SOLUTION-FOCUSED GROUP THERAPY
IN A RESIDENTIAL CARE SETTING:
AN OUTCOME STUDY CONDUCTED IN MALAYSIA

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Kent State University College
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for the degree of Doctor of Philosophy

By
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The purpose of this study was to examine the effect of solution-focused group therapy on substance abusers in a residential care setting conducted in Malaysia. In specific, the effect was assessed by measuring the treatment outcomes and psychological well-being of participants at pre- and post-treatment, and other factors including indication of abuse, period of sobriety, and psychological aspects that includes symptoms, life-functioning, self-harm, and general well-being were investigated in relation to treatment outcomes.

A total of 57 participants who received residential treatment at Cure and Care Malaysia Clinic met the participants’ inclusion criteria; agreed to be participated in the study and completed pretest and posttest of the study. The participants were given a four-week treatment of solution-focused group therapy. The participants completed two instruments, the Outcome Questionnaire that measured treatment outcomes and the Clinical Outcome in Routine Evaluation that measured psychological well-being. Participants also provided responses about their substance abuse history including period of sobriety, types of substance, and treatment history.
The instruments data were analyzed using independent t-test, correlation analysis, and multiple linear regression. Independent t-test analyses indicated significant differences on treatment outcomes and psychological well-being of participants at post-treatment evaluation. Regression analyses indicated that period of sobriety and psychological aspects – namely symptoms, life-functioning, self-harm, and general well-being differentially predicted treatment outcomes. By examining variations in participants’ period of sobriety and psychological aspects and how much they contribute to treatment outcomes, this study highlights these factors play some major role in treatment outcomes.

These results are discussed in detail herein. Implications of the findings along with the limitations of the study are presented. Recommendations of future research are also described.
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CHAPTER I
INTRODUCTION AND LITERATURE REVIEW

Substance abuse is a global problem and efforts to combat substance abuse are the number one priority in many countries (United Nation Office on Drugs Crime; UNODC, 2014). The former Prime Minister of Malaysia, Mahathir Mohamad, declared that "substance abuse [is the] number one enemy of the nation" (National Drug Policy, 1983). The National Anti-Drug Agency (NADA) reported that the number of clients with substance abuse issues reached 14,381 in 2013, which is a substantial increase from 10,301 the previous year. According to statistics from NADA, between January to September 2013, an average of 17 new substance abuse cases and 20 relapse cases were reported every day in Malaysia (2013).

The increase of clients with substance abuse issues in Malaysia is seen across all types of substances, including heroin, cocaine, and marijuana, among others. Moreover, the demand for amphetamine-type stimulants (ATS), ecstasy, methylenedioxy-methamphetamine, or MDMA, and other synthetic drugs is increasing in Southeast Asian countries including Malaysia. The production of synthetic drugs has overtaken traditional drugs (opioid-based drugs) as they are easily produced using precursors available in the country. Malaysia has much to explore and with which to experiment before it can arrive at truly effective ways and means to combat drug abuse (Abd. Halim, 2010 & NADA, 2013).
Substance abuse issues negatively affect the nation's economy and societal norms. The Malaysian government reportedly spent about 4,291,159.30 Malaysian Ringgit (equivalent to $15,019,057.50) over a period of 10 years, from 1993 to 2003, for rehabilitation center management. Additionally, substance abuse problems also give rise to other issues, such as criminal cases and job loss. Of all these issues, the most important is the psychological distress or mental health condition of substance abusers (Baharudin, Mislal, Ibrahim, Sidi, & Nik Jaafar, 2013 & Flynn & Brown, 2008).

In Malaysia, the National Anti-Drugs Agency (NADA) was established in 1996 under the Ministry of Internal Security to spearhead all programs related to treating and managing substance abuse issues. From its establishment, strategies in National Drug Policy had focused on prevention, criminal law enforcement, treatment and rehabilitation, and the building of international relationships. Within these strategies, clients with substance abuse issues were viewed as criminals and therefore had to go through compulsory drug detention programs and even long-term incarceration. These programs included military-style training, vocational skills training, and religious classes (Vicknasingam & Mazlan, 2008).

In 2005, the medical care component was highlighted in an effort to provide integrated treatment for substance abuse clients. This shift signals a remarkable change in Malaysian policies and approaches to drug treatment. The Ministry of Health has been given the authority to provide for the medical treatment of heroin dependence. This
treatment includes harm-reduction programs (e.g., methadone maintenance therapy) and needle syringe exchange programs (Kamarulzaman & Saifuldeen, 2010).

In 2010, the orientation of drug treatment in Malaysia had shifted from compulsory drug detention programs to ambulatory care programs. The new model of care was introduced because of the need for cost-effective treatment. This model does not view substance abuse clients as criminals, and treatment is open and voluntary. The treatment itself is less time-consuming and of lower intensity (Kamarulzaman, 2012). Although the programs have been implemented widely throughout the states in Malaysia, only a few studies have focused on the psychosocial component of the treatment program, the efficacy of which remains uncertain.

**Purpose of the Study**

The purpose of the present study is to explore the utility of Solution-Focused Group Therapy (SFGT) in Malaysian culture by investigating its effect on substance abusers in a residential care setting conducted in Malaysia. The study examines the treatment outcomes and psychological well-being of the participants.

Over the past decade, solution-focused therapy has been a subject of interest for researchers in the field of substance abuse. The utility of solution-focused therapy has been tested on clients with substance abuse and drinking problems in individual and group formats. The therapy has been applied in community clinics, hospitals, drug treatment centers, and prisons (Berg & Miller, 1992; Berg & Reuss, 1997; de Shazer & Isebaert, 2003; Mason, Chardler, & Grasso, 1995). For drug treatment centers, solution-focused group therapy (SFGT) is a pragmatic option. This permits a therapist to treat
more than one client in a therapeutic group setting, which is cost-effective (LaFountain & Garner, 1996; McCollum, Trepper, & Smock, 2004; Proudlock & Wellman, 2011).

