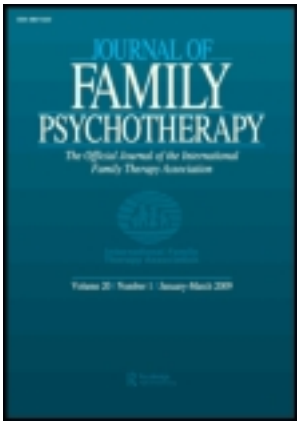

Journal of Family Psychotherapy

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wjfp20

Solution-Focused Group Therapy for Substance Abuse

Eric E. McCollum [a], Terry S. Trepper [b b b] & Sara Smock [c]

[a] Marriage and Family Therapy Program, Virginia Tech Northern Virginia Center, Falls Church, VA, USA

[b] Family Studies Center, Purdue University Calumet, Hammond, IN, 46323, USA

[c] Virginia Tech University, Blacksburg, VA, USA

Available online: 23 Sep 2008

To cite this article: Eric E. McCollum, Terry S. Trepper & Sara Smock (2004): Solution-Focused Group Therapy for Substance Abuse, Journal of Family Psychotherapy, 14:4, 27-42

To link to this article: http://dx.doi.org/10.1300/J085v14n04_03

SPECIAL SECTION: SOLUTION-FOCUSED BRIEF THERAPY FOR ALCOHOL AND SUBSTANCE ABUSE

Solution-Focused Group Therapy for Substance Abuse: Extending Competency-Based Models

Eric E. McCollum
Terry S. Trepper
Sara Smock

ABSTRACT. Solution-Focused Therapy provides a framework by which a competence-based group treatment can be provided to clients who are struggling with substance abuse and dependence. Solution-Focused Group Therapy (SFGT) both preserves the underlying philosophy

Eric E. McCollum is Professor and Clinical Director, Marriage and Family Therapy Program, Virginia Tech Northern Virginia Center, Falls Church, VA.

Terry S. Trepper is Professor of Psychology, Professor of Marriage and Family Therapy, and Director, Family Studies Center, Purdue University Calumet, Hammond, IN 46323.

Sara Smock is a doctoral student, Virginia Tech University, Blacksburg, VA.

Address correspondence to: Eric E. McCollum, Marriage and Family Therapy Program, Virginia Tech Northern Virginia Center, 7054 Haycock Road, Falls Church, VA 22043 (E-mail: e.mccollum@vt.edu).

Journal of Family Psychotherapy, Vol. 14(4) 2003
http://www.haworthpress.com/web/JFP

Digital Object Identifier: 10.1300/J085v14n04_03

of competence-based approaches and can be delivered in a group format. The other primary competence-based treatment approach in the substance abuse field, Motivational Interviewing, remains an individual approach that has yet to be successfully formulated for group treatment. There is a need for competence-based group treatment in the substance abuse field, however, since the majority of treatment agencies provide treatment in a group format, and group treatment has the advantages of providing social support, modeling of success, and inspiring hope. This paper reviews the literature on Motivational Interviewing and Solution-Focused Therapy, argues for the usefulness of SFBT in group format, briefly describes a format for SFGT, and provides a case example of a SFGT session.

KEYWORDS. Solution-Focused Therapy, group therapy, substance abuse, substance abuse treatment, drug abuse, drug abuse treatment

INTRODUCTION

Treatment models that focus primarily on client strengths and competencies (i.e., competence-based models), rather than primarily on failures and deficits, have made a significant impact on the field of substance abuse treatment in the past 20 years. In contrast to models of treatment that assume the client has the disease of addiction and must be confronted about his or her denial of the impact of the addiction, or that assume the client lacks the skills or cognitive structures to refrain from drug use (e.g., Kadden et al., 1994; Monti, Abrams, Kadden, & Cooney, 1989), competence-based approaches assume that there is at least ambivalence about change on the part of the client and that the client has any number of competencies that can be brought to bear on his or her effort to end addiction.

Motivational Interviewing (MI–W. R. Miller & Rollnick, 2002) is the most widely researched competence-based model in the substance abuse field. Much of the research on MI has focused on alcohol abuse where its efficacy is generally accepted (Burke, Arkowitz, & Dunn, 2002). Studies that examine the efficacy of MI with drugs of abuse other than alcohol are fewer and have primarily examined the effect of MI on treatment initiation and participation, rather than outcome. Despite the fewer number of

studies, Burke et al. conclude that there is growing evidence that MI is efficacious for this population, too.

