

# SAMHSA ADVISORY

Substance Abuse and Mental Health  
Services Administration

## GROUP THERAPY IN SUBSTANCE USE TREATMENT

Group therapy is a therapy modality wherein clients learn and practice recovery strategies, build interpersonal skills, and reinforce and develop social support networks. It typically involves a group of 6 to 12 clients who meet on a regular basis with one or two group therapists. The 2019 National Survey of Substance Abuse Treatment Services reports that 93 percent of substance use disorder (SUD) treatment facilities, across different settings, provide group counseling (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). The popularity of this type of group therapy has been shaped by the influence of mutual-support groups, the potential for cost containment, and its efficiency in delivering psychoeducation while teaching coping skills to many individuals at once.

Based on SAMHSA's [Treatment Improvement Protocol \(TIP\) 41, Substance Abuse Treatment: Group Therapy](#), this *Advisory* provides an overview of goals, processes, group-specific approaches, resources, and common elements that support favorable outcomes in group therapy. It does not address nontreatment groups, specifically peer and mutual-support groups. Nonetheless, these groups can also support recovery and add significant value to the treatment process (e.g., reinforcing coping strategies, modeling recovery behavior, providing hope, and minimizing the stigma often associated with SUDs).

### **Key Messages**

- Group therapy, used extensively in SUD treatment, consists of individual theoretical approaches adapted to the development of specialized manual-based group treatments.
- Several core processes predict outcomes in many SUD group therapy settings, including therapeutic alliance, group affiliation, and culturally responsive practices.
- Across the continuum of care, group therapy can be an effective and efficient modality for improving treatment engagement, developing and practicing coping skills, and supporting recovery.
- Group therapy is one of the most common approaches in SUD treatment settings. There is broad need for clinical supervision and formal training in specific group processes and dynamics, as well as evidence-based SUD group therapies.

Group therapy has therapeutic advantages. It provides potential benefits in promoting social support, reducing isolation and stigma, developing effective communication and interpersonal skills, and practicing recovery-oriented coping strategies with group members (Wendt & Gone, 2017; Wenzel et al., 2012). There is a growing body of evidence that group therapy is cost effective and produces

client outcomes comparable to individual therapy in SUD treatment acceptance, retention, reductions in frequency of use, abstinence rates, and psychological symptoms and distress (Burlingame et al., 2016; Lo Coco et al., 2019; Olmstead et al., 2019; Sobell & Sobell, 2011; Sobell et al., 2009). Adding group therapy as a component to individually oriented SUD treatment approaches improves treatment engagement, abstinence rates, and perceived peer support (de Moura et al., 2017).

## Groups in SUD Treatment: An Overview

Group therapy is a common way to deliver SUD treatment interventions in various types of treatment settings. Group therapy is used in hospital-based units providing medically supervised withdrawal, outpatient and intensive outpatient programs, nonhospital residential treatment centers, halfway houses, continuing care groups, and outpatient groups for those engaged in medication-assisted treatment (Pugatch et al., 2014; Sokol et al., 2018).

Groups differ in their overall purpose and goals. Some groups address a specific point in recovery, such as early recovery and relapse prevention. Other groups provide psychoeducation on various topics, including the consequences of SUDs, family impact, and the use of support systems. Other groups focus on managing specific co-occurring health conditions (e.g., HIV/AIDS), psychological symptoms (e.g., anger management), and mental disorders (e.g., social anxiety, mood disorders). Groups may focus on populations (e.g., gender- and age-specific and criminal justice groups).

There are culturally specific groups that integrate cultural practices and values into treatment and others that provide an affirming space for recovery (e.g., for LGBTQ+ individuals).

Many SUD treatment programs use individual theoretical approaches and rework them into group therapy (Wendt & Gone, 2017). Groups often use a combination of strategies, such as motivational interviewing, stages-of-change interventions, psychoeducation, supportive approaches, and skill development. In the past decade, evidence-based group therapies for SUDs have evolved using motivational and cognitive-behavioral approaches or a combination of both (Sobell & Sobell, 2011).