The present study builds on previous research (Smock, Trepper, Wetchler, McCollum, Ray, & Pierce, 2008) on the efficacy of SFGT by examining the treatment outcomes in clients with substance abuse issues in Malaysia. Although SFGT is widely-used, more quantitative research is needed to test its efficacy in different treatment settings, specifically comparing outcomes between-patient or out-patient settings, hospital long-term care, and community settings (Gingerich & Eisengart, 2000; Kim, 2008; Smock et al., 2008; Proudlock & Wellman, 2011). Furthermore, few studies test SFGT implementation in different cultures. This chapter includes a review of the literature on substance abuse treatment with particular interest in Malaysian culture and SFGT in substance abuse treatment.

**Rationale of the Study**

This study is the first to use SFGT for substance abuse in a residential care setting in Malaysia. For this reason, this study provides a solution-building perspective for drug treatment providers or agencies working with substance abuse clients, which emphasizes the clients’ personal strengths and resources rather than their deficits and weaknesses, and is appropriate for clients with differing needs and concerns (de Shazer, 1985; Pichot & Smock, 2009). Moreover, utilizing a solution-building perspective may meet treatment objectives within a shorter amount of time (Pichot & Smock, 2009).

In addition, exploring the utility of SFGT in Malaysian culture will make a significant contribution to the existing body of knowledge. Specifically, addiction
counselors will gain cultural competency in using strength-based approaches to treat clients with substance abuse issues, and professional psychotherapists can learn about Malaysian culture even as the field moves toward multi-cultural therapy.

Problem Statement

Residential care settings are focal points for treating individuals with substance abuse issues. Psychological distress (e.g., depression, anxiety, and post-traumatic disorder etc.) is prevalent among individuals with substance abuse issues. Severe psychological distress may interfere with therapeutic compliance and thus lower the chances for recovery. Due to the increase of substance abuse, an integrated treatment program that provides psychosocial and medical care to deal with comorbidity of psychological disorders and substance abuse needs to be given attention (Lotfi, 2008).

From the 1980s until the 2000s, Malaysia’s compulsory drug detention programs utilized traditional approaches in substance abuse treatment. Traditional approaches emphasized a medical model, physical training, confrontational interventions, community interest, and vocational acquisition skills (Abd. Halim, 2010; Kamarudin, 2007; Mazlan, Schottenfeld, & Chawarski, 2006). In the past, substance abusers had to acknowledge being addicts before developing any treatment plan. It was assumed that acknowledging the problem meant that addicts had decreased their defensiveness and denial, as these behaviors were always associated with the sub-culture of substance abusers in Malaysia (Ibrahim & Kumar, 2009). Traditional approaches were problem-focused and lacked flexibility in drug treatment, while substance abusers come with different characteristics.
and different needs. For instance, they enter treatment at different stages of substance abuse and present different concerns and needs.

In 2010, the focus of drug treatment was transformed from compulsory drug detention programs to ambulatory care programs known as Cure and Care programs. The central idea of these programs is that substance abusers receive open access services. Program interventions are characterized as “integrative,” which includes day care, medical detoxification, drug substitution therapy, and psychotherapy (Kaur, 2012). Despite this positive step, Kamarulzaman (2012) argued that the programs gave very little attention to the psychotherapeutic and mental health care components.

The lack of attention given to psychotherapeutic components of the ambulatory care programs in Malaysia have resulted in efforts to explore the potential of utilizing SFGT in residential care settings. SFGT is a solution-oriented approach and is cost-effective therapy, but was not specifically designed for delivery in residential care settings (James, Alemi, & Zapeda, 2013). There is a need to test its efficacy for treating substance abuse in residential care settings (de Shazer & Isebaert, 2003; Mott & Gysin, 2003; Smock et al., 2008). Previous studies have focused on using this treatment in outpatient community settings (Coe, 2000; Spilsbury, 2012), rural settings (West, 2010), and college settings (McCollum, Trepper, & Smock, 2003; Hayes, Curry, Freeman, & Kuch, 2010).

Given the rise of individuals presenting with substance abuse issues in Malaysia, it is clear that affordable and effective treatment for substance abuse is a vital need. Furthermore, the utilization of SFGT in Malaysia is still at an early stage; thus, there is
limited and inconclusive evidence regarding its effectiveness compared to other drug treatment programs. Cross-cultural issues must be taken into account pertaining to the applicability of SFGT before it is widely implemented in drug treatment programs in Malaysia. Furthermore, the efficacy of SFGT in treatment of substance abusers in Malaysian residential care settings deserves exploration.

**Research Questions**

The following research questions guide the present study:

1. What effect does solution-focused group therapy have on treatment outcomes as assessed by Outcome Questionnaire?
2. How does solution-focused group therapy increase psychological well-being of the participants immediately post-treatment as assessed by Clinical Outcome in Routine Evaluation?
3. Are there differences in indications of abuse as assessed by UNCOPE on treatment outcomes as assessed by Outcome Questionnaire?
4. Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?
5. Is there a relationship between psychological well-being of the participants as assessed by Clinical Outcome in Routine Evaluation and treatment outcomes as assessed by Outcome Questionnaire in post-treatment?
6. Which aspects of psychological well-being as assessed by Clinical Outcome in Routine Evaluation are most predictive of treatment outcomes as assessed by Outcome Questionnaire?
Operational Terms

Previous research provided explanations for the following terms used in the present study.

