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SOLUTION-FOCUSED GROUP THERAPY FOR LEVEL 1 SUBSTANCE ABUSERS

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The present study compared solution-focused group therapy (SFGT) with a traditional problem-focused treatment for level 1 substance abusers. Outcome research on the e ectiveness of solution-focused group therapy is minimal, especially in treating substance abusers. In the present study, clients were measured before and after treatment to determine therapeutic e ectiveness. Clients in the solution-focused group significantly improved on both the Beck Depression Inventory and the Outcome Questionnaire. The clients in the comparison group did not improve significantly on either measure. Therapist skill level and adherence to theoretical models were measured in each group to reduce confounding variables.

Many individuals and families suffer from the ill effects of substance abuse, especially in the United States. Galanter and Kleber (1994) estimated that 18% of the American population experiences some type of substance abuse during their lifetime. According to the results from the 2001 National Household Survey on Drug Abuse, an estimated 15.9 million Americans, 12 years of age and older, used an illegal drug the month prior to the survey. This survey also found a statistically significant increase in the use of marijuana, cocaine, and prescription medication from the year 2000 to 2001 (U.S. Department of Health and Human Services, 2001). Substance abuse is clearly one of the primary public health concerns Americans face.

In the past, inpatient rehabilitation involving long-term treatment served as the primary method for treating addicts. Because of questions concerning cost-effectiveness, many treatment facilities are reducing the amount of inpatient services offered while increasing outpatient programs (Moos, 1989). Outpatient treatment of substance abuse primarily involves traditional problem-centered approaches, many of which are based on the 12 Steps of Alcoholics Anonymous (AA). Although the utilization of this traditional model provides aid to some, research

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shows that the effectiveness of treatment varies among different types of clients (Institute of Medicine, 1990; Miller & Hester, 1989.

Solution-focused brief therapy (SFBT) is a short-term treatment intervention that focuses on creating solutions to one's problems (de Shazer, 1988). There has been a growing interest in using SFBT with substance abusers. Several authors have described the usefulness of SFBT with alcoholics and drug abusers (Berg & Miller, 1992; Berg & Reuss, 1997; Juhnke & Coker, 1997; Mason, Chandler, & Grasso, 1995; McCollum & Trepper, 2001; Miller & Berg, 1995). In addition, several clinicians have applied SFBT to group therapy for substance abuse (LaFountain & Garner, 1996; Metcalf, 1998; Pichot & Dolan, 2003; Springer, Lynch, & Rubin, 2000; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996; Zimmerman, Prest, & Wetzel, 1997). Using SFBT in a group format allows clinicians to serve more individuals efficiently. Another advantage of applying SFBT to group settings is its ability to create a milieu for solution-building to help ameliorate substance abuse. Metcalf (1998) suggests that using SFBT in a group setting can be uplifting, especially when working with individuals struggling with "out-of-control behaviors," such as drug abuse (p. 68).

Substance Abuse Treatment Research

Most substance abuse research studies examine traditional problem-focused approaches to treatment. For example, several studies suggest that individuals attending AA after completing residential treatment are more likely to sustain their sobriety than those who fail to attend aftercare (Miller & Hester, 1986; Polich, Armor, & Braiker, 1981; Thurstin, Alfano, & Nerviano, 1987; Vaillant, 1983). Although AA may be beneficial for some, Galaif and Sussman (1995) conclude that AA is not likely to aid individuals who are nonreligious and/or are members of minority classes.

Project MATCH (Project MATCH Research Group, 1993), the largest clinical trial study completed to date for alcohol treatment, longitudinally compared 12-step group, motivational enhancement therapy, and cognitive-behavioral skills training. Although there were no overall significant differences between the three groups, individuals with certain traits tended to do better in specific treatments (Project MATCH Research Group, 1997, 1998). For example, those with high levels of anger did better in the motivational enhancement treatment.

Although motivational enhancement has sometimes been compared with solution-focused treatment, differences do exist. SFBT differs from motivational enhancement therapy in the amount of time spent talking about problem areas and the preferred future of the client. Where motivational enhancement explores the nature and extent of the person's substance abuse to develop dissonance between current status and stated goals, SFBT—while not naïve to the reality of substance abuse—focuses more specifically on the client's stated goals and how to achieve them. Motivation in SFBT comes from helping the client develop a more finely articulated vision of life without the problem behavior. SFBT also expands its focus to include other life problems that clients connect to their alcohol use and that they wish to address in treatment, which is another difference from motivational enhancement.

Few efficacy studies examining SFBT for substance abuse exist. Gingerich and Eisengart (2000), in a review of SFBT outcome studies, found 15 efficacy studies on SFBT. Out of the 15 studies, only two possessed populations that included substance abusers. The first study concluded that 36% of the SFBT group only used two sessions to meet the study's standard of recovery whereas the comparison group (time-unlimited eclectic treatment) only had 2% reach recovery after two sessions (Lambert, Burlingame, et al., 1998). Polk (1996) completed a case study involving a male client with a drinking problem. The client stated that he worked more and drank less over the duration of treatment. Even though SFBT is used widely with substance abusers, more quantitative research needs to be conducted testing the efficacy of the model.