### Group member selection

Matching clients with the appropriate group is vital to successful treatment. In addition to admission criteria and the group's purpose, a client's needs, current goals, and ability to participate determine appropriateness. For example, a female client who presents with an SUD and trauma history may be better served

Percentage of SUD Treatment Facilities Offering Special Programs or Groups	
Special Program or Group	Percentage
Adolescents	24
Adult men	47
Adult women	49
Clients with co-occurring disorders	53
Criminal justice clients (not including DUI/DWI offenders)	36
DUI/DWI offenders	24
Lesbian, gay, bisexual, or transgender (LGBT)	23
Older adults	23
People with HIV/AIDS	20
Pregnant or postpartum women	24
Veterans	22
Source: SAMHSA, 2020.	

in a women-only group. Clients who are not suited for group therapy should be reevaluated if conditions change. The following list describes client circumstances that may justify ruling out group therapy at a particular point in time (American Group Psychotherapy Association, 2007; Greenfield et al., 2014):

- Inability to attend group therapy regularly
- Currently misusing substances
- Intellectual disability or a neurocognitive disorder that prevents the client from communicating with other group members, understanding or attending to the group process, or following through with group tasks
- Current psychosis, mania, or other symptoms that would hamper participation
- Inability to follow group rules established by the treatment program and group members

### ***Elements that enhance outcomes: Group cohesion and therapeutic alliance***

Group cohesion and therapeutic alliance improve outcomes for individuals who participate in group therapy for SUDs. Favorable outcomes include treatment acceptance, engagement, and retention in group therapy, as well as enhanced abstinence rates or reduction in substance misuse frequency.

- **Group cohesion** refers to the quality of relationships among group members, including the client–therapist connection. It includes the perception of interpersonal and emotional support and affiliation in the group (Burlingame et al., 2018; Dolgin et al., 2020; Sugarman et al., 2016; Yalom & Leszcz, 2005). Group cohesion is associated with positive outcomes across treatment settings, theoretical approaches, and client populations. Group therapists should encourage member–member interactions rather than conducting individual therapy in a group format, model how members can give balanced positive and negative feedback, and highlight commonalities and foster similar experiences among group members (Burlingame et al., 2018; Kivlighan et al., 2020; Sobell & Sobell, 2011; Valeri et al., 2018).
- **Therapeutic alliance** is the development of a working relationship and bond between a group member and therapist. It includes an agreement on goals and tasks to address the presenting problems (Ardito & Rabellino, 2011; Bordin, 1979; Martin & Garske, 2000). Group therapists begin to foster therapeutic

### ***Enhancing Group Cohesion***

- Ask members to share if they ever experienced a similar circumstance, feeling, or thought as expressed by a specific group member.
- Ask the group to provide feedback to another group member on what they see as working well and what is not working so well regarding self-care.
- Brainstorm with the group about how to manage a specific high-risk situation using a concrete example from a group member.
- Use role-plays to practice coping or refusal skills, then reverse roles so that another member can experience and empathize with the group member’s situation while learning recovery skills.

### ***Enhancing Therapeutic Alliance***

Prior to participation, walk through an example of a typical group session. Talk about how group sessions begin and end. Discuss normal experiences in group sessions, such as being anxious about giving feedback to another member or sharing an experience or emotions with the entire group, hearing a painful story from another participant, or learning about a member leaving the group. A key ingredient in building alliance is using reflective listening and periodic check-ins, (e.g., “Is it okay with you if I share what I just heard and observed?”).

alliance with the first interaction with a client. Group therapists should prepare clients to join the group by explaining the group process, treatment expectations, and group rules prior to participation. Furthermore, they should develop shared goals for group therapy. In group sessions, therapists adopt culturally responsive practices to build alliance and show support and empathy as the client negotiates recovery challenges. Therapeutic alliance is associated with positive group treatment outcomes across theoretical approaches and client populations (Crits-Christoph et al., 2013; Davis et al., 2015; Flückiger et al., 2013; Meier et al., 2005; Sobell & Sobell, 2011; von Greiff & Skogens, 2019).