Solution-Focused Group Therapy. According to Pichot and Smock (2009), SFGT is based on solution-focused brief therapy (SFBT), which is a solution-building philosophy. Unlike problem-solving approaches, solution-building approaches begin with the client's description of his or her desired goals. This is followed by an evaluation to assess his or her current situation relative to the desired goals. The counseling approach is focused on discovering the client's resources and strengths to cope with his or her problems by assessing the exceptions (period of success). Pichot and Smock (2009) defined six focal points of SFBT that informs its strategies and techniques: miracle questions, scaling, differences questions, relationship questions, exception questions, and compliments. These strategies continue to be relevant to group work in SFGT. Miller and de Shazer (1998) defined miracle questions as the "centerpiece of this approach" (p.366).

For the purpose of this study, SFGT refers to group therapy that delivers solution-oriented therapy to substance abusers in a residential care setting in Malaysia. The treatment flow and steps are based on Pichot and Dolan's (2003) manual of SFGT. The major strategies and techniques to be used in the present study are structuring the opening session, and implementing such solution-oriented therapy as miracle questions, doing something different, identifying exceptions, discovering and expanding solutions, coping question, and compliments.
The opening session will focus on the clients' progress since the last meeting as well as identify coping strategies through exception questions. Exception questions are used to discover times when problems could have happened but did not. Coping strategies are identified by the clients themselves and highlighted in the group discussion through reflection, strengths amplification, and legitimate compliments (Pichot & Dolan, 2003). These techniques are used during each group session and the length of group therapy is one hour-and-half weekly for four weeks.

*Residential Care Setting.* The Substance Abuse and Mental Health Services Administration (SAMHSA, 2005) describes the residential care setting as a primary treatment site for substance abusers. Treatment is provided in a variety of settings: long-term (12 months or more) and short-term (3 months or less) residential programs, criminal justice-based programs and halfway houses. Residential settings involve an overnight or longer stay in the treatment centers, where the individuals follow the treatment programs developed by health providers with the clients' agreement. Treatment programs in residential settings include psychosocial modalities, therapeutic-community modalities, faith-based modalities, and pharmacological treatment. The focus of residential care settings in substance abuse treatment is to alleviate withdrawal symptoms as well as to treat addiction problems (SAMHSA, 2005).

For the purpose of this study, a residential care setting refers to Cure and Care 1Malaysia Clinic, which is located in the central zone of Peninsular Malaysia. The National Anti-Drug Agency of Malaysia is responsible for the operation of the clinic. Treatment providers include counselors, physicians, medical assistants, psychiatrists,
pharmacists, administration staff, and police forces. The clinic utilizes the ambulatory care programs that provides both outpatient and inpatient drug treatment programs for substance abuse clients.

Clients undergo medical detoxification prior to residential treatment. They stay overnight in the clinic and abide by the rules set by the treatment providers; for example, the use of drugs and alcohol are prohibited. The clinic also utilizes psychosocial modalities including early recovery treatment, relapse prevention, family programs, individual and group therapy, vocational assistance, spiritual guidance, and substitution maintenance therapy. The terms “clinic” and “center” are used interchangeably in this study to refer to Cure and Care 1Malaysia Clinic.

Substance Abusers. The Diagnostic Statistical Manual 5 (DSM 5, 2013) uses the term substance-use disorders under the addictions and related disorders category to describe individuals affected by substance use problems. Overall, there are eleven symptoms that represent substance-use disorders and the symptoms are assessed along a continuum, i.e. mild, moderate, and severe (American Psychological Association [APA], 2013). The World Health Organization (2014) defines substance abuse as "use of a substance for a purpose not consistent with legal or medical guidelines" (Terminology and Classification section, para. 2). The term abuse is used to represent the harmful use of any substances as it is assumed the term abuse is less judgmental and less pathological sounding than addiction. The consequences of substance abuse are significantly associated with detrimental health effects, while consequences in substance use disorders
are observed inclusively that includes social consequences, psychological, and occupational problems (WHO, 2014).

For the purpose of this study, substance abusers are Malaysian individuals, who have abused and/or misused any group of substances including cannabis, opiates, cocaine, ATS, ecstasy, and alcohol. They are clients with substance abuse issues who undergo drug treatment programs at Cure and Care 1Malaysia Clinic who range in age from 19- to 65-years-old. The substance abusers may or may not have had drug treatment prior to admission to the current treatment center. They also have experienced relapse at least once during their recovery and exhibited co-occurring symptoms of psychological distress while undergoing the residential treatment programs.

Co-Occurring Symptoms. SAMHSA (2005) describes co-occurring symptoms in substance abuse as co-occurring disorders that refer to both substance-related and mental health disorders. Co-occurring disorders are defined from two perspectives: individual level and service level. At the individual level, co-occurring disorders are defined when the individual exhibits "at least one disorder or each type can be established independent of the other and is not simply a cluster of symptoms from (a single) disorder" (SAMHSA, 2005, p. 3). At the service level, co-occurring disorders refer to three inclusion criteria: prediagnosis, postdiagnosis, and unitary disorder with acute signs and/or symptoms of a co-occurring condition (SAMHSA, 2005, p.3). In other words, individuals with substance use disorders also suffer from other mental health disorders, in which the previous and current symptoms exhibited by the individuals must be considered before co-occurring disorders are determined to be present. Rates of co-occurring personality
disorder, mood disorder, and general anxiety disorder in substance abuse were found to be 44%, 28%, and 24% respectively (Stinson, Grant, Dawson, Ruan, Huang, & Saha, 2005).

For the purpose of this study, co-occurring symptoms in substance abuse refer to general psychological distress symptoms exhibited by substance abusers including stress, depression, trauma, and general anxiety. The determination of co-occurring symptoms in substance abusers is decided when their conditions do not fulfill the symptoms set for other major disorders in DSM 5 (e.g., major depression disorder or borderline personality disorder), and the conditions do not warrant further psychiatry and medical attention at the current time.