It is clear that affordable and effective treatment for substance abuse is a vital need. Given SFBT's potential to offer briefer and less intrusive intervention, it would seem reasonable to further examine the effectiveness of SFBT for substance abusers. In addition, applying SFBT to a group setting seems to further the possibilities of creating efficient treatment. Another advantage of using SFBT is its success with mandated clients, who usually enter treatment involuntarily.

The purpose of this study was to compare the effects of solution-focused group therapy (SFGT) and a traditional problem-centered group therapy for level 1 substance abusers. Comorbid problems, like depression, were examined to determine if SFGT is also effective in minimizing coexisting conditions. The following served as the research question for this study: Is SFGT more effective than traditional problem-focused group treatment for level 1 substance abusers?

METHOD

Participants

Fifty-six clients referred for substance abuse treatment at an urban, midwestern, university-based community marriage and family therapy clinic served as the subjects in this study. Subjects were randomly assigned to either the treatment (27) or to the control (29) group. Thirty-eight out of 56 clients completed the required six group therapy sessions. While 56 pretests were collected, only 38 posttests were completed: 19 in the control group and 19 in the treatment group. Thus, 67% of the clients who entered the substance abuse treatment program completed treatment.

The 38 final participants consisted of 30 men and eight women. Nineteen clients were single, five were engaged, seven were married, three were cohabiting, two were separated, four were divorced, and none of the clients were widowed or chose "other." The age of clients who completed treatment ranged from 18 to 50 years, with the average age being 31. Seventeen of the clients were Caucasian, 11 were African American, eight were Hispanic, and two were Native American.

In terms of substance use, 58% had at least one family member who currently abused substances. The mean duration of reported sobriety was 7–12 months. The substances most commonly tried were alcohol, marijuana, cocaine, and nicotine. The participants began using alcohol or illicit drugs between the ages of 5 and 33, with the majority of clients beginning at ages 16–18.

Procedure

All participants in the study met the criteria for level 1 substance abusers. According to the American Society of Addiction Medicine (1996), level 1 substance abusers require outpatient treatment services for no more than 9 hr per week. In addition, participants in this study met the following requirements: (a) stated that they had a substance abuse problem or evidence exists of recent substance usage (e.g., failed urine analysis); (b) did not require inpatient treatment; and (c) agreed to all of the guidelines listed in the informed consent. Those who did not meet the criteria still received treatment from the clinic, but were not included in the study.

Most of the participants were referred by the local probation department, with the remaining self-referred. As clients were referred to the clinic, they were assigned case managers. Case managers were graduate students in the marriage and family therapy master's program at the university. During the initial session the case manager had the client fill out standard paperwork, participate in a general assessment, and discuss the opportunity of being in a group therapy research project. If the client met the criteria and agreed to be in the study, he or she took the pretest. Then, the researcher randomly assigned the subject to one of the two conditions, SFGT or the control group. After a participant attended six group sessions, the posttest was

administered to evaluate progress. It should be noted that the results of the posttest had no bearing on the final clinical disposition of the case; that is, whether to terminate the client or suggest further treatment. If the client did not receive a recommendation for termination, he or she continued treatment at the clinic.

Experimental group. Solution-focused group therapy served as the experimental group for this study. The SFGT treatment was conducted by two co-therapists, both graduate students in the marriage and family therapy master's program. One of the co-therapists rotated into the group each week, with each therapist being present for two consecutive weeks. The SFBT model suggests that the therapist-group relationship is not the focus of treatment (Berg & Reuss, 1997), and therefore this rotation was viewed as clinically appropriate. This model of therapist rotation is a standard practice in SFGT (T. Pichot, personal communication, August 15, 2001). Therapist rotation also was used to lessen the effects of individual therapists on the treatment outcome. In addition, the remainder of the therapist team, who all rotated into the therapy sessions at prescribed times, along with a clinical supervisor, sat behind a two-way mirror to aid the therapists in manual adherence.

The session format is described in the SFGT Treatment Manual (available from the first author) and outlined in Table 1. Each group therapy session was 1.5 hr along with a 10-min break for the therapists to consult with the therapy team. Each session was video-recorded for supervision and model adherence evaluation.