In their review, Burke, Arkowitz and Dunn (2002) make an important point about what is being tested in the empirical studies of MI that they review. Despite MI's clear manualization for NIAAA's Project Match (W. R. Miller, Zweben, DiClemente, & Rychtarik, 1994), Burke and colleagues found that most of the studies included in their review used "adaptations" of MI as the form of treatment tested rather than a pure MI approach. Adaptations are defined as treatments that "incorporate additional non-motivational interviewing techniques while retaining motivational interviewing principles as the core of treatment as well as . . . interventions that have been specifically adapted for use by non-specialists" (p. 218). Thus, there has been considerable latitude in the models tested under the rubric of MI. Burke et al. conclude that "virtually all of the published empirical studies . . . deal with the efficacy of [adaptations of MI], with no studies addressing the efficacy of motivational interviewing in relatively pure form" (p. 218). Therefore, the published research on the efficacy of MI might be better thought of as tests of the underlying philosophy of MI, rather than tests of a specifically defined set of techniques for operationalizing that philosophy. Later in this paper, we will present the case that Solution-Focused Brief Therapy (SFBT–I. K. Berg & Miller, 1992; I. K. Berg & Reuss, 1997; de Shazer & Isebaert, in press), while differing in its technique and implementation, addresses many of the same underlying philosophical principles of competence-based treatment as does MI, and thus has the promise of also being useful in the treatment of substance abuse. One of its advantages is that it can be delivered in a group modality–something that MI has yet to achieve.

MI and its adaptations are typically delivered individually–that is, by one counselor meeting with one client. Efforts to develop and demonstrate the efficacy of a group modality of MI have so far been unsuccessful. Walters, Ogle and Martin (2002) present a review of the studies that have tested group formats of MI and conclude that "Group-based approaches have been implemented by people quite experienced with individual approaches and thus far have yielded disappointing results" (p. 390). Further, in designing their multi-site protocol, NIDA's Clinical Trials Network (CTN) Design Team reported that not only could they find no data on the effectiveness of MI delivered in a group format, they could find no treatment manuals for group delivery of MI (Carroll et al., 2002). This presented a problem when the CTN protocol was introduced at treatment agencies that offered group treatment only. The CTN Design Team addressed this problem by providing the MI portion of the protocol

in a pre-group individual assessment/evaluation session and then placing clients in traditional (i.e., non-MI) group treatment. The effects of the competence-based intervention were judged based on retention and outcome in the traditional treatment group.

Why a group format? If MI can be effectively delivered individually, what purpose does a group format delivery of another competence-based approach serve? There are both theoretical and practical reasons to consider such an approach. Practically, group formats are often more cost-effective than individual approaches. Not only can more clients be served by a smaller number of clinicians in a given time, the costs of missed appointments can be mitigated since the group will meet even when some members are not present, while a missed individual appointment results in the clinician delivering no service during that time. In addition, the culture in many community drug treatment facilities is to deliver service primarily, or exclusively, in group form. Developing a competence-based group approach may be more "culturally sensitive" for such agencies since it does not require the agency or its staff to change their accustomed way of doing things or the administrative structures (e.g., room assignments, scheduling protocols, staff hours) that support it. Such an approach will also use the skills and familiarity with group work that many agency staff value as part of their professional role. Thus, a group format may be more likely to be used in community agencies than an approach that involves significant change in how services are delivered.

Theoretically, the social context of a group can offer strong support for people attempting to make changes of many kinds (Yalom, 1995). Positive social support may be particularly important for people with substance abuse problems whose larger social context at least tolerates, if not encourages, substance use and abuse. Many treatment approaches recommend that clients find or develop a social group that supports an abstinent lifestyle (e.g., Henggeler et al., 1991; Liddle, 2002; McCollum, Trepper, Nelson, Wetchler, & Lewis, 1993), and distance themselves from drug-using friends and activities. Group therapy offers a beginning step in this direction.