*Treatment Outcome Study.* In research methods in clinical psychology review, Spokas, Rodebaugh, and Heimberg (2008) describe treatment outcome studies used to examine the effects of treatment on clients. This includes assessing treatment efficacy and investigating the mechanisms of change produced by effective interventions in the treatment. Various treatment designs are employed that inform research designs in treatment outcome studies that include no-treatment control group design, treatment-as-usual control group design, comparative treatment design, and effectiveness studies. Spokas et al. (2008) discuss factors that contribute to high-quality studies of treatment outcomes including treatment manuals, therapist training and supervision, treatment adherence assessment, and reduction of missing data. The selection of appropriate treatment designs, adherence to effective treatment factors, and appropriate statistical measures improves the quality of studies of treatment outcomes. The authors state the
specificity of the outcomes is imperative, rather than generic success rates in the field of addiction treatment outcomes. That is, treatment outcomes need to be operationally defined by clarifying the outcomes measures and using clear descriptions.

For the purpose of this study, an outcome study conducted in Malaysia refers to the treatment outcomes of SFGT in participants. The outcomes specifically refer to the participants' change in symptom distress, social role functioning, interpersonal relationship, and psychological well-being that will be measured using two instruments, the Outcome Questionnaire and the Clinical Outcomes in Routine Evaluation. The treatment outcomes are assessed at the end of group therapy sessions by comparing pre- and post-treatment results.

**Literature Review**

The current body of literature pertaining to substance abuse and treatment in general will be explored, with emphasis on substance abuse treatment in Malaysia. This section highlights literature that includes (a) cultural dimensions in Malaysia, (b) substance abuse in Malaysia, (c) treatment of substance abuse, and (d) solution-focused group therapy in substance abuse treatment.

**Cultural Dimensions in Malaysia**

Malaysia is a multi-ethnic country located in Southeast Asia. The country consists of three major ethnicities: Malay, Chinese, and Indian. The Malay ethnicity accounts for the majority group (50% of the population), followed by Chinese (22.6%), Indigenous (11.8%), Indian (6.7%), and other minority ethnicities such as Kadazan, Dusun, and Banjar (8.9%). Malay language is recognized as the national language of the
country (Department of Statistic Malaysia, 2014). Although different ethnics in Malaysia share a large segment of cultural dimensions such as collectivism, family or group orientation of life, past-time orientation, and other sentiments, there are some differences in degree and priority of values. For example, the Malay rank honesty as first in their list of values, while the Chinese rank courtesy, and the Indians rank family (Fontaine & Richardson, 2005). These values to some degree inform their lives including interpersonal relationships, lifestyle, and mental health issues. In this section, the context in which the Malay ethnicity depicts collectivist and past-time orientation culture are discussed, including strategies in life to handle life stressors and its relevance for how psychological distress and symptoms are experienced.

**Collectivism.** Individualism and collectivism are cultural dimensions used to understand how an individual perceives his or her relationship to the group of which he or she is a member (Hofstede, 1986). The characteristics of an individual in individualist cultures includes self-contained, independent, and clearly bounded, meanwhile, an individual in collectivist culture includes enmeshed, interdependent, and contextualized (Sampson, 1989; Markus & Kitayama, 1991). Malaysian being a collectivist society is thoroughly discussed in previous studies (e.g., Hofstede, 1986; Tafarodi & Smith, 2001; Fontaine & Richardson, 2005). This includes the ethnic Malay in Malaysia as an ethnic that values collectivist culture, which is an emphasis is placed on “we” rather than “I” orientation in describing one’s relationship with the group or society. The ethnic Malay focuses on group harmony, being loyal to fulfillment of group expectations, and
prioritizing the group over the individual to maintain group harmony (Fontaine & Richardson, 2006).

Some values encompassed in collectivist culture include self-reliance and loss of face. Self-reliance in collectivist culture is described as one not being a burden to one’s ingroup (e.g., family, relatives, and community). This is contrast with individualist culture employed by mostly Western countries that describes self-reliance as being able to pursue one’s goal (Tafarodi & Smith, 2001). Self-reliance values are thought to have influence on loss of face value in collectivist culture, which means being a burden to one’s group can lead to shame for the group.

Given the importance of self-reliance and face-saving values in collectivist culture, the ethnic Malay values group and social harmony, and thus life events that threatens group harmony may be perceived as stressful and adversely affect psychological well-being of its members. Fontaine and Richardson (2005) reported that external events such as offence could lead to depression as the consequences of the offence; for example, going to jail could bring shame to one’s family or group. Too much concern about how the group perceive oneself may cause the members of collectivist culture to have greater vulnerability in depressive sensitivity to life events (Tafarodi & Smith, 2001).

In addition, the collectivist culture influences ways of how psychological distress and symptoms are experienced. Cheng, Leong, & Geist (1993) report that Malaysia is one of the Southeast Asian countries shown to have higher rates of expressed symptomology for personal and emotional problems, and yet mental health services are
still underused in the country. This is due to stigmatization attached to personal and emotional problems, and seeking help for mental disorder could lead to loss of face. Rather, symptoms of psychological distress are presented as less stigmatized problems, such as issues associated with career or education (Cheng et al., 1993). Furthermore, due to the great emphasis on saving face in collectivist culture, self-harm associated with personal and emotional problems among ethnic Malays was underreported in Malaysian society though the prevalence estimates are also low. This is due to factors that include religion, fear of psychiatric hospitalization, loss of face, and sense of dishonor to their families (Khan, Sulaiman, & Hassali, 2012).

In view of how collectivist culture influence psychological distress and symptoms experienced in the Malay ethnic group, its value (group-oriented) to some degree can also be a protective factor for individuals in developing coping strategies for life in general. For instance, having close and good relationships with relatives and the community foster a strong group spirit. This spirit becomes a foundation to develop a sense of responsibility to help family members and individuals who is part of the community in the name of mutual cooperation (Lim, 1998).