Control group. The Hazelden model series "The Primary Recovery Plan" served as a basis for the control group in this study (Hazelden Foundation, 1998; see Table 2 for a summary description). This program is a traditional problem-focused psychoeducational approach that

Table 1
Solution-Focused Group Therapy Session Format

Ask group Introduction Question. Invite group members to identify themselves when they answer the question.
Group leaders silently identify common themes from group answers and find a broader theme that includes all the common themes.
This is done by having the group leaders write down a common theme.
At the same time, the group behind the mirror is developing a common theme. The team will call in to let the leaders know what they think the theme is. The leaders will decide on the theme to present.
Group leaders reflect out loud the theme of the group.
Group leaders ask the group's permission for the group to address the theme identified unless another issue (emergency) needs to be addressed.
Ask a future-oriented question based on the theme.
Get as many details as possible about the future-oriented question asked.
Listen for any exceptions mentioned by the clients, and follow up any exceptions by getting as many details as possible.
Ask scaling questions to determine client's current level of progress towards his or her goal.
Find out what the client has done to have reached and maintained his or her current level of progress.
Find out where the client thinks other people in his or her life would rate him or her and what the client is doing that would cause them to rate him or her there.
Ask group members what role the theme plays in working towards their Miracles.
Give group members "feedback" from the team.
Invite the clients to assign themselves homework by passing out homework sheets.

Table 2
Hazelden "The Primary Recovery Plan" Control Group Session Format

Introduction: Have clients introduce who they are and state their drug of choice.
Check in with clients to see how things are going.
  More specifically, the therapists will discuss times during the past week when group members were influenced by substances.
Apply the appropriate module from the Hazelden Experiential Learning Program.
  (The specifics of the modules cannot be outlined because of copyright.)
  The following modules will be used:
    Module One: Moods and mood-altering substances
    Module Five: How substance dependence affects your attitude
    Module Six: Understanding denial and psychological defenses
    Module Nine: Grief and loss in recovery
    Module Eleven: Dealing with anger in recovery
    Module Fourteen: Preventing relapse
Give group members feedback from the team.
Homework is assigned from the Hazelden material.

has been used in a variety of drug treatment settings. "The Primary Recovery Plan" contains 14 modules. Since the control group was compared with a 6-week brief therapy group, the Hazelden program needed to fit into a similar time frame. We carefully chose modules that covered the main topics in substance abuse treatment and that were not redundant. We also were able to offer two modules in some sessions, since our sessions were 1.5 hr. Each session was video-recorded for supervision and model adherence evaluation.

The control group consisted of two therapists, who were graduate students, conducting therapy at all times. The co-therapists rotated at the completion of the six sessions. The Hazelden program suggests that the therapist-group relationship, unlike for SFGT, *is* an important component of treatment (Corey & Corey, 1997), and thus the therapists remained constant throughout the six sessions of the model's cycle. One of the therapists rotated after the six modules to maintain the therapeutic relationship while allowing the same number of therapists to be involved in the control group as in the treatment group. In addition, a therapist team, along with a clinical supervisor, sat behind a two-way mirror to aid the therapists in manual adherence.

Posttest

Posttest evaluations were completed on all subjects after six therapy sessions. These evaluations were conducted by the researcher, using the standard assessment instruments described below.

Instruments

Prior to the initiation of group therapy, participants provided information about their demographics, history of family and personal substance use, and recognition of presession change. The pretest and posttest included the Beck Depression Inventory (BDI), the Substance Abuse Subtle Screening Inventory (SASSI), questions evaluating social cost measures, and the Outcome Questionnaire (OQ-45.2).

The therapists were assessed using the Family Therapist Rating Scale to measure therapist skill level. This was performed to reduce the confound of unknown treatment quality between groups. Three mental health students, with training in systemic theory but not affiliated with

the research project and blind to the research questions, rated the therapists' skills. In addition, the raters scored the therapists on adherence to SFGT or the Hazelden model using a checklist containing the main tenets of each modality.

Substance abuse subtle screening inventory (SASSI-3). The SASSI-3, an updated version of the widely used screening device, was given to all clients at pre- and posttest as a means to classify subjects. Subjects were classified as either having a low or high probability of possessing a substance dependence disorder. It has been shown to have a reliability of .93 when classifying male and female drug users as possessing substance dependence disorder (Miller, 1985).

Outcome questionnaire (OQ). The Outcome Questionnaire (OQ) 45.2 is a self-report measurement of treatment effectiveness on interpersonal functioning, symptom distress, and social role. This scale was chosen because of its ability to measure a client's progress throughout the course of treatment. The OQ was given to each client pre- and posttreatment to measure the effectiveness of therapy. Lambert, Burlingame, et al. (1998) report a high level of reliability (.84) for the OQ.

Beck depression inventory (BDI). The BDI is a very widely used, reliable (.73–.92) instrument for measuring depression (Beck, Steer, & Garbin, 1988). The BDI was chosen as an outcome measure because research suggests that depression is a common comorbid condition with substance abuse (Brennan & Moos, 1996; Brennan, Moos, & Mertens, 1994; Havassy & Wasserman, 1992).

