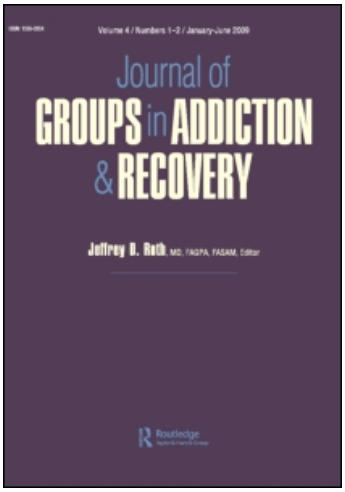


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# An Examination of Individual and Group Outcomes of Male and Female Community Treatment Clients

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# An Examination of Individual and Group Outcomes of Male and Female Community Treatment Clients

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**ABSTRACT.** *Aim*: To examine outcome differences between men and women matched to either individual or group community-based treatment.

*Design*: A pre-post design that began with 173 participants, 115 male and 58 female. Of 90 males matched to individual counseling only 16 attended while 12 of 13 matched to group counseling attended. Of 45 female participants matched to individual counseling one-third attended while six of seven women referred to group counseling attended. The BASIS-32 was used to examine outcome differences.

*Findings*: All participants who completed counseling had significantly better post-treatment scores than pre-treatment scores. Significantly more men than women dropped out after the assessment process was completed, prior to commencing treatment. Dropout was more likely to occur if a person was assigned to individual than to group coun-

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seling. Despite clinically matching clients to either individual or group counseling there were no statistical significant differences in pre-test scores between either counseling modality for men or for women. However, six-month post-treatment scores for both men and women who had participated in group counseling were significantly lower than for those who had received individual counseling.

*Conclusion*: The most important attribute in achieving a positive outcome was attending counseling, something more women than men did, though more positive sustained change was also observed in those assigned to group rather than to individual counseling. doi:10.1300/J384v01n03_03 

**KEYWORDS.** Group counseling, individual counseling, program outcomes, sex differences



## *INTRODUCTION*

Historically, biological, psychological, and sociological differences between men and women have been noted regarding their use of psychoactive substances with many opposing opinions and perspectives offered. Questions, concerns, and varied hypotheses have been raised regarding the significance of a client's sex on addiction-treatment processes and outcomes (Dawson 1996; Hodgins et al. 1997; Jarvis 1992; Kaskutas et al. 2005). Consumers, practitioners, and researchers have all indicated that key factors pertaining to treatment are different for men and women, with women more likely to experience difficulty navigating through the complex and often disjoined treatment continuum (Green et al. 2002). While women remain a minority in substance-abuse treatment, constituting approximately one-third of the population seeking assistance (Downey et al. 2003), the concerns for women's treatment outcomes have gradually gained importance (Conners & Franklin 2000; Floyd et al. 1996). However, there still remains much to be known regarding the implications of a client's sex on treatment programming (Pelissier et al. 2003; Neale 2004; Weisner 2005).

Research suggests that women entering addiction treatment are younger and less educated than are their male counterparts (Wechsberg et al. 1998; Brady et al. 1993; Weisner & Schmidt 1992). There is also exten-

sive research to indicate that women have different baseline characteristics and greater problems than men prior to treatment including greater psychological distress, more medical problems, and more family and social difficulties (Callaghan & Cunningham 2002; Kim et al. 2004; Marsh et al. 2004; McGovern et al. 1998; Pelissier et al. 2003; Schneider et al. 1995).

Reviewing treatment issues by sex is crucial as historically it has been men who have designed and run the majority of treatment programs (Annis et al. 1998; Nelson-Zlupko et al. 1995; Sterling et al. 2004). Thus, the issue of recruiting and training addictions counselors and having them be aware of issues pertaining to a client's sex and practicing in a feminist-informed manner have been noted as being of importance (Alterman et al. 2000; Neale 2004).

When assessing outcomes in addiction treatment, greater client improvement has been linked to services that have been matched to clients' needs (Rowan-Szal et al. 2000). A common example is single parents with children, the majority of whom are female, who may not be successful in a residential program or in a community treatment program run in the evening because of child-care issues but who may succeed in the same treatment program that is offered during the day while the children are at school or if child care is provided. It has also been demonstrated that an eclectic approach to treatment beginning with matching clients' needs is an effective approach in addiction counseling (Taxman & Bouffard 2003); however, differences by sex appear to have some effect upon the length of time individuals remain in treatment (Green et al. 2002). Much of the literature in this area tends only to examine demographic issues between men and women without focusing upon the impact of the actual treatment services received (Schneider et al. 1995). Thus, it is not surprising that policy makers and funding organizations have tended to react most favorably to findings that support group programs as being superior to individual counseling as group work is typically less expensive to provide than is individual therapy (Grella et al. 1999).