**Past-time orientation.** Time orientation that includes past-time and future-time orientation are cultural dimensions used to understand how a society values some connections with its past while dealing with the current challenges (Hofstede, 1991). The members of future-time oriented cultures prioritize pragmatic approaches to solving problems, focusing on efforts (e.g., persistence and thrift) and modern education to prepare for the future. In contrast, the members of past-time oriented cultures prioritize
traditions and normative tasks (e.g., fulfillment of social obligations like reciprocating favors) as sources for inspiration or guidance to live in present (Hofstede, 1991). Malaysia’s being a past-time orientation society is supported by previous studies (Hofstede, 1991; Lim, 1998; Gong, 2001). The Malay ethnic group in Malaysia favors traditions as they bring inspiration, motivation, hope, and direction for change in the present-time orientation (Gong, 2001).

The context in which the Malay ethnicity depicts past-time orientation culture can be seen in their ways of thinking (Hofstede, 2001). For instance, younger individuals often defer to their elders (e.g., parents, grandparents, etc.) for inspiration and advice. Within future-oriented culture, the question is posed “How would you handle this if you were in my situation?” while the past-oriented individual will ask “What did you do in the past when you faced the same situation as I do now?” This form suggests the commitment and devotion that link to traditions and respect of oneself to his or her family. This practice confirms that past-time orientation is present in the Malay ethnic cognitive frame (Hofstede, 2001).

These contextual descriptions of collectivism and past-time orientation of cultural dimensions in the ethnic Malay highlight the fact that the Malay ethnic group in Malaysia differ from individualistic and future-orientated cultures in how they experience psychological distress and the way they perceive the importance of managing the symptoms. The contextual descriptions of culture are important to address as psychological well-being and symptoms can only be understood within the cultural context in which they occur (Berry, Poortinga, Breugelmanas, Chasiotis, & Sam, 2011).
Substance Abuse in Malaysia

Substance use in Malaysia started during British colonization in the 19th century, when Chinese migrant laborers brought in to work in the tin mines used opium as self-medication. Meanwhile, cannabis was largely used by Indian workers brought in to Malaysia to work in rubber plantations to cope with workplace stress. Up to now, illicit drugs were imported from the Golden Triangle in Burma, Laos, and Thailand, increasing the supply of drugs to neighboring countries like Malaysia (Mazlan, Schottenfeld, & Chawarski, 2006).

With respect to laws related to substance abuse, Malaysia has severe anti-drug laws operated by the narcotics department of the Royal Malaysian Police. Individuals who test positive in urine drug-testing are registered in a government registry of drug users and detained for criminal prosecution or mandatory drug treatment. Furthermore, Royal Customs of Malaysia controls the import and export of drug pharmaceuticals, while the Pharmaceutical Services Department of the Ministry of Health is responsible for drug law enforcement controlling the sale of pharmaceutical to the public (Mazlan et al., 2006).

Types of substances in Malaysia. Heroin has traditionally been the main substance abused, beginning in the late ‘70s (Chawarski, Mazlan, & Schottenfeld, 2006; UNODC, 2013). Heroin accounts for 63% of drug abuse treatment admission and 69% of drug-related criminal offences prosecuted in Malaysia (UNODC, 2013). The statistics have consistently escalated. The main mode of heroin administration is injection, followed by “chasing the dragon” or smoking. Heroin use was identified as prevalent
among males, Malays, and Muslims (Chawarski et al., 2006; Narayanan, Vicknasingam, & Robson, 2011). Despite heroin abuse problems increasing since the ‘70s, the abuse of amphetamine-type stimulants (ATS), specifically methamphetamine and methedrine, has become a major problem since 2000. In Malaysia, ATS are available in tablet and crystallized forms, such as “ice” and “syabu”. ATS routes of administration includes inhalation and smoking (Chawarski et al., 2006; McKetin, Kozel, Douglas, Ali, Vicknasingam, & Lund, 2008; Scorzelli, 2009).

Consequently, increased heroin and ATS use has caused severe negative effects in Malaysian society. The increase in ATS use is associated with higher crime rates, social problems, and family dysfunction. With respect to public health, ATS is a drug class that causes serious heart disease and high rates of suicidal behaviors (McKetin et al., 2008). These effects challenge existing treatment programs, and neither the private nor public health sectors are prepared to treat ATS users and their medical complications. Most existing substance abuse programs in Malaysia are designed to treat heroin abuse (Mazlan et al., 2006). Meanwhile, alcohol appears to be prevalent among the non-Malays ethnicity in that 34% of them were heavy drinker. Of this percentage, alcohol problems appear to relate more to the Indians ethnic group (Jernigan & Indran, 1997).

**Human Immunodeficiency Virus (HIV) and other infectious diseases.** In Malaysia, HIV and other infectious diseases such as Hepatitis C and pulmonary tuberculosis (TB) are significantly associated with drug-related risk behaviors, particularly among heroin abusers. The problem is prevalent in adults (Chawarski et al., 2006). Major risk behaviors in substance abusers were identified in relation to HIV
infection: injection drug use (IDU), needle sharing, and sexual transmission through lack of consistent condom use. Furthermore, Malay males ranging from 20 to 40 years old had higher rates of HIV and other infectious disease as compared to Chinese and Indian groups. This suggests that different drug subcultures exhibit varying patterns of use and risk behaviors that develop within different ethnic groups. The significant association between risk behaviors among heroin abusers and HIV/AIDS infection indicates the importance of developing and implementing substance abuse treatment programs for heroin abuse as well as addressing risk behaviors by incorporating psychoeducation and psychotherapy components of treatment (Chawarski et al., 2006).

**Treatment of Substance Abuse**

In reviewing the published literature pertaining to substance abuse treatment, this section is divided into three sections: traditional approach, alternative approach, and post-modern approach. The description of each approach is presented followed by its application in substance abuse treatment in Malaysia.