Social cost questions. Ten social cost questions were also asked at pre- and posttest evaluations. Employment and relationship satisfaction served as the two main areas of measurement. The purpose of asking these questions was to assess how employment and relationship status had been affected by treatment.

RESULTS

Statistical Analysis

Analyses of variance (ANOVA) were run to assess for differences between groups in treatment. An ANOVA was run on both the BDI and the OQ. No significant differences were found between groups on either measure. Mean scores for the OQ and BDI were higher for the treatment group at pretest, meaning that this group possessed more comorbid symptoms than the control group. Since there were differences in posttest scores, an analysis of covariance (ANCOVA) was completed to control for pretest differences on the OQ and the BDI. Results showed no significant differences between groups on the OQ and the BDI when controlling for pretest scores. Thus, when analyzing between group differences on the OQ and the BDI, no significant differences were found.

In an attempt to further analyze the possible treatment effects, we examined within-group differences. A paired samples *t*-test was completed on the BDI and the OQ, for both treatment groups, to determine if each treatment produced significant changes. The first analysis was run on the control group's BDI scores, comparing pre- and posttest data. The results indicated that although there were differences in BDI scores (i.e., that a client's state of depression decreased), it was not significant (.086; see Tables 3 and 4). A similar analysis was run on the treatment group, and a statistically significant improvement in clients' depression (.002) was found. Thus, only clients in the solution-focused group possessed scores on the BDI indicating significantly less depression after treatment.

We also examined within-group differences on the Outcome Questionnaire. A paired samples *t*-test was completed on the pre- and posttest scores to determine if significant positive change had occurred within both treatment groups. The first analysis was run on the control group's OQ scores, comparing pre- and posttest data. Although there was a change in OQ scores (i.e., that clients did benefit from treatment), it was not significant (.27). A paired samples *t*-test did show a significant pre- to postimprovement on the solution-focused group's OQ

Table 3
Control Group Related Samples t-*test for the Beck and the OQ*

	M (*SD*)	*t* (*df*)	*p*-Value
Beck pretest	8.53 (6.23)	1.82 (18)	.086
Beck posttest	6.05 (6.37)		
OQ pretest	43.63 (20.13)	1.15 (18)	.27
OQ posttest	39.37 (17.49)		

Note. Lower scores are better for both measures. OQ = Outcome Questionnaire.

Table 4
Treatment Group Related Samples t-*test for the Beck and the OQ*

	M (*SD*)	*t* (*df*)	*p*-Value
Beck pretest	14.63 (10.71)	3.6 (18)	.002
Beck posttest	7.42 (10.00)		
OQ pretest	51.47 (21.49)	3.64 (18)	.002
OQ posttest	39.16 (20.35)		

Note. Lower scores are better for both measures. OQ = Outcome Questionnaire.

scores (.002). Thus, only SFGT showed significant differences in treatment when comparing pre- and posttest data.

Moderate effect sizes were also found for the OQ and the BDI. For the BDI the effect size was .64 (Cohen's *d*—90% confidence interval: .08–1.17) and for the OQ Symptom Distress subscale the effect size was .61 (Cohen's *d*—90% confidence interval: .05–1.14). These findings are important given that depression and substance abuse often co-occur and treatment of depression improves outcomes for substance abuse treatment (Zickler, 1999).

Although the SASSI is not intended to be used as an outcome measure, two subscales on the SASSI were examined to see if clients remained the same before and after treatment. The obvious attributes (OAT) and the subtle attributes (SAT) were the subscales that were compared at pre- and posttest. The OAT and SAT had reliabilities in this study that are congruent with SASSI's reliabilities. A paired samples *t*-test showed no significant differences in the OAT and SAT difference scores between groups. This finding suggests that the treatment and control groups faired similarly at pre- and posttest on the SASSI. A table of group ratings on the SASSI is included to illustrate similarities between groups (see Table 5). This result can be compared with the data gathered in Project MATCH (Project MATCH Research Group, 1997, 1998).

DISCUSSION

Many individual clinicians and programs all around the world are using solution-focused brief therapy to treat substance abuse. At the same time, there has been little empirical research on the effectiveness of this model with this population (Berg & Miller,

Table 5
SASSI Total Scores Between the Control and Experimental Groups

	Control group	Treatment group	Total
High probability of substance dependence disorder	12	12	24
Low probability of substance dependence disorder	4	7	11
Inflated defensiveness score	1		1
Random answering pattern	2		2

1992; Berg & Reuss, 1997; Juhnke & Coker, 1997; Mason et al., 1995; McCollum & Trepper, 2001). The results of this study, while preliminary and complex, suggest that solution-focused group therapy may be a useful treatment for some level 1 substance abusers. Before discussing the findings and their implications, we will provide a brief review of some of the ways in which we attempted to reduce the possibility of variables confounding the results.