While research exploring differences by sex in addiction counseling is prevalent, the actual measurement of treatment outcomes for both men and women is much more limited (Green et al. 2002; Pelissier et al. 2003). Of the research that is available, the outcomes have been somewhat contradictory, from finding significant differences (Marsh et al. 2004) to finding virtually no difference (Fiorentine et al. 1997; Kaskutas et al. 2005; Toneatto et al. 1992). Studies have indicated that women fare as well as men in formal substance-abuse treatment, though it has

been documented that women follow through less often after a formal referral than do their male counterparts (Downey et al. 2003; Callaghan & Cunningham 2002). Differences include the discovery that women typically address different topics during the first three months of treatment dissimilarly to men, and that they focus more upon crisis intervention and conflict and personal issues while men focus more upon alcohol use and legal issues. Women also tended to attend more sessions than did men (Rowan-Szal et al. 2000). As well, Marsh, Cao, and D'Aunno (2004) reported that the sex of the client does influence adjunct addiction-treatment services and service outcomes. Additionally, Schneider, Kviz, Isola, and Filstead (1995) indicated that being married is more protective for relapse in men than women and that fewer years of problem drinking in women, but more years of problem drinking for men, led to risk of relapse.

There is also ample research examining treatment effectiveness of various different models of group therapy, but only a few studies that have directly compared group therapy outcomes to those of individual counseling (DeRubeis & Crits-Christoph 1998). Of these studies, there does not appear to be any research examining differences by sex between group and individual treatment programs. Csiernik and Troller (2002), when evaluating the effectiveness of a relapse prevention group, found that while there was a gradual increase of positive coping responses over time for men, there was a significantly greater increase by women. This study found that clients did learn coping skills and were less likely to use alcohol and/or drugs again if they completed treatment. However, the gains made by female clients were the reason for the overall success found in the study and women had statistically significant superior outcomes both two and six months post-treatment compared with men, though the sample size was small in this initial exploratory study of agency outcomes. This finding led to the investigation of the hypothesis does one sex have better outcome results in community-based individual versus group counseling than did the other?

## *METHODOLOGY*

### *Participants*

All new clients between January 1, 2002 and December 31, 2003 of a community-based addiction-treatment agency in London, Ontario were asked if they would volunteer to participate in a study examining treat-

ment outcome. Of the 173 individuals who consented to participate 115 (66.5%) were male and 58 (33.5%) were female.

### *Measure*

The study employed the Behavior and Symptom Identification Scale (BASIS-32), a non-diagnosis specific 32-item instrument developed to measure the mental health status of clients prior to and at the conclusion of treatment as well as at multiple follow-up points. The BASIS-32 is a patient self-report-rating scale of symptom and problem difficulty, used primarily to assess outcomes of treatment. It is designed to be given by a qualified health care provider at the commencement of treatment to serve as a baseline assessment of the patient's perspective of his/her own symptoms and problems. The BASIS-32 can then be used at discharge or at a time point during treatment to assess improvement in symptom and problem difficulty from the client's perspective. Improvement is ascertained by comparing scores at intake with scores at discharge or subsequent points in time. Decreases in self-reported symptom and problem difficulty are one measure indicating improvement (www.basissurvey.org). The instrument examines five major areas of difficulty: relation to self/others, daily living/role functioning skills, depression/anxiety, impulsive/addictive behavior, including substance abuse and psychosis. Actual questions pertain to how difficult it has been in the past week to avoid drinking alcohol taking or misusing illict drugs, controlling temper along with overall life satisfaction (Eisen et al. 1999).

### *Procedure*

All community-treatment clients were assessed before being matched to either individual or group treatment. Individual community treatment entailed one-to-one work with an addictions counselor and may have had a low-risk drinking strategy or harm reduction as a goal. Clients may also have been referred to one-to-one work if they were not adequately stable with their goal of abstinence to be referred to the abstaining groups, if they had mental health concerns such as anxiety disorders or issues of post traumatic stress that precluded them from group involvement, though stable concurrent disorder clients did participate in group counseling, or if the complexity of the clinical profile warranted individual community treatment. Finally, individuals were referred to individual counseling if the times of the group meetings conflicted with work, school, or other personal obligations.