Sharry (2001) discusses the particular application of SFBT in the group setting and points out how many of the curative factors that Yalom enumerates are consonant with SFBT. Group support is one such factor. Clients who make a commitment to change in a group have an added motivation to carry through, given that several people know of their commitment, not just their counselor. Support is also necessary at times of relapse or perceived failure to rekindle optimism and hope. As group members hear the experiences and successes of their peers, they may dis-

cover solutions to problems that would not occur to them otherwise, or would not be accepted if they were "prescribed" by a professional. Yalom (1995) claims that such vicarious learning is one of the curative factors in group therapy in general. Finally, Miller and Rollnick (2002) report that the development of hope is a vital ingredient in behavior change. Sharry contends that instilling hope is one of the primary curative factors in SFB group therapy and results from clients seeing one another make progress and thereby developing hope for themselves and confidence in the treatment. In addition, Sharry reports that group empowerment–the recognition that group members are isolated in their experience of difficulties and can band together against negative views of people with problems such as theirs–can be an important influence in promoting hope, confidence, and change.

Potential pitfalls of a group format. Although advantageous in many ways, the group format is not without potential pitfalls. Some pitfalls apply to group treatment in general while others apply specifically to delivering an MI approach in a group. All group approaches struggle with such issues as how to manage resistant members, maintain appropriate group norms, control the intensity of intra-group interaction, and maintain the therapeutic nature of the group culture. There is an extensive literature on dealing with such issues. Yalom (1995) provides a general overview while Sharry (2001) discusses these issues in the specific context of SFBT. In substance abuse treatment groups, the possibility exists that the group may support denial and resistance, may undermine the progress of members who are succeeding at their goals, or may otherwise form a negative culture. Since many agency staff are trained and experienced in group treatment, they should already have the skills to deal with such issues, and be comfortable in the group environment.

In addition to typical group issues, some of the pitfalls are specific to MI and have made it difficult to produce a group version of this treatment. Of most importance is the fact that MI is an individualized process, aimed at accommodating each client's specific readiness for change and his/her specific life circumstances–the level of substance abuse and the specific health and social risks faced as a result of that use–as well as the client's individual goals and future vision, to develop a sense of discrepancy that will lead to change efforts. Delivering such an individually-focused intervention in a group setting runs the risk of either diluting the intervention to attend to the group process (e.g., introducing themes drawn from MI in a rotating fashion as psychoeducational groups often do regardless of the specific needs or stage of change of the group members), or not using the therapeutic potential of the group in order to specif-

ically focus on one member at a time (described by one of our colleagues as doing "individual therapy with an audience"). In fact, this appears to be the primary pitfall encountered in efforts to design a group format version of MI (e.g., Carroll et al., 2002; Walters et al., 2002).

A second pitfall identified by Walters, Ogle and Martin is that MI group sessions may lack adequate "talk time" for clients to generate change talk. Amrhein, Miller, Yahne, Palmer and Fulcher (cited in Walters et al., 2002) hypothesize that increasingly strong change statements in session elicit behavior change. Not only is active talk time limited in a group, other clients may diffuse the focus on change talk. The SFGT model, in contrast, focuses almost exclusively on giving clients opportunities to generate "change talk." The session begins with the therapists asking about successful movement toward goals in the past week, follows with further elaboration of goals and plans to reach them and ends with the clients assigning their own therapeutic "homework" for the upcoming week–the activities they are willing to undertake to move them closer to achieving their goals.

In a following section, we will describe SFGT in detail and delineate how it is consistent with the underlying philosophy of MI as well as what advantages it brings to group delivery. At this point, however, another issue needs to be addressed. Why SFGT and not MI?

Why SFGT? It is fair to ask why the effort should be made to develop and implement SFGT when MI has much more empirical support in its individual formulation. We contend that the SFGT model of competence-based group treatment manages to preserve and attend to the underlying philosophy of MI while addressing some of the pitfalls encountered in the efforts to produce a group version of MI. And, while the SFBT model has not been as extensively researched as has MI, there is some evidence for its efficacy.

Early reviews of the SFBT research (McKeel, 1996, 2000) declared SFBT "promising" based on simple follow-up studies and case reports. The most recent review of the outcome research on SFBT (Gingerich & Eisengart, 2000) found 15 studies that claimed to assess the outcome of SFBT when used to treat various presenting problems. The review authors judged only five of these studies to be reasonably well-designed although these five all report positive outcomes for SFBT. Gingerich and Eisengart conclude that "the 15 studies provide preliminary support for the efficacy of SFBT but do not permit a definitive conclusion" (p. 8).