Therapist Rating

To reduce the chance of a confounding variable, therapist skill level, the Family Therapist Rating Scale was given to all participating therapists. Since the reliability of the scale was high (.77), it was considered an accurate measure of the skill level of the therapists (Piercy & Laird, 1983). When doing Cronbach's (1951) alpha in our sample, a reliability of .83 was found. Thus, the Family Therapist Rating Scale was a reliable means to control for therapist skill level.

Mental health students with systemic training administered the Therapist Rating Scale. According to Piercy and Laird (1983), the scale is designed to be filled out by anyone with knowledge of family therapy theory. Thus, the individuals rating the scale were well qualified to administer the test.

An additional measure was taken to ensure that each therapist received an accurate measurement. Each therapist was measured by three different individuals to ensure an accurate rating. All raters were given the same therapy sessions to watch but completed their scales individually. Therapist evaluators did not discuss their ratings with anyone. An average rating score was determined for each therapist. After performing an independent samples *t*-test, there was no significant difference between the therapists in the treatment group and those in the control group. In addition, the inter-rater reliability for this scale was .678. Thus, the confound of therapist skill level was reduced in this study by using the Therapist Rating Scale (Piercy & Laird, 1983).

Therapist Adherence

Another confounding variable that needed to be reduced in this study was therapist adherence to their particular model. A series of seven questions were given to measure therapist adherence to the model they were using (see Table 6). The same therapist raters were used to complete the adherence items. Again, each therapist was rated by three evaluators and then their scores were averaged. Computing descriptive statistics on both groups showed that every item, except one, was consistently followed by all therapists in both treatments. As six out of seven elements of adherence were followed, therapists' adherence to their particular model was assumed.

Table 6
Model Adherence Checklists

SFBT Model Adherence Checklist		
Were scaling questions asked during the session (e.g., on a scale of 1–10)?	Yes	No
Did the therapists ask the clients if there were times when exceptions to their problems existed?	Yes	No
Did the therapists incorporate the clients' goals into the session?	Yes	No
Did the therapists try to connect the different experiences of clients to other members of the group?	Yes	No
Did the therapists try to help each member focus on possible solutions to their problems?	Yes	No
Did the therapists take a consulting break?	Yes	No
Did the therapists give compliments to each member of the group?	Yes	No
Hazelden Model Adherence Checklist		
Did the therapists ask the group to discuss their week?	Yes	No
Did the therapists use a psychoeducational approach when conducting the later part of the therapy session?	Yes	No
Did the therapists promote group interaction?	Yes	No
Did the therapists seem to stick with the topic of the day?	Yes	No
Did the therapists seem to focus on each member's problem with substance abuse?	Yes	No
Were the therapists helpful in explaining the nature of substance abuse?	Yes	No
Did the therapists seem to stick with the key ideas presented in the Hazelden material?	Yes	No

Note. SFBT = solution-focused brief therapy.

Treatment Effectiveness

Decreasing depression among substance abusers. Depression has been shown to be positively correlated with alcohol use (Brennan & Moos, 1996; Brennan et al., 1994) and other abusing drugs (Havassy & Wasserman, 1992). In addition, specific drugs such as cocaine have shown a relationship with depression (Meyer, 1992). In a recent study Bonin, McCreary, and Sadava (2000) found a significant relationship between depression and problematic drinking. Because of the high comorbidity of depression and substance usage, the BDI was used to measure the level of depression pre- and posttreatment. The purpose was to show that a decrease in depression was a correlate of decreased use of substances.

Other research on SFBT has been completed testing clients' level of depression pre- and posttreatment. Sundstrom (1993) conducted an experimental research study testing to see if SFBT faired better than Interpersonal Psychotherapy for Depression (IPT) for the treatment of depression. Results from this study found that clients in both groups did significantly better after treatment. Although SFBT was not found to be better than IPT, this study did show that clients became significantly less depressed after SFBT.

In summary, since depression and substance abuse tend to be comorbid conditions, it makes sense to measure mood before and after substance abuse treatment. Research conclusions suggested a statistically significant difference occurring in the treatment group on the BDI

but not in the control group. This finding supports the thought that SFBT is an effective method of decreasing depression for level 1 substance abusers.