*Traditional approaches.* Approaches in substance abuse treatment, in conjunction with medications and psychosocial interventions, are the key components of treatment for substance abuse clients. Psychotherapy increases treatment compliance in clients and working alliances between therapists and clients (Spilsbury, 2012). Traditional approaches of substance abuse include social model, medical model, and therapeutic community model (TC).

*Social model.* The social model of substance abuse recovery started to gain popularity in the 1940s. It focuses on the destructive behavior and poor socialization
skills of substance abusers. The model suggests those deficits were learned, and thus, maintaining sobriety was the responsibility of the abusers (Room, Kaskutas, & Piroth, 1998). Therefore, an effective way to aim at the deficits is by providing cognitive behavioral therapy that emphasizes confrontational techniques. That is, individuals with substance abuse issues are to blame for their addiction and thus, labeling substance abusers as "addicts" is required as part of treatment (Mott & Gysin, 2003; Room et al., 1998).

In Malaysia, the social model approach in substance abuse treatment was implemented in rehabilitation centers in 1983. It is a "tough and rough" approach, including military-style training and provision of rehabilitation orders. The approach is no longer practiced in Malaysia after the government realized there were many other components needed in order to provide an effective substance abuse treatment (Adam, Wan Ahmad, & Abd. Fatah, 2011; Kamarudin, 2007).

**Medical model.** The medical model in substance abuse treatment is based on the notion that addiction is a disease that can be treated into remission by decreasing addiction symptoms. The model suggests clients with substance abuse issues are patients, and the interventions include viewing oneself as an addict, providing diagnosis and psychological evaluation, and psychoeducation (SAMHSA, 1997; Mott & Gysin, 2003). The 12 steps of Alcoholic Anonymous (AA) are consistent with the model, with an additional spiritual view of addiction and recovery. AA groups are commonly provided along with other interventions in the medical model of substance abuse treatment (Galanter, 2007).
In Malaysia from the 1990s to the 2000s, the medical model approach was incorporated with the social model and served as the primary approach, with an emphasis on long-term institutional incarceration of up to two years. The main goal was to achieve full abstinence. The approach includes cold turkey detoxification, reinforcement treatment, and community supervision. The interventions of the approach include military-style physical training and psychosocial (Vicknasingam & Mazlan, 2008).

Vicknasingam and Mazlan (2008) provide a comprehensive review of the impacts of the approach to drug policies in Malaysia. They assert that long-term institutional incarceration proved to be unsuccessful because of medical and therapeutic neglect in the approach. Increased relapse rates were observed within the first year following discharge. Accordingly, in 2005, medical professionals started to be actively involved in substance abuse treatment by providing medical treatment for heroin abusers. As a result, drug substitution therapy was introduced in addition to psychosocial approaches (social model and medical model). Medical treatment started to be given in addition to the primary approach in residential treatment settings (Singh, Chawarski, Schottenfeld, & Vicknasingam, 2013; Vicknasingam & Mazlan, 2008).

**Therapeutic community model.** TC model views substance abuse issues as a disorder that affects all aspects of clients' lives. Therefore, the treatment model aims at changing clients' fundamental lifestyles and identities, including cognition and behavior. A therapeutic community is purposely created to facilitate changes, including staff members and peers who serve as role models and guide the recovery process (De Leon, 1995). This approach is also described as "community as method." The interventions
include peer confrontation, encounter groups, and morning meetings (Bunt, Muehlbach, & Moed, 2008).

As of 2008, Malaysia had 28 government-aided drug treatment centers operating throughout the country. Four government drug treatment centers employed a comprehensive TC, 14 centers used psychosocial modality, and 10 centers employed a combination of TC and the psychosocial approach (Nazar, 2008). TC was provided in residential settings. In addition, 12-step immersion was incorporated in the treatment. Clients’ inclusion in the treatment was mandated through rehabilitation for up to 12 months (Narayanan et al., 2011; Nazar, 2008).

The government policy makers began to question the efficacy of these forms of substance abuse treatment as the number of new and relapsing clients cases each year continued to rise, suggesting ineffectiveness of the traditional forced rehabilitation approach (Ibrahim & Kumar, 2009; Narayanan et al., 2011). Considering generally poor results and the government’s financial stake in funding treatment programs, an initiative to develop a cost-effective approach was explored.

**Alternative approaches.** The alternative approach to substance abuse treatment consists of harm reduction and the ambulatory care programs. The alternative approach in substance abuse treatment is described as providing more treatment options, in which recovery can range from total abstinence to moderation or maintenance of substance use. The focus is on helping substance abuse clients function as individuals (Dutra, Stathopoylou, Basden, Leyro, Powers & Otto, 2008; Marlatt & Witkiewitz, 2002).
The Malaysian government started to provide more options in substance abuse treatment in the early 2000s, with harm reduction and the ambulatory care programs introduced through implementation of the alternative approach to substance abuse treatment (Vicknasingam & Mazlan, 2008).

**Harm reduction.** Fundamentally, the harm reduction approach in substance abuse treatment is characterized as reducing harm to substance abusers as well as to society (Ball, 2007). In Malaysia, the harm reduction approach was tentatively introduced in 2006 with encouraging results. The harm reduction approach was introduced in response to an increased number of HIV/AIDS cases among injecting drug users (IDU) in Malaysia (Chawarski et al., 2006; Reid, Kamarulzaman, & Kaur Sran, 2007). The treatment programs in the harm reduction approach includes methadone maintenance treatment (MMT), and needle and syringe exchange programs (NSEP). Reid et al., (2007) reviewed the results of the harm reduction approach since its implementation and found that new HIV/AIDS cases among IDUs decreased and more heroin abusers came forward seeking drug treatment (Chawarski et al., 2006; Reid et al., 2007).