### **Group preparation from initiation to termination**

Group therapists should be mindful that new clients are typically in unfamiliar territory, unacquainted with clinical and recovery language, group processes, and treatment procedures. Treatment engagement and outcomes are fortified when client preparation occurs prior to group attendance. The preparation should address when the client will end group therapy and the process of termination, including available continuing care services and the process of referring clients, which may be handled by a case manager or aftercare coordinator (Sobell & Sobell, 2011).

### **Stigma**

Stigma is a process in which people with SUDs are devalued, labeled, and excluded in society. It fosters health inequalities and is associated with negative outcomes for those with SUDs. Stigma is linked to premature discontinuation of treatment, increased risky behavior, and delayed recovery. Stigma can be self-imposed or imposed by others, including other group members, family, staff, and society. Person-first language, positive recovery stories, acceptance, and commitment to group therapy may help address stigma and its far-reaching effects (Livingston et al., 2012; Luoma et al., 2008, 2014). In addition, community-based approaches may decrease stigma through social media messaging and education about SUDs and their contributing factors. Stigma can be reduced by community recovery activities and advocacy groups (e.g., recovery runs/walks, public policy forums, the use of recovery ambassadors) (National Academies of Sciences, Engineering, and Medicine, 2016).

## **Group Structure and Development**

### **Group structure and formats**

Most studies evaluating group SUD treatments use a fixed number of sessions, closed-group format, and manual-based approaches. Less is known about SUD treatment groups with open formats, varied session lengths, and those that use nonmanualized approaches. Factors to consider include the following:

- Closed groups offer advantages in evaluating treatment effectiveness using a specific approach or strategy. Closed groups are more likely to build group cohesiveness and support among members, resulting in less client turnover, which is associated with better outcomes (Pavia et al., 2016; Sobell & Sobell, 2011; Wendt & Gone, 2017).
- Group therapists in SUD treatment may transition in and out of group due to staffing demands. This may disrupt group cohesiveness, trust, and the level of self-disclosure. Treatment providers should avoid this practice whenever possible (Morgan-Lopez & Fals-Stewart, 2008).

### **Open and Closed Groups**

Open groups accept group members on a rolling basis with no end date. Clients can enter group at any time. Closed groups have a specific start and end date and typically accept clients only at the beginning of the process (Sobell & Sobell, 2011).

- Therapists' ability to use and adapt specific techniques as situations in the group dictate (as opposed to using predetermined exercises and content) is associated with better outcomes in general. There is some evidence that clients become dissatisfied within open group formats when the same content is reintroduced to new members. Consequently, less time is devoted to group interaction and there are fewer opportunities to build on content and group processes from previous sessions. Client satisfaction is not only tied to treatment engagement but also to outcomes (Owen & Hilsenroth, 2014).

## **Agenda setting**

To effectively facilitate an SUD group, therapists need to prepare and set an agenda for each session, because predictability helps create a safe and therapeutic working environment (Sobell & Sobell, 2011). However, counselors should remain flexible and open to changing the agenda as needed. Agendas should emphasize elements of the group that will be consistent across all sessions. This means that therapists need to mark the opening and closing of sessions in the same way each time. Agendas used in early sessions might also cover the reinforcement of group rules and how group members share or provide feedback. If needed, the counselor can add these items to later agendas as reminders. In addition to group processes, agendas can also cover session content, like planned exercises, educational material, and content to address individual and group-specific concerns and needs.

## **Group size**

There is no consensus on the most effective group size in SUD treatment. Literature suggests that group size should range from 6 to 12 individuals to effectively address clients' needs and to enable all members to participate (Sobell & Sobell, 2011; Velasquez et al., 2016). Group size also depends on the purpose of group therapy. For example, groups that focus on education with some processing and sharing may effectively accommodate larger groups (e.g., psychoeducational multifamily group sessions). Groups with fewer than six members are less likely to survive as a result of attrition and absenteeism, whereas larger groups are likely to have fewer member–member interactions (Wendt & Gone, 2018; Yalom & Leszcz, 2005). There is no scientific determination of maximum group size; group size restrictions vary across states, counties, and healthcare delivery systems and insurance plans.