De Shazer and Isebaert (in press) present outcome data from an SFBT-oriented inpatient program for alcohol abuse in Belgium. They contacted, by telephone, 118 patients who had been treated in their pro-

gram at four years post-discharge. Of these, 84% were judged to be improved–50% reported being abstinent and 34% reported practicing controlled drinking (three or fewer drinks a day with two or more abstinent days per week). Contacts with family members, where available, were used to verify the patient's own reports. De Shazer and Isebaert contrast these findings to those of Polich, Armor and Braiker (1980) who report a 7% abstinence rate at four years for traditional, abstinence-only programs. While the de Shazer and Isebaert findings are intriguing, this study suffered from some of the methodological flaws Gingerich and Eisengart (Gingerich & Eisengart, 2000) identified in their review including no contemporaneous comparison group, no random assignment, and patient's self-report as the primary outcome measure.

WHAT LEADS TO CHANGE IN SUBSTANCE ABUSE TREATMENT?

Miller and Rollnick (2002) list several principles that underlie successful treatment for substance abuse. We summarize them as follows:

- Change occurs naturally.
- Formal interventions augment natural change processes and don't replace them.
- Brief interventions can have a lasting impact.
- People who believe they are going to change, and whose therapists believe they are going to change, do so, while those who are told they won't change, don't.
- A client talking positively about change (change talk) predicts subsequent change while a client arguing against change is associated with less change.
- The therapist's empathy, confidence in the client, and ability to help the client focus on change talk all facilitate change.

None of these components are unique to MI and all are addressed in SFGT.

Change occurs naturally and formal interventions augment it. One of the underlying assumptions of SFGT is that change is always occurring although clients and therapists who are focused only on the occurrence of problems may miss instances of difference (I. K. Berg & Miller, 1992). The solution-focused technique of searching for exceptions–that is, looking for times when the problem *didn't* occur–helps to elicit instances of

change. The solution-focused therapist then uses those instances to help the client elucidate the ingredients of the exception and amplify them. A client who wished to abstain from marijuana, for instance, might be asked to describe a time when he wanted to get high and didn't. What was going on that allowed him to abstain? Who was there? What was he thinking? How can he increase the presence of these components of not using when he feels again at risk to use? Unlike more prescriptive approaches, the client generates the list of skills he or she needs, rather than being taught them based on the assumption that he or she has a skill deficit.

Brief interventions can have a lasting impact. SFBT is, in fact, brief. De Shazer (1991) reports an average of five sessions as being typical of SFBT. Brevity provides several benefits. First, it responds to the increasing demand for cost-effective services in a climate of changing health care economics. Second, brief by design, SFBT attempts to promote change quickly in early sessions. This tends to provide more clients with active interventions since many clients drop out after only a few sessions. Third, brevity is more acceptable to many clients who are identified early in a substance-abuse career before family, job and other community ties have been disrupted. A brief intervention at this point may be more acceptable (and cost-effective) than the traditional regimen of inpatient or intensive outpatient treatment followed by prolonged aftercare (W. R. Miller, 1993).

Belief in change leads to change. SFGT begins with the assumption that clients not only want to change, they in fact *are* changing all the time. That is, their problem behavior fluctuates in both frequency and intensity and those fluctuations can be amplified to produce more change. Thus, the belief in change, at least on the part of the therapist, is built into the model. For clients, SFGT focuses on helping them develop a detailed description of their preferred outcome for treatment and elaborating that description so that it becomes concrete and the steps to attaining it become clearer. As the desired outcome becomes clearer and the path to it more detailed, the client's belief in change increases. Several therapeutic techniques are used to facilitate this process. First, the "miracle question" (de Shazer, 2003) and its variants (see, for instance, Pichot & Dolan, 2003) engage the client in imagining a future when he or she is without the problem that brought them to treatment. What would be different? What would be happening? What are the behavioral and interpersonal descriptors of life without the problem? What would their friends notice?

As the miracle is elaborated, the therapist helps the client look for already existing examples of the change he or she is seeking, even if they are not yet of the magnitude the client wishes. For instance, the client who

wishes to stop drinking may report four days when he drove home after work instead of going to the bar where his drinking friends congregate. On those days, he managed to abstain from alcohol. Belief in change grows as evidence of already existing change accrues.

Finally, each session begins with a review of the past week focusing on steps the client has taken to move closer to his or her goal. Even when relapses occur, how they were limited and what the client can learn by examining the relapse direct the client back toward evidence of change.