There were a variety of different community-treatment groups offered by the agency during the course of the study in which participants became involved, all of which were approximately two hours in duration. The Mixed Goal Group was an open-ended group with a maximum of 12 sessions. This group was for clients working on low-risk drinking and/or a harm reduction goal. All the remaining groups were exclusively abstinence-based with clients having had on average at least one to two weeks of sobriety or being drug-free as an indicator of their beginning comfort with and stability with an abstinent lifestyle. The goal of the abstaining groups was to help strengthen and maintain abstinence via mutual support, development of alternate coping strategies and developing mechanisms to restructure lifestyles.

The Women's Group and the Men's Group were both open-ended with a maximum of 24 sessions. Participants contracted for up to eight sessions per treatment contract and may have re-contracted to the maximum though some may have contracted for as little as one or two sessions and would still have been considered treatment complete. Contrarily, the Relapse Prevention Group was a closed eight-week group. Clients who wished to participate in a group modality but who could not attend through the day, when the men's and women's groups were held, typically attended the Relapse Prevention Group as did clients who had developed stability in their abstinence often after attendance at either the men's or women's group.

Clients were considered "dropouts" if they only completed the pre-treatment BASIS-32 instrument but stopped attending after contracting for any type of community treatment. Some clients never attended a session after the assessment process while others participated to varying degrees but did not reach the stage of completing the post-treatment BASIS-32 instrument. As well, clients participating in the agency's Heartspace program that provides service for substance-involved pregnant and/or parenting women with children up to the age of six did not participate in this research study.

Pre-treatment data collection occurred during each client's initial assessment session. Post-treatment data collection occurred at the last session of community treatment, though a few clients did have their post-treatment questionnaire mailed directly to them if they missed their last scheduled appointment. Due to the open-ended nature of groups at the agency, difficulties in data collection arose as not all clients who originally agreed to participate in the study informed their group facilitator when they decided to complete group earlier than they had initially contracted. Some clients who dropped out near the end of their treatment

contract and did not complete a post-treatment instrument were mailed the instrument once the drop out was identified.

All clients who volunteered for the study received a letter prior to the BASIS-32 being sent to them at both the two and six months post-treatment intervals informing them that the instrument would be forthcoming and to please complete it as soon as possible upon receipt and return it to the agency in the stamped, self-addressed envelope. One week later, at two months and six months after the last community treatment session the BASIS-32 was mailed out to each of the study's participants. Reminder letters were also sent to those who did not return the BASIS-32 follow-up instruments. This process resulted in an 89.6% retention rate two months post-treatment and a 66.7% response rate at the six-month follow-up point.



## *RESULTS*

Of the 115 male participants 90 (78.3%) were assigned to individual counseling after the assessment process with 25 (21.7%) matched to group work while of the 58 women, 45 (77.6%) were matched to individual counseling and 13 (22.4%) to group counseling. However, only 74 (82.2%) men matched to individual counseling completed the BASIS-32 during their initial assessment while only 16 (17.8%) actually met with their counselor. Of the 25 men referred to group counseling 13 (52.0%) completed the BASIS-32 with 12 (48.0%) attending and completed counseling. Similarly only 30 (66.7%) of the 45 women matched to individual counseling completed the initial BASIS-32 while 15 (33.3%) attended the individual counseling sessions and completed the post-treatment BASIS-32 instrument. Seven (53.85%) of thirteen women assigned to group counseling completed the initial BASIS-32 while six (46.1%) attended and completed the group counseling sessions. Men were much more likely to drop out after the assessment process than were women particularly those assigned to individual counseling ($\chi^2 = 4.10$, $df = 1$, $p < 0.05$) (Table 1).

Pre-test BASIS-32 scores for those who completed treatment were lower than those obtained during the assessment process for all groups with the exception of women matched to individual counseling. Statistically significant differences were found between the pre-treatment and post-treatment scores for all four groups at the $p < .002$ level or better. While improved scores were also recorded two and six months post-treatment as compared to pre-treatment scores, there was a slight up-

ward drift among men matched to both individual and group counseling and also among women matched to individual counseling. However, women matched to group counseling had a statistically significant decrease ($t = 3.998$, $df = 2$, $p < .057$) despite this being the smallest group and suffering a 50% six month post-treatment attrition rate in responses (Table 2).