Although the harm reduction approach was demonstrated to be helpful in decreasing new HIV/AIDS cases, some challenges and barriers remain, including dose setting of methadone and laws that criminalize and arrest methadone users attending MMT and NSEP (Reid et al., 2007). This is because methadone users and substance abusers caught carrying needles and syringes are subject to mandatory testing and forced treatment or imprisonment under Section 37 of the Dangerous Drugs Act 1952 (The Commission of Law Revision, Malaysia, 2006).
Furthermore, implementing such treatment programs in Muslim societies such as Malaysia imposes continuous challenges, especially among policy makers and religious leaders (mainly Islamic). Accepting the idea of harm reduction implies the government of Malaysia is giving up the goal of achieving a drug-free nation (Kamarulzaman & Saifuddeen, 2010; Narayanan et al., 2011). An alternative approach is needed that provides brief drug treatment programs and cost-effective solutions for substance abuse clients to have more options for substance abuse treatment.

**Ambulatory care programs.** Since the 1980s, Malaysia has implemented various approaches to treat substance abuse but these have not stopped new cases of substance abuse from occurring, nor have they prevented rising relapse rates. An alternative approach that was introduced was the ambulatory care program in combination with harm reduction. Treatment providers – government agencies and other organizations– demanded cost-effective treatment approaches that included ATS and pharmacological aspects of recovery. In response, the Malaysian government started shifting its attention from traditional approaches (abstinence-based; TC model) to solution-focused approaches (maintenance-based) (Kaur, 2012).

By 2010, the focus of drug treatment programs in Malaysia was transformed from compulsory drug detention to ambulatory care, which is known as the Cure and Care treatment program. This program is based on the concept of an open, voluntary treatment concept that is less time-consuming and at a lower intensity (Kaur, 2012). The program’s philosophy is that clients who voluntarily seek treatment should not fear legal
consequences. Moreover, the program assumes that forced treatment would impede the recovery process.

In Malaysia, among the first government-aided treatment centers that implemented the ambulatory care programs was Cure and Care 1Malaysia Clinic. The model of care utilizes outpatient and inpatient drug treatment programs. The clinic provides three packages of treatment programs: thirty days, sixty days, and ninety days. The substance abusers undergo medical detoxification before proceeding to inpatient setting treatment programs. For inpatient drug treatment programs, the treatment components include psychotherapy (guidance and counseling), day care, medical detoxification, drug substitution therapy, and referral and advocacy to the aftercare program (NADA, 2013). Since 2010, more than 9000 substance abuse clients have visited the clinic and received treatment. Furthermore, a number of former clients found employment after the treatment program was at 56.3% (Kaur, 2012).

Kamarulzaman (2012) investigated the effects of the treatment program. She reported that 74% of substance abusers who registered at the clinic experienced drug-induced psychoses, which increased the risk of relapse and the development of co-occurring symptoms such as depression, anxiety, memory loss, and problems in memory retention. She recommended the improvement of the psychotherapy component of the treatment program to treat co-occurring symptoms (Kamarulzaman, 2012). Very little attention is given to mental health care in this model of care for substance abusers. Consequently, co-occurring symptoms among substance abusers often go unrecognized and hence untreated (Baharudin, 2013). An evidence-based psychotherapy approach is
needed not only to diversify drug treatment programs, but also to support the utilization of the ambulatory care program in Malaysia.

*Post-modern approaches.* Post-modern approaches are different from traditional and alternative approaches of substance abuse treatment that are problem-focused. The post-modern approach uses a social constructionist philosophy which states that reality could be defined and constructed in many ways (Anderson, 1997). This philosophy is employed by solution-focused therapy in substance abuse treatment; that is, the reality of recovery is constructed by the clients themselves and the therapy focuses on building solutions rather than focusing on problems. The solution-building approach emphasizes three components: identifying the solutions, exceptions, and having hope in the future (Pichot & Smock, 2009).

Grant (2012) compared the effects of solution-focused and problem-focused coaching sessions on positive and negative affect, self-efficacy, and goal-setting behaviors among college students. A total of 225 subjects were involved in the study, in which 108 participants were randomly assigned to a problem-focused coaching session and 117 participants were assigned to solution-focused coaching session. The participants completed a set of measurements that consisted of the Positive and Negative Affect Scale, Self-efficacy Questions, and Goal Approach Scale before and after sessions. The results of the two groups were compared.

The results suggested that solution-focused group had higher scores on positive affect, self-efficacy, and goal approach at post-test as compared to problem-focused group ($p < .01$). Solution-focused group also showed lower negative affect scores at post-
session as compared to problem-focused group, $F(1, 223) = 4.36, p < .05$). Grant (2012) concluded that solution-focused questions (e.g., miracle questions) were effective in enhancing the participants’ desired goals and generated significantly more actions steps to achieve those goals. However, he emphasized there is still a need to identify what constitutes effectiveness in solution-focused therapy in mental health care (Grant, 2012).

**Solution-Focused Approach in Substance Abuse Treatment**

In reviewing published literature pertaining to solution-focused therapy in substance abuse treatment, this section is divided into 2 sub-sections: solution-focused brief therapy (SFBT) and solution-focused group therapy (SFGT), which evolved from SFBT.

*Solution-Focused Brief Therapy.* SFBT is rooted in a post-modernism philosophy of knowledge that believes in the notion of multiple truths in explaining a reality (de Shazer, 1991). The development of SFBT can be traced back to the work of de Shazer, Insoo Kim Berg, and associates in the early 1980s at the Brief Family Therapy Center in Milwaukee, Wisconsin (Berg, 1994; Berg & De Jong, 1996; Berg & Miller, 1992; de Shazer, 1985). They discovered that when clients are frequently asked about their problems and symptoms, they tend to be trapped in the problem-saturated story of their life. This prevents clients from seeing the fact that they do have some strengths themselves (Berg & De Jong, 1996; de Shazer, 1991).