"Change talk" leads to change. As is obvious from the description in the previous section, clients are guided to talk about change throughout the course of SFGT. Clients who are not yet ready to commit to change, or who claim to want nothing from coming to group, are treated with respect and attention, offered the chance to participate if they wish, but are not confronted about their denial of problems or their "low motivation." While change talk is the primary focus, some clients are not ready to consider change until they know that the therapists have "honored the problem" (de Shazer & Isebaert, in press). It is not forbidden to talk about problems in the group but the therapist quickly guides such conversations to the desired changes the client wants and what evidence there might be of such changes already existing, at least in part.

A second aspect of eliciting change talk is that clients are asked to set their own goals for treatment, some of which may not directly focus on substance abuse. This diffuses the kinds of resistant and argumentative conversations that can be generated when a therapist prescribes what goals the client should pursue. Clients are more likely to expend effort on attaining goals they have set for themselves than on goals that are imposed on them.

Therapist factors play an important part in successful treatment. The respectful, empathic and non-confrontational role of the therapist in MI is also a feature of SFGT. SFGT therapists begin with the assumption that clients do not wish to waste their time in group and that there is some benefit or change that they are seeking, even if it isn't the one the therapist or the referral agent might choose for them. Clients are invited to set their own goals and design their own strategies for attaining them. Confrontation, unsolicited advice-giving, and telling the client what his or her goals "ought" to be are eschewed in the SFGT model because they suggest that the client is somehow deficient and lacks the resources to contribute to his or her own well-being. Rather, the SFGT therapist goes out of the way to communicate respect for the client and acceptance of wherever the client currently is in the process of change.

What is unique about SFGT? Despite their philosophical similarities, there are important differences between the two models, especially in their implementation.

MI is fundamentally a motivation enhancement and treatment initiation approach, especially as it has been tested with substance abuse (Burke et al., 2002). The fundamental assumption is that once sufficient motivation is developed, change will occur as a natural process. SFGT, in contrast, *takes motivation as a starting place and provides techniques to further support change*. For example, Miller (2000) writes, "After a goal is negotiated, [SFBT] specifies how to use a client's own unique resources and strengths to accomplish this goal" (para. 4). The therapist uses a variety of techniques–e.g., scaling questions, exception-finding questions, relapse evaluation and prevention, and amplifying change–to support clients though the process of change. SFGT, then, provides interventions geared to a wider spectrum of the change process than does MI.

In addition, MI relies on very specific individual feedback about substance abuse consequences to build motivation for change. This has made it hard to implement Motivation Enhancement Therapy (MET) in group, as we described earlier. Because SFGT does not rely on such individualized feedback, and instead uses each client's goals and exceptions and their commonalities with other group members as the basis for developing motivation and support for change, it can be more easily implemented in group format. A group implementation of SFBT, like the one being developed in this project, adds the important component of group support to clients' ongoing change efforts.

The following description of the organization of each SFGT session provides a sense of the flow of treatment and some of the techniques used. It is based on a model described by Pichot and Dolan (2003).

1. The group begins with therapists asking clients to report on successes achieved while completing the previous session's self-assigned homework.
2. An introductory question is then asked that serves to direct the client's thinking to a future focus, to demonstrate that the focus of this group is on something other than only problematic behavior, and to build group cohesion and comfort. Examples of such a question might be: "What is one thing that you have done since last time you were here to help you get closer to where you want to be?
3. The therapists ask the miracle question or another future-oriented question based on the theme and prompt clients for detailed responses. Continuing the example, the therapists might ask, "Suppose

you were able to make the right choice for yourself more often than not. How would that help each of you move toward the goals you're working on here?"

4. Using scaling questions, the therapists assess each group member's current level of progress toward his/her goal. "On a scale of 1 to 10, where 1 is you have made no progress and 10 is you have completely achieved your goal, where would you put yourself today?"
5. The therapists ask each client where on the scale the client feels other important people in their life would rate them, and to what the client would attribute this rating–"Where do you think your (family members, probation officer, Child Protective worker) would rate your progress? Why would they make that rating?" If there is a discrepancy between the client's rating and their view of the important person's rating, ask about reconciling that discrepancy. "What would that person need to see happen for them to agree with your view of your progress?"
6. The therapists find out what each client has done to reach and maintain her or his current level of progress. The therapists ask about, and punctuate, group members' exceptions with as many details as possible. "Describe another time when you were able to make the choice that was right for you. How did you do that?"
7. The therapists connect each person's goals, struggles and successes with each other as a way to build group support and model solutions.
8. The therapists then take a break and formulate compliments for each client and a common summary theme for the group session that knits together the issues and solutions brought by each group member.
9. After the break, the therapists return to the group and offer the common theme they have developed (e.g., "making the right choice") as well as the compliments for each group member.
10. The clients are then invited to assign themselves tasks for the upcoming week based on their specific goals and the theme of the current session. "What are you willing to do, between now and the next time we meet, to move you closer to your goal?" They write their tasks on an end-of-session summary that becomes part of the treatment record.
11. The clients read their self-assigned tasks to the group.
12. Group adjourns.