## **Culturally responsive practices**

Although there is recognition of the importance of developing cultural competence in SUD treatment, little research is available on culturally responsive practices in group therapy. One study of 13 SUD treatment providers found that racial, ethnic, and cultural considerations were not regularly integrated into the group process (Wendt & Gone, 2018).

Developing cultural competence is an ongoing learning process. It involves the following components across modalities and settings (Sue et al., 2019):

- **Cultural awareness:** The willingness and ability to recognize and self-reflect on the importance of race, ethnicity, and culture—that not everyone shares the same beliefs, values, practices, or experiences. Cultural awareness is the recognition that these attributes play a significant role in all group interactions and in the interpretation of communication and actions of others in the group. Cultural humility is also part of cultural awareness—the commitment to lifelong learning, self-reflection, showing interest in others, and understanding that imbalances in power and privilege exist among clients, co-workers, and administrative staff (Tervalon & Murray-Garcia, 1998).

### **Culture**

Culture includes race, ethnicity, gender, age, religion, sexual orientation, ability, geographic region, and class. Culture involves shared beliefs, values, and practices. In group therapy, culture not only shapes help-seeking behaviors and beliefs about illness and treatment, but also communication patterns within the group (Cohen, 2009; Sue et al., 2019).



- **Cultural knowledge:** A commitment to learning about other cultures by researching, using a cultural guide or mentor from the group population, attending culturally specific events, and asking group members about their culture with a welcoming and inquisitive attitude. Being culturally responsive means addressing how group dynamics may produce further burden on clients at a time when they need services. It involves the recognition of how culture, racism, discrimination, and microaggressions affect individual group members, group processes, and communication, regardless of the group therapy approach (Harris, 2012; Kivlighan et al., 2019).
- **Cultural knowledge of behavioral health:** Learning about healing practices, help-seeking preferences, and acceptable treatments reflected in the group composition. For example, some cultures have specific names for emotional and behavioral problems and cultural explanations for their cause. Other cultures are more likely to distrust behavioral healthcare services and institutions. Group members from some cultures may be more likely to express mental distress through physical symptoms. All cultures have prescribed ways of viewing emotional issues and drug and alcohol misuse.
- **Cultural skills:** Anticipating culturally specific needs of group members. An essential cultural skill in group therapy is effective, appropriate, and respectful communication, including knowledge about body language, attention to gestures and touch, and vigilance about microaggressions that might occur in group process. Other skills include securing translation services, surmounting language barriers, anticipating need for accessibility services, and using culturally specific community resources. Being responsive to cultural diversities can make the difference in how group members respond to services and in treatment outcomes (Gainsbury, 2017; Kivlighan et al., 2019).

### **Microaggressions**

Microaggressions are derogatory comments, insults, or nonverbal behaviors, whether intentional or unintentional, that reflect prejudice, hostility, stereotypes, and generalizations toward a person based solely on their membership in a marginalized group (such as gender identity, ethnicity, race, sexual orientation, socioeconomic status). The effects of microaggressions can be cumulative and affect mental and physical health (Nadal et al., 2014; Sue, 2010; Wang et al., 2011).

### **Groups across the continuum of care**

Across the continuum of care, SUD treatment groups use support, psychoeducation, skill development, and interpersonal processes to assist clients in addressing their emotions, thoughts, and behavior in recovery. Irrespective of setting, population, and the clients' phase of recovery, most SUD treatment groups use a combination of motivational interviewing, cognitive-behavioral, and stages-of-change strategies. Early recovery groups are more likely to focus on psychoeducation, support, and skill development, while late recovery groups tend to emphasize relapse prevention, social skills, and relationship concerns.