Symptom distress, interpersonal relationship, and social role for substance abusers. The Outcome Questionnaire (OQ) was chosen to measure client change in both the control and treatment groups. The OQ is a reliable test that can measure a client's progress through treatment even over brief periods of time. As the treatment conducted in this project was brief, the OQ served as a reliable way to show client change as a result of treatment. The OQ includes three subscales that address symptom distress, interpersonal relationship, and social role along with items that address substance abuse. The first subscale, symptomatic distress, is loaded with items that measure anxiety, depression, and substance abuse (Lambert, Burlingame, et al., 1998). Items in this subscale were selected using *DSM-III-R* criteria for depression, anxiety, and substance abuse as one guide. The second subscale, interpersonal relations, measured the following concepts based on the most common complaints reported by clients in therapy: friction, conflict, isolation, inadequacy, and withdrawal (Horowitz et al., 1991). Social role, the final subscale, possesses items measuring the client's level of dissatisfaction, conflict, distress, and inadequacy related to one's family roles, employment, and leisure life. This domain was included in the OQ based on literature stating that satisfaction in social role highly correlates with overall life satisfaction (Beiser, 1973; Blau, 1977; Frisch, Cornell, Villanueva, & Retzlaff, 1992; Veit & Ware, 1983). Results from this study found a significant difference occurring, from pre to post, on the OQ only in the SFBT group. Since the items of the OQ measure issues correlated with substance abuse, such as depression (e.g., Brennan & Moos, 1996), anxiety (e.g., Kanzler & Rosenthal, 2003), life satisfaction (e.g., Frisch, 1989), and interpersonal conflict (e.g., Philippot, Kornreich, & Blairy, 2003), one can conclude that significantly improved change scores on the OQ indicate improvement in comorbid conditions after treatment.

Lambert, Okiishi, Finch, and Johnson (1998) also used the OQ to assess client progress from SFBT. In their study, a control group was used to compare the rate of client improvement of SFBT. Their conclusions stated that 36% of SF clients improved significantly after only two sessions whereas only 2% of the control group improved after two sessions. Other studies have shown that clients significantly benefit from SFBT (Cockburn, Thomas, & Cockburn, 1997; Lindforss & Magnusson, 1997; Seagram, 1997; Zimmerman et al., 1996), but more research is still needed.

Since obvious and subtle attributes on the SASSI were similar at pre- and posttreatment for both groups, the conclusions of this study are similar to those of Project MATCH (Project MATCH Research Group, 1997, 1998). Thus, if SFGT is equally effective plus can lower depression and improve interpersonal functioning and social role while lowering symptom distress, SFGT offers the ability to reduce the comorbid issues of substance abusers. This conclusion suggests it may be preferential to SFGT with level 1 substance abusers.

Social cost. A series of 10 questions were also asked dealing with social cost. Employment and relationship satisfaction served as the two main areas of measurement. Although there were not significant findings on the social cost questions, this may have been partially because of the fact that a number of clients were not employed. In addition, since only six sessions existed between pre- and posttests, the effects of gaining employment may have been missed in this short amount of time.

The social cost questions relating to interpersonal relationships did show a trend for improvement. Although statistical significance was not reached, relationship satisfaction did increase more in the SFBT group.

A final consideration is that the social cost questions were generated by the experimenter and their reliability and validity were not established. As the OQ contains items dealing with social cost, and significant findings *did* occur with this measure, the OQ may be a better source of determining the effects of treatment on social cost.

Implications for Practitioners

The results from this study suggest that SFGT can be an effective approach for treating level 1 substance abusers, demonstrating similar and sometimes better results than a traditional substance abuse treatment program. Findings from this project provide initial support for the underlying theoretical rationale. Not only is SFGT cost effective, but also its effects can have a lasting impact. Brief therapies in general have been shown to be useful in the treatment of substance abusers. For example, 24 experimental studies have shown that brief motivational interventions display significantly better outcomes than more extensive treatments (Bien, Miller, & Tonigan, 1993; Institute of Medicine, 1989). SFGT, being a brief, resiliency-based approach, may be an effective and cost efficient way to treat a population that demands a great deal of resources.

Additionally, group therapy in general is an extremely cost-effective modality, which is why it is so often incorporated into the treatment plans for level 1 substance abusers in mental health facilities around the world. SFGT, as a group modality, allows for more individuals to benefit from treatment. Of course, there are other benefits to the group therapy model, such as the use of the group dynamic and peer support to help develop solutions, and to offer encouragement in the change process.

Another reason for using SFGT with substance abusers lies in its unique approach. Clients receiving SFBT treatment determine their own goals and outcomes for therapy (de Shazer, 1990). This allows the client to take ownership over his or her treatment, usually leading to more cooperation and ultimately more successful outcomes. As clients in SFGT are asked to set their own goals, sometimes they may not be directly centered on substance abuse (McCollum, Trepper, & Smock, 2004). Placing clients in charge of determining their goals and course of treatment, instead of the therapist dictating the course of therapy, seems to be ideal to promote change.

CONCLUSION

Overall, the results from this study suggest that SFGT may be a useful approach in the treatment of level 1 substance abusers. In this study, while clients who received either SFGT or a traditional treatment approach both improved overall, clients who received SFGT improved significantly on comorbid factors while the clients in the traditional treatment approach group did not improve significantly. Clients in the SFGT group improved significantly on the BDI and the OQ, whereas the subjects in the traditional treatment group did not.