The following case example gives an idea of how a SFGT session is actually conducted.

CASE STUDY FOR SFGT

During the session four members were present–Frank, Sue, Bob, and Larry. Since the group was open-ended some members were just starting while others had attended several sessions. Two therapists, John and Laura, were present in the room and a team sat behind the two-way mirror to aid with treatment.

The therapists began the session by reviewing the previous week's homework questions. The therapists provided the clients a copy of their written homework sheets from the past week so that they could discuss their progress. The following dialogue occurred when discussing the previous week's homework with one group member:

John: "So Frank, what did you do since the last time you came here to work on what is important to you?"

Frank: "Well, I spent a few hours filling out job applications this week. It was hard because I don't have my license right now so finding a ride is difficult."

Laura: "Wow! You were able to arrange for a ride and apply for employment this week. That is great. How were you able to do that?"

Frank: "I finally asked my sister if she could spare a few hours to help me find a job. You know we don't always get along so asking her for a ride was not easy."

John: "You have mentioned several times that finding a job is an important goal for you so filling out applications was an important step."

After discussing homework with all clients, the therapists asked the following future-oriented question: "If you could have one quality, or trait, that you currently don't have, what would it be?" This type of future-oriented question allowed the clients to continue to focus on their future and the steps that it would take to reach their goals. Each group member answered the question and the therapists made connections between the clients' answers. The following dialogue occurred during this part of the session.

Laura: "I want to ask all of you a question. If you could have one quality that you currently don't have, what would it be?"

Bob: "Well, I have always wished that I had more will power. A lack of will power is what has brought me here. I always end up giving in to drinking when I am with my friends and that gets me into trouble. I lost my job and have no money to do what I want to do because of my drinking. I am only able to not drink when I am at home alone."

John: "Bob, did you say that you are able to not drink when you are at home alone?"

Bob: "Yes."

John: "It sounds like you have some will power already but are wanting more."

Bob: "Yeah, I guess I am able to refrain from drinking sometimes."

Laura: "That's great. What about the rest of you? What quality that you currently don't have would you like to possess?"

Larry: "I just want to stay out of trouble so I can spend more time with my daughter. My ex-wife won't allow me to keep Jamie on the weekends because of my prior drug use. Maybe if I were able to get a job and stay out of trouble I could see my daughter more."

Laura: "So what trait would you need to possess to be able to do all of that?"

Larry: "I have never thought about that before. I guess for me I would like to be more responsible. Yeah, that would prove to my ex-wife that I could handle Jamie for an entire weekend."

John: "Larry, I just want to say that you have been very faithful in attending our group sessions and are beginning to show the trait of responsibility by coming to group. Also, it sounds like you and Bob are both trying to work towards staying out of trouble so that you can focus on the important areas of your lives."

This dialogue shows several things that SFGT therapists do during a session. The therapists look for exceptions–in this case, times when the clients are exhibiting qualities they want to possess. Also, the therapists try

to make connectors between the clients in order to build group cohesion. Staying focused on the goals while using the client's language and direction are very important throughout the entire process.

Once every member of the group had been asked the opening future-oriented question, the therapists asked the clients this version of the miracle question, linking it to their previously identified wish for the future: "So, if while you guys were sleeping tonight something happened, let's say a miracle, and you possessed the trait that you want, how would you know if no one told you that this miracle happened? Who would notice the new trait and what would they say?" Each group member answered the question and again the therapists made connections between the group members' responses.

To see how close each member was to his or her miracle, the therapists asked the members to scale themselves according to how close they were to obtaining their desired trait (10 being that they had the trait completely and 1 being that they were in total absence of the trait). Each client identified his/her ranking on the scale. Note that the therapists do not assign a value to the numbers the clients selected but allow the clients to explain what their rating meant.