Both men and women receiving individual counseling had greater BASIS-32 scores at every measurement point than did those men and women participating in group counseling. Interestingly, at the assessment phase the mean BASIS-32 scores were greater for those assigned to group counseling than to individual counseling. This however had changed for the 49 individuals who moved to the treatment phase indicating that more individuals with high BASIS-32 scores assigned to group counseling dropped out compared to those assigned to individual counseling. It also appears as if more women with lower BASIS-32 scores dropped out of the individual counseling option as there was an increase from 1.29 at the assessment time to 1.46 at the pre-treatment stage.

While there was no significant difference between the mean male individual counseling pre-test BASIS-32 scores when compared with the mean male group counseling pre-test scores there was a significant difference six months post-treatment ($t = 3.205$, $df = 6$, $p < .018$). Likewise there was not a significant difference between BASIS-32 scores of women who were assigned to individual counseling versus group work, however the six-month post-treatment scores were significantly lower for women who had participated in group counseling ($t = 22.556$, $df = 2$, $p < .002$).

TABLE 1. Participation Levels

| | Attended | Assessment Completed | Counseling | | | |
|---|---|---|---|---|---|---|
| | | BASIS-32 | Pre-Test | Post-Test | 2 Months | 6 Months |
| Individual Counseling | | | | | | |
| Men | 90 | 74 | 16 | 16 | 13 | 7 |
| Women | 45 | 30 | 15 | 14 | 13 | 13 |
| Group Counseling | | | | | | |
| Men | 25 | 13 | 12 | 12 | 12 | 9 |
| Women | 13 | 7 | 6 | 6 | 3 | 3 |

TABLE 2. BASIS-32 Scores

| | Dropout | Pre-Test | Post-Test | 2 Months | 6 Months |
|---|---|---|---|---|---|
| Individual | | | | | |
| Men | 1.26 | 1.1 | 0.63 | 0.75 | 0.65 |
| Women | 1.29 | 1.46 | 0.59 | 0.89 | 0.94 |
| Group | | | | | |
| Men | 1.35 | 1.0 | 0.54 | 0.59 | 0.61 |
| Women | 1.64 | 0.79 | 0.41 | 0.15 | 0.13 |



## *DISCUSSION*

Both men and women who completed individual counseling scored lower on the BASIS-32 at the completion of their sessions than they did prior to treatment with there being an upward drift observed among women's scores. Both men and women who completed group counseling scored lower on the BASIS-32 at the completion of group work than they had prior to treatment this time with a slight, though statistically insignificant, upward drift among men, but with a statistically significant decrease for the female group participants. Those assigned to individual counseling had greater mean scores throughout the treatment process than did members assigned to group. Those assigned to group work had a greater overall decrease in their BASIS-32 scores and were the most likely to complete their treatment program.

An unanticipated finding was the significant difference in follow through with many more men than women dropping out of the counseling process. This was an especially pertinent discovery for the agency as it acts in a gateway capacity for the London community. Clients had waited at a minimum several weeks for an initial assessment and then completed an extensive assessment protocol and then negotiated a treatment plan with the counselor and then made the additional commitment to voluntarily participate in a formal research study and yet they still did not follow through with the actual counseling process.

Though overall all those who completed treatment did better after treatment was completed as well as two and six months post-treatment, those matched to group counseling had superior outcomes. However, while it appears that those assigned to group counseling do better, there are other possible interpretations that must be considered as a result of the ethical constraints of conducting community-based research. The outcomes may be influenced by the clinical matching process that oc-

curred as there was not random assignment to individual and group counseling. Those assigned to group counseling in this study tended to be more stable in their abstinence and while men were less likely to have more problematic mental health issues, this was not the case among women. Thus, as assignment to groups was purposeful, based upon client need and clinical judgment, there are a variety of internal validity issues that arise. As well, the number of dropouts forced collapsing of the various groups into one larger category rather than allowing for an analysis by the various group formats employed by the agency and thus caution needs to be exercised when generalizing the results beyond those of this agency. Finally, the BASIS-32 is a self-report instrument and as such is limited by clients' perceptions of their coping strategies and by efforts to look good or please their counselor despite the anonymous nature of the instrument.

Nonetheless, the findings do add additional information to the complex issue of how best to maximize addiction treatment outcomes and which works better for men and for women: individual or group counseling. Most important however, especially for this community-based agency where the study was conducted, was that it was again demonstrated that treatment matters and that it makes a significant difference in the lives of clients who attend counseling. It has also indicated that for this organization additional attention needs to be focused upon enhancing client retention between assessment and counseling in the future.

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