While this study's results must be considered preliminary, the results are important, since this is the first study comparing the effects of SBFT in a group setting with substance abusers to traditional drug treatment. It is hoped that these initial positive findings will lead to much more research in the use of solution-focused therapy for the treatment of substance abuse. It is clear that this approach can be useful for many if not most clients. The fact that this resiliency-based approach is already in use all over the world suggests that it is seen by clinicians themselves as helpful. We believe that increased research will help the drug abuse and mental health fields by offering evidence for yet another effective therapy to be used to help in the amelioration of substance abuse.

REFERENCES

American Society of Addiction Medicine. (1996). *Patient placement criteria for the treatment of substance-related disorders* (2nd ed.). Chevy Chase, MD: Author.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, *8*, 77–100.

Beiser, M. (1973). Components and correlates of mental well-being. *Journal of Health and Social Behavior*, *15*, 320–327.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-oriented approach*. New York: Norton.

Berg, I. K., & Reuss, N. (1997). *Solutions step-by-step: A substance abuse treatment manual*. New York: W. W. Norton.

Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. *Addictions*, *88*, 305–325.

Blau, T. H. (1977). Quality of life, social interaction and criteria of change. *Professional Psychology*, *8*, 464–473.

Bonin, M. F., McCreary, D. R., & Sadava, S. W. (2000). Problem drinking behavior in two community-based samples of adults: Influence of gender, coping, loneliness, and depression. *Psychology of Addictive Behaviors*, *14*, 151–161.

Brennan, P. L., & Moos, R. H. (1996). Late-life problem drinking: Personal and environmental risk factors for 4-year functioning outcomes and treatment seeking. *Journal of Substance Abuse*, *8*, 167–180.

Brennan, P. L., Moos, R. H., & Mertens, J. R. (1994). Personal and environmental risk factors as predictors of alcohol use, depression, and treatment seeking: A longitudinal analysis of late-life problem drinkers. *Journal of Substance Abuse*, *6*, 191–208.

Cockburn, J. T., Thomas, F. N., & Cockburn, O. J. (1997). Solution-focused therapy and psychosocial adjustment to orthopedic rehabilitation in a work hardening program. *Journal of Occupational Rehabilitation*, *7*, 97–106.

Corey, M. S., & Corey, G. (1997). *Groups: Process and practice*. New York: Brooks/Cole.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, *16*, 297–334.

Frisch, M. B. (1989). Quality of life therapy: An integrative model of etiology, assessment, and treatment of depression and related disorders. Paper presented at the World Congress of Cognitive Therapy, Oxford, UK.

Frisch, M. B., Cornell, J., Villanueva, M., & Retzlaff, P. J. (1992). Clinical validation of the quality of life inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment*, *4*, 92–101.

Galaif, E. R., & Sussman, S. (1995). For whom does Alcoholics Anonymous work? *The International Journal of the Addictions*, *30*, 161–184.

Galanter, M., & Kleber, H. D. (Eds.). (1994). *The American Psychiatric Press textbook of substance abuse treatment*. Washington, DC: American Psychiatric Press.

Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, *39*, 477–498.

Havassy, B. E., & Wasserman, D. A. (1992). *Traumatic events and post-traumatic stress disorder in treated cocaine abusers. Problems of Drug Dependence, 1992: Proceedings of the 54th Annual Scientific Meeting of the College on the Problem of Drug Dependence* (pp. 138). Rockville, MD: National Institute on Drug Abuse.

Hazelden Foundation. (1998). *The primary recovery plan: Practical solutions for the substance dependent client* [treatment manual]. Center City, MN: Author.

Horowitz, L. M., Locke, K. D., Morse, M. B., Waikar, S. V., Dryer, D. C., Tarnow, E., et al. (1991). Self-derogations and the interpersonal theory. *Journal of Personality and Social Psychology*, *61*, 68–79.

Institute of Medicine. (1989). *Prevention and treatment of alcohol problems: Research opportunities*. Washington, DC: National Academy of Sciences.

Institute of Medicine. (1990). *Broadening the base of treatment for alcohol problems*. Washington, DC: United States Government Printing Office.

Juhnke, G. A., & Coker, J. K. (1997). A solution-focused intervention with recovering, alcohol-dependent, single parent mothers and their children. *Journal of Addictions & Offender Counseling*, *17*, 77–88.

Kanzler, H. R., & Rosenthal, R. N. (2003). Dual diagnosis: Alcoholism and co-morbid psychiatric disorders. *The American Journal on Addictions*, *12*, S26–S40.

LaFountain, R. M., & Garner, N. E. (1996). Solution-focused counseling groups: The results are in. *Journal for Specialists in Group Work*, *21*, 128–143.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., et al. (1998). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy*, *3*, 249–258.

Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice*, *29*, 63–70.

Lindforss, L., & Magnusson, D. (1997). Solution-focused therapy in prison. *Contemporary Family Therapy*, *19*, 89–103.