Bob: "I guess I am at a 6."

Laura: "A 6? How are you at a 6 and not a 3 or 4?"

Bob: "Well, I guess I am a 6 because I can abstain from drinking when I am at home and if I were at a 3 or a 4 I wouldn't be able to do that."

John: "What about you, Sue?"

Sue: "Well, I would give myself a 5 because sometimes I am able to be patient with my daughter."

Laura: "It sounds like both of you guys possess the trait some of the time, but want to be more consistent?"

Sue: "Yes, I want to have the trait all of the time."

Bob: "Me too, I want to be able to control my drinking in any situation."

DISCUSSION

SFGT has found clinical application in the substance abuse treatment field, and appears to make conceptual sense as an application of competence-based principles to treatment. As such, it has the advantage of fitting the group therapy model common in most treatment agencies, thus not requiring extensive modification of the organization structures agencies use to deliver treatment. It also takes advantage of the unique curative factors of group therapy–factors that are of particular benefit to people struggling with substance abuse problems. The next step in the development of this approach is to conduct empirical tests of its usefulness. While there are conceptual reasons to think that it can be useful in treating people with substance abuse problems, there is, as yet, no empirical evidence that it is.

REFERENCES

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.

Burke, B. L., Arkowitz, H., & Dunn, C. (2002). The efficacy of motivational interviewing and its adaptations: What we know so far. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (2nd ed., pp. 217-250). New York: Guilford Press.

Carroll, K. M., Farentinos, C., Ball, S. A., Crits-Christoph, P., Libby, B., Morgenstern, J. et al. (2002). MET meets the real world: Design issues and clinical strategies in the Clinical Trials Network. *Journal of Substance Abuse Treatment*, *23*, 73-80.

de Shazer, S. (1991). *Putting difference to work*. New York: Norton.

de Shazer, S. (2003). *The miracle question*. Retrieved February 17, 2003, from *http://www.brief-therapy.org/steve_miracle.htm*

de Shazer, S., & Isebaert, L. (in press). A solution-focused approach to the treatment of problematic drinking: The Bruges model. *Journal of Family Psychotherapy*.

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

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A. et al. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly*, *1*, 40-51.

Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D. et al. (1994). *Cognitive-behavioral coping skills therapy manual: A clinical research guide for treating individuals with alcohol abuse and dependence*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Liddle, H. A. (2002). *Multidimensional family therapy for adolescent cannabis users. Cannabis Youth Treatment Series* (Vol. 5). Rockville, MD: Center for Substance Abuse Treatment.

McCollum, E. E., Trepper, T. S., Nelson, T. S., Wetchler, J. L., & Lewis, R. A. (1993). *Systemic couples therapy for drug abusing women: A treatment manual*. West Lafayette, IN: Purdue Research Foundation.

McKeel, A. J. (1996). A clinician's guide to research on solution-focused brief therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 251-271). San Francisco: Jossey-Bass.

McKeel, A. J. (2000). *A selected review of research on solution-focused brief therapy*, Retrieved August 9, 2001, from *http://www.enabling.org/ia/sft/Review%20McKeel.htm*

Miller, S. D. (2000). *Description of the solution-focused brief therapy approach to problem drinking*. Retrieved February 6, 2003, from *http://www.drugabuse.gov/ADAC/ADAC8.html*

Miller, W. R. (1993). Behavioral treatments for drug problems: Lessons from the alcohol treatment outcome literature. In L. S. Onken, J. D. Blaine, & J. J. Boren (Eds.), *Behavioral treatments for drug abuse and dependence. NIDA Research Monograph Series, No. 137. NIH Pub. No. (ADM) 93-3684*. Rockville, MD: National Institute on Drug Abuse.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1994). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence (NIH Publication No. 94-3723)*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence*. New York: Guilford Press.

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

Polich, J. M., Armor, D. J., & Braiker, H. B. (1980). *The course of alcoholism: Four years after treatment*. Santa Monica, CA: Rand Corporation.

Sharry, J. (2001). *Solution-focused groupwork*. London: SAGE Publications, Ltd.

Walters, S. T., Ogle, R., & Martin, J. E. (2002). Perils and possibilities of group-based motivational interviewing. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (2nd ed., pp. 377-390). New York: Guilford.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.