### **Group Approaches in SUD Treatment**

Group-specific SUD treatment approaches are divided into three areas: theoretical models, populations, and clinical issues. The following reference lists reflect a sample of some current approaches:

#### **Groups using specific theoretical approaches**

- *Group Cognitive Therapy for Addictions* (Wenzel et al., 2012)
- *Group Therapy for Substance Use Disorders: A Motivational Cognitive-Behavioral Approach* (Sobell & Sobell, 2011)

- *Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual* (Velasquez et al., 2016)
- *Mindfulness-Based Relapse Prevention for Addictive Behaviors: A Clinician's Guide* (Bowen et al., 2010)
- *Motivational Interviewing in Groups* (Wagner et al., 2012)

## **Groups focusing on specific populations and clinical issues**

- *Anger Management for Substance Use Disorder and Mental Health Clients: A Cognitive–Behavioral Therapy Manual* (Reilly & Shopshire, 2019)
- *Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT): A Group Cognitive Behavioral Therapy for Depression in Clients With Co-Occurring Alcohol and Drug Use Problems—Group Leader's Manual* (Hepner et al., 2011)
- *Integrated Group Therapy for Bipolar Disorder and Substance Abuse* (Weiss & Connery, 2011)
- *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002)
- *Treating Women With Substance Use Disorders: The Women's Recovery Group Manual* (Greenfield, 2016)

## **Group Facilitation and Professional Development**

### ***SUD group therapists' credentials***

Foremost, the therapist needs to abide by the ethical and professional standards of their credentialing and governing bodies. Each state has its own licensing, certification, and supervision requirements that enable SUD counselors to provide services. Those services include, but are not limited to, both individual and group therapy (National Association of State Alcohol and Drug Abuse Directors, 2013). There is no specific SUD group therapy license or certification designation.

### ***Fundamental skills of a group therapist***

In addition to helping clients integrate into a new group, reinforcing group rules, and facilitating the group process during sessions, the therapist needs to promote emotional safety. Safety involves setting limits, redirecting topics, and helping group members process difficult exchanges, behaviors, and feelings.

Clients need to feel support and compassion from the group therapist. The therapist must build an alliance with each member and facilitate and promote communication among members so that they share with and learn from each other. The therapist maintains the focus on individual and group goals throughout the process. Though many SUD treatment therapists use primarily psychoeducation in groups (Wendt & Gone, 2017), group facilitation should include a combination of supportive, skill building, and relational strategies to capitalize on the benefits of group therapy.

### ***Common challenges in providing group therapy***

Despite the fact that group therapy is a main modality in SUD treatment, there is little research that addresses group-specific interventions and formats. This disparity between practice and supporting research results in several challenges:

- Providers rely on individual approaches in group therapy.
- Evidence-based group-specific treatments are often thought to be inflexible.
- Training in how to facilitate group therapy, including group dynamics, is not widely available.

For providers, studies support the benefits of early training in group skills and principles, culturally responsive group practices, and management of group dynamics. Therapists need support and training in how to use group-specific resources, and when and how to deviate from session agendas to maintain flexible clinical strategies (Flückiger et al., 2013; Wendt & Gone, 2017, 2018).

## **Professional development**

Even though state requirements differ and there is no specific SUD group therapy license or certification, therapists who provide group therapy in SUD treatment need to commit to professional development in group-specific skills and competencies. These activities include training opportunities in general group therapy, adopting guidelines for best and evidence-based practices designed specifically for SUD treatment, and engaging in supervision. Supervision specific to group practice should include establishing professional development plans; providing support and guidance in group dynamics, strategies, and modalities; and engaging in evaluative processes to support adoption of group-specific competencies.

## **Resources**

- **[Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)**
  - [Substance Abuse Treatment: Group Therapy Inservice Training](#)
  - [TIP 41, Substance Abuse Treatment: Group Therapy](#)
- **[American Group Psychotherapy Association \(AGPA\)](#)**
  - [Guidelines for Creating Affirming Group Experiences: Recommendations from the AGPA Task Force for Diversity, Equity, & Inclusion](#)
  - [Practice Guidelines for Group Psychotherapy](#)
- **[National Institute on Drug Abuse \(NIDA\), Clinical Trials Network \(CTN\)](#)**
  - [The Challenge of Evidence-Based Group Therapy for Substance Use Disorders—CTN Webinar](#)
- **[Rand Corporation](#)**
  - [Building Recovery by Improving Goals, Habits, and Thoughts \(BRIGHT\): A Group Cognitive Behavioral Therapy for Depression in Clients with Co-Occurring Alcohol and Drug Use Problems—Group Leader’s Manual](#)



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