

AOTA Evidence Briefs **Substance-Use Disorders**

*A product of the American Occupational Therapy Association's Evidence-Based Literature Review Project

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Both group and individual cognitive-behavioral counseling to prevent relapse can benefit people with low to severe problems of alcohol and drug use

Graham, K., Annis, H. M., Brett, P. J., & Venesoen, P. (1996). A controlled field trial of group versus individual cognitive–behavioural training for relapse prevention. *Addiction*, 91, 1127–1139.

Level: IA1a

Randomized control trial, 20 or more participants per condition, high internal validity, high external validity

Why research this topic?

The majority of people treated for addiction relapse after treatment. Little attention has been paid to helping such people maintain the gains they make in treatment. In particular, research has not adequately explored the potential of *systematic* approaches to preventing relapse. One such approach uses "cognitive-behavioral training," where the individual is asked to identify high risk situations where the potential to return to drinking is high and then prepares alternative coping responses so as to maintain abstinence, followed by actual use of the coping skills in a real situation. The approach works best in an individual-counseling format because the therapist tailors the therapy to the individual. However, group models have been successful and are more economical.

What did the researchers do?

Graham, Annis, Brett, and Venesoen (1996), all affiliated with the Addiction Research Foundation (London, Ontario, Canada), decided to compare the effectiveness of an individual versus a group model of cognitive—behavioral training to prevent relapse. They recruited participants from two sites: a 26-day residential program on the Alcoholics Anonymous/Narcotics Anonymous 12-step model of recovery, for people with moderate to severe alcohol or drug problems (Site A), and an outpatient evening counseling program for people with low to moderate severity of problems (Site B). At Site A, 119 people completed the initial assessment, but 26 subsequently dropped out, and 2 more were dropped. Thus, the final sample at Site A was 91 people: 58 men and 33 women, whose average age was 35.4 years. At Site B, 151 completed the initial assessment, but 28 dropped out and another 22 were dropped. Thus the final sample at Site B was 101 people: 82 men and 19 women, whose average age was 39.4 years.

At both sites the researchers alternately assigned groups graduating from treatment to an individual or a group format. Both formats involved a highly structured program carried out in 12 weekly sessions. Sessions in the individual format were 45–60 minutes long, in the group format 69–90 minutes long. Generally, each session included individual or group discussion of (1) desires to use alcohol or drugs, or actual use of them, during the preceding week; (2) common high-risk situations; (3) high-risk situations likely to occur during the week coming up; and (4) strategies for coping with these situations. The therapists gave the participants weekly homework assignments requiring them to prepare for and experience a high-risk event, and the therapists asked the participants to report weekly on their cravings for and use of alcohol and drugs.

The outcome areas of interest were *attendance* (as measured by the number of sessions attended); *completion of homework* (as measured by a 5-point scale of mastery); *client feedback* (as measured by the Client Satisfaction Questionnaire, the Situational Confidence Questionnaire, and the Drug-Taking Confidence Questionnaire); *alcohol and drug use* (as measured by the Alcohol Dependence Scale, the Drug Abuse Screening Test, and the Timeline Followback Method); and *psychosocial status* (as measured by the Centre for Epidemiological Studies Depression Scale, the Rosenberg Self-Esteem Scale, the Multidimensional Scale of Perceived Social Support, the Life Satisfaction Scale, the Personal Assertion Analysis, and the Affect Balance Scale). Assessments were made, variously among the instruments, before the study began and at 3-, 6-, 9-, and 12-month follow-ups.

What did the researchers find?

Average attendance at both sites for both formats was high—more than 8 sessions (out of 12). Completion of homework assignments also was high, more so at Site A than Site B. Further, the proportion completing the program was high—73% at Site A, 69% at Site B. There was a trend at both sites for more participants in the group format than in the individual format to stay with the program until the last or second-to-last session.

The participants at Site A returned homework for **significantly** (see *Glossary*) more sessions than the participants at Site B. Additionally, they scored significantly higher on mastery of the relapse prevention task.

The participants at both sites and in both formats scored the program high on satisfaction, but the participants at Site A scored it significantly higher than the participants at Site B.

The participants at both sites reported high levels of confidence in their ability to resist alcohol in eight types of situations.

On the measures of alcohol and drug use, there was a difference between sites, the participants at Site A showing significantly higher rates of use than those at Site B. This outcome was expected, given the higher severity of problems among the Site A participants. Allowing for this difference, the researchers found **no significant** (see *Glossary*) differences between the individual and group formats.

On the measures of **psychosocial** (see *Glossary*) status, again allowing for the difference between sites, the researchers found that the participants in the group format reported significantly higher social support from friends than the participants in the individual format. No other significant differences emerged between formats.

What do the findings mean?

For therapists and other providers, the findings suggest that people who have received treatment for low to severe problems of alcohol and drug use can benefit equally from group and individual cognitive—behavioral counseling to prevent relapse. Thus, programs can use the more economical group format when possible but use the individual format when group participation is not feasible (e.g., because of transportation problems).

What are the study's limitations?

A potential limitation of the study is contamination. However, the researchers dropped the participants who might have contributed to this contamination from the study.

Another potential limitation was the small sample size, caused by numerous dropouts (including those just described). The researchers conclude, however, that several factors support their interpretation of no differences between the formats—for example, no overall trend toward one format and no differences between formats even with more liberal definitions of "significance."

GLOSSARY

psychosocial—"Involving both psychological and social aspects" (*Merriam Webster's Collegiate Dictionary*, 10th ed., s.v.).

nonsignificant (or no significance)—A statistical term that refers to study findings that are likely to be due to chance differences between the groups rather than to other factors (e.g., the treatment of interest). A nonsignificant result is not generalizable outside the study. Like significance, a nonsignificant result does not indicate the clinical effect. Often studies will show nonsignificant results, yet the treatment group's mean will be better than the control group's. This is usually referred to as a trend in the right direction. Because significance is closely determined by sample size, nonsignificant results would often become significant if the sample size were increased.

significance (or significant)—A statistical term that refers to the probability that the results obtained in the study are not due to chance but to some other factor (e.g., the treatment of interest). A significant result is likely to be generalizable to populations outside the study.

Significance should not be confused with *clinical effect*. A study can be statistically significant without having a very large clinical effect on the sample. For example, a study that examines the effect of a treatment on a client's ability to walk may report that the participants in the treatment group were able to walk significantly longer distances than those in the control group. However, after reading the study one may find that the treatment group was able to walk, on average, 6 feet, whereas the control group was able to walk, on average, 5 feet. Although the outcome may be statistically significant, a clinician may not feel that a 1-foot increase will make his or her client functional.

■ Terminology used in this document is based on two systems of classification current at the time the evidence-based literature reviews were completed: *Uniform Terminology for Occupational Therapy Practice—Third Edition* (AOTA, 1994) and *International Classification of Functioning, Disability and Health (ICIDH-2)* (World Health Organization [WHO], 1999). More recently, the *Uniform Terminology* document was replaced by *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002), and modifications to *ICIDH-2* were finalized in the *International Classification of Functioning, Disability and Health* (WHO, 2001).

This work is based on the evidence-based literature review completed by Virginia Stoffel, MS, OTR, FAOTA and Penelope Moyers, EdD, OTR, FAOTA.

For more information about the Evidence-Based Literature Review Project, contact the Practice Department at the American Occupational Therapy Association, 301-652-6611, x 2040.

