al., 2010). However, it may be necessary for clinicians to signal that they welcome group consideration of ethnoracial issues for group members to bring them up (Singh et al., 2012). One potential approach is to prepare clients for intercultural groups by conducting a cultural assessment and then querying the extent to which clients are comfortable working with individuals from different ethnoracial backgrounds (Haley-Banez & Walden, 1999).

Third, clinicians might consider ways for facilitating group members to support one another in matters pertaining to social justice. For example, Hays et al. (2010) recommended for group clinicians to help clients to identify a "common struggle" related to social justice and to assist groups in forming an alliance for addressing oppression. These approaches are consistent with group psychotherapy curative factors such as universality and group cohesion (Yalom & Leszcz, 2005).

Fourth, we recommend for clinicians to be careful about attributing responsibility exclusively on individual client factors, to the exclusion of sociocultural factors (Hays et al., 2010). For example, conventional application of 12-Step principles in groups may be alienating to ethnoracial minorities due to a conceptualization of addiction problems as "person centered"—relying on a dramatically decontextualized notion of personal responsibility (Caplan & Nelson, 1973)—rather than reflecting social justice considerations. In particular, we

recommend for clinicians to be mindful that legal problems stemming from racial discrimination can be enormous detriments to the well-being of ethnoracial minorities with SUDs—on a macrolevel, arguably much more so than SUDs themselves (Alexander, 2012; see Khenti, 2014; Pettit & Western, 2004).

Finally, there is a danger of invalidating complaints of racial discrimination as resistance or denial, when in fact group engagement that validates these reality-based experiences may help clients to more productively solve actual problems and remain more engaged with treatment. Fortunately, several researchers have articulated culturally-relevant community-level approaches to 12-Step recovery that enable a bridging of individual responsibility and contextual contributors (Eliason, Amodia, & Cano, 2006; Evans, Achara-Abrahams, Lamb, & White, 2012; Humphreys, Mavis, & Stöffelmayr, 1994). For example, Evans and colleagues (2012) report that within many African American and Native American communities, "culturally indigenous recovery support services" augment mainstream 12-Step approaches through having a broader etiology, a clearer focus on community recovery, and a greater role of political advocacy.

Limitations

Three limitations of this study should be noted. First, due to the case-based nature of this study, caution should be exercised about the extent to which clinicians' reported experiences generalize more broadly to other SUD specialty treatment clinics and clinicians—particularly in contexts with differing client demographics. However, the three clinics in this study have many commonalities with what is known about SUD specialty clinics within the United States (see Wendt & Gone, 2017). Second, the findings reported in this article are primarily based in responses to a single question (along with follow-up questions) from a broader study. Participants' responses certainly would have resulted in more details and greater complexity if there would have been greater coverage of ethnoracial considerations. Finally, this study did not include direct observation of SUD treatment or direct consideration of client perspectives, which we strongly recommend for future research. In spite of these limitations, this article nonetheless provides preliminary empirical data that have implications for SUD group psychotherapy and may inform future research.

CONCLUSION

Although group psychotherapy is the predominant treatment modality for SUD specialty care, and in spite of considerable research on the role of ethnoracial factors in the development of and recovery from SUDs, very limited research has addressed the incorporation of ethnoracial considerations within SUD group psychotherapy. We aimed to narrow this research-practice gap through this study consisting of semistructured interviews with 13 SUD specialty group clinicians in the United States. Although these results are tentative and limited in their international generalizability, they provide preliminary challenges in incorporating ethnoracial content and processes within SUD group psychotherapy settings. We hope that these results along with our recommendations are useful in helping researchers and clinicians to more effectively meet SUD group clients "where they are at" as ethnoracial beings.

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