Mason, W. H., Chandler, M. C., & Grasso, B. C. (1995). Solution-based techniques applied to addictions: A clinic's experience in shifting paradigms. *Alcoholism Treatment Quarterly*, *13*, 39–49.

McCollum, E. E., & Trepper, T. S. (2001). *Family solutions for substance abuse: Clinical and counseling approaches*. Binghamton, NY: Haworth Press.

McCollum, E. E., Trepper, T. S., & Smock, S. (2004). Solution-focused brief group therapy for drug abuse: Rationale, content, and approaches. *Journal of Family Psychotherapy*, *14*, 27–42.

Metcalf, L. (1998). *Solution-focused group therapy*. New York: The Free Press.

Meyer, R. E. (1992). New pharmacotherapies for cocaine dependence revisited. *Archives of General Psychiatry*, *49*, 886–887.

Miller, G. A. (1985). *The substance abuse subtle screening inventory (SASSI) Manual*. Springville, IN: The SASSI Institute.

Miller, S. D., & Berg, I. K. (1995). *The miracle method: A radically new approach to problem drinking*. New York: W. W. Norton.

Miller, W. R., & Hester, R. K. (1986). The effectiveness of alcoholism treatment: What research reveals. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Process of change* (pp. 243–248). New York: Plenum Press.

Miller, W. R., & Hester, R. K. (1989). Inpatient alcoholism treatment: Who benefits? *American Psychologist*, *41*, 794–805.

Moos, R. H. (1989). Understanding the quality and outcome of treatment. *Substance Use and Misuse*, *33*, 2789–2794.

Philippot, P., Kornreich, C., & Blairy, S. (2003). Nonverbal deficits and interpersonal regulation in alcoholics. In P. Philippot, R. S. Feldman, & E. J. Coats (Eds.), *Nonverbal behavior in clinical settings* (pp. 209–231). New York: Oxford University Press.

Pichot, T., & Dolan, Y. (2003). *Miracles happen: One agency's journey to look beyond client problems*. Binghampton, NY: Haworth Press.

Piercy, F. P., & Laird, R. A. (1983). A family therapist rating scale. *Journal of Marital and Family Therapy*, *9*(1), 49–59.

Polich, J. M., Armor, D. J., & Braiker, H. B. (1981). *The course of alcoholism: Four years after treatment*. New York: Wiley.

Polk, G. W. (1996). Treatment of problem drinking behavior using solution-focused therapy: A single subject design. *Crisis Intervention*, *3*, 13–24.

Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research*, *17*, 1130–1145.

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7–29.

Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research*, *22*, 1300–1311.

Seagram, B. C. (1997). *The efficacy of solution-focused therapy with young offenders*. Unpublished doctoral dissertation, York University, New York, Ontario, Canada.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: W. W. Norton.

de Shazer, S. (1990). Brief therapy. In J. K. Zeig & W. M. Munion (Eds.), *What is psychotherapy? Contemporary perspectives* (pp. 278–282). San Francisco: Jossey-Bass.

Springer, D. W., Lynch, C., & Rubin, A. (2000). Effects of solution-focused mutual aid group for Hispanic children of incarcerated parents. *Child and Adolescent Social Work*, *17*, 431–442.

Sundstrom, S. M. (1993). *Single-session psychotherapy for depression: Is it better to focus on problems or solutions?* Unpublished doctoral dissertation, Iowa State University, Ames.

Thurstin, A. H., Alfano, A. M., & Nerviano, V. J. (1987). The efficacy of AA attendance for aftercare of inpatient alcoholics: Some follow-up data. *International Journal of Addiction*, *22*, 1083–1090.

U.S. Department of Health and Human Services. (2001). *Results from the 2001 national household survey on drug abuse: Volume I summary of national findings*. Rockville, MD: Author.

Vaillant, G. E. (1983). *The natural history of alcoholism: Causes, patterns, and paths to recovery*. Cambridge, MA: Harvard University Press.

Veit, C. T., & Ware, J. E. (1983). The structure of psychological distress and well-being in general populations. *Journal of Consulting and Clinical Psychology*, *51*, 730–742.

Zickler, P. (1999). *Treating mood disorders in drug abuse patients yields improvement in both conditions*. NIDA Notes, 13(6). Retrieved November 9, 2007 from http://www.drugabuse.gov/NIDA_Notes/NNVol13N6/Mood.html.

Zimmerman, T. S., Jacobsen, R. B., MacIntyre, M., & Watson, C. (1996). Solution-focused parenting groups: An empirical study. *Journal of Systemic Therapies*, *15*, 12–25.

Zimmerman, T. S., Prest, L. A., & Wetzel, B. E. (1997). Solution-focused couples therapy groups: An empirical study. *Journal of Family Therapy*, *19*, 125–144.