To create a solution-oriented story in clients, three main techniques were developed in SFBT: exception questions, relationship-oriented questions, and scaling (de Shazer, 1991). Exception questions are described as exploring clients' strategies in times
when a problem was not very severe or did not occur. This is based on the belief that problems do not happen all the time in human life (de Shazer, 1991). An example would be the questions, “When was the last time you felt you had a better day? What was it about that day that made it a better day?” Relationship-oriented questions are used to ask clients how someone else might see their changes. For instance, the question, “What would your family say when they see changes in you?” facilitates a client to discover what and how the changes would look like to others. This is appropriate to apply especially with clients who have difficulty in describing future changes or have poor insight skills. The information is used for goal development (de Shazer, 1991).

Finally, scaling is described as a tool to measure changes toward desired goals. According to de Shazer (1991), the function of scaling in solution-focused therapy goes beyond rating clients’ progress; scaling is used to construct viable solutions and resources for clients. To simplify the techniques in SFBT, they are operated in future-oriented mode, in which clients are asked to project themselves into a future where the present problems do not exist. Mott and Gysin (2003) emphasized that visualizing future changes facilitates the practice of new actions, which in turn produces changes in clients and decreases the problem.

In addition to these techniques, miracle questions are essential in SFBT, making it very different from problem-focused therapy (Miller & de Shazer, 1998; Pichot & Smock, 2009). Miracle questions serve as a tool to encourage clients to believe that change is possible; that is, clients focus on a situation where the problems do not exist,
thus allowing hope in clients to be created. In addition, more possibilities for change can be explored (Pichot & Smock, 2009).

When applied to addiction treatment, substance abuse clients are viewed from strengths and potential perspectives rather than deficits and resistance. Clients are empowered with their own abilities to make change. Mott and Gysin (2003) stressed that the solution-focused approach in addiction is action-oriented, with little attention given to the clients' past. Current and future successes are more important. Soliciting the details of changes in the future serve as a mechanism of change in SFBT as it creates a catalyst for change in clients and leads to developing hope. Indirectly, this approach can renew a client’s sense of self-worth, particularly for clients who have been stigmatized and traumatized in connection with substance abuse issues (Mott & Gysin, 2003).

Spilsbury (2012) utilized miracle questions, exception questions, and future-oriented questions in a case study with a client diagnosed with major depression and alcohol dependence. In addition to anti-depressant medicines, SFBT was provided for three sessions at monthly intervals. The outcomes were assessed at pre- and post-treatment using the Depression Anxiety Stress Scale (DASS), maintenance of abstinence, and the client’s self-reported goal attainment (using scaling technique). Pre- and post-treatment assessments were compared. The results indicated that the client scored lower in DASS after treatment than in pre-treatment. Spilsbury (2012) described that the client’s depression score had moved from severe to normal range.

With respect to alcohol dependence, the client reported that he maintained abstinence after the three-month and one-year follow-ups. In his discussion, he
highlighted that miracle and exception questions provided a non-confrontational approach in goal development. Spilsbury (2012) suggested that techniques in SFBT provide flexibility that is an important factor in dealing with clients presenting with substance abuse and/or alcohol dependence issues and co-occurring symptoms (depression).

In a similar case study, Hayes, Curry, Freeman, and Kuch (2010) conceptualized the utility of scaling and miracle question techniques with a female college student who was diagnosed with alcohol dependence. The techniques were used together with Motivational Interviewing techniques (e.g., identify readiness of change). Six individual sessions were provided for six weeks. They noted that scaling questions allowed the client to measure her own meaning of improvement and relate that meaning to abstinence. The client was encouraged to describe behavioral changes that took place during abstinence and her strengths were amplified in the sessions in order to encourage her to continue changes in behavior. Hayes et al. (2010) suggested that even though his study focused on individual counseling, clients with severe substance abuse issues may receive significant benefits from a group-therapy format, as well.

In substance abuse treatment, therapists are inclined to prefer group formats of SFBT to serve as a treatment structure in residential setting agencies, as well as to reduce the costs of mental health care (Coe, 2000; Smock et al., 2008).

**Solution-Focused Group Therapy.** Since SFGT is considered a comparatively new approach to therapy in substance abuse treatment, the majority of the studies found
were mainly conceptual or descriptive. In this section, descriptive studies are presented first, followed by a review of studies that employed an experimental research design.

West (2010), in his review of the application of SFGT with alcohol and other drug abuse clients in rural settings, asserts the importance of constructing clients' strengths in therapy. He explains that clients with substance abuse issues are accustomed to talking about their failures (e.g., relapse, negative experiences, and criminal cases). To break this cycle of problem-saturated stories in clients, therapists should focus on what is working for clients through exception questions or, as West calls it, the client’s “period of success”. This honors the different stages of change that clients go through. West also suggests that SFGT techniques are useful in group therapy with substance abuse clients, where the members are at varying stages of change (West, 2010). Although this study is interesting, its anecdotal nature does not effectively substantiate the efficacy of the approach.

West’s (2010) insight on the utility of exception questions in treating clients at different stages of change was previously discussed by Lewis and Osborn (2004) in a study, where they examine the compatibility of clients' readiness for change prior to receiving solution-focused therapy. The authors explain that the notion of change in solution-focused therapy is not compatible with the transtheoretical model of change, which suggests that changes happen through systematic stages. Solution-focused therapy, in contrast, suggests that change is constant and that clients already demonstrate a desire to change when they seek treatment (Walter & Peller, 1992). In identifying
readiness for change in solution-focused therapy, scaling questions function as an assessment of pre-session change (Walter & Peller, 1992; West, 2010).

Froerer, Smock, and Seedall (2009) provide a theoretical explanation and justification of how SFGT is employed with clients diagnosed with HIV/AIDS. They outline some values added by SFGT to treatment, especially focusing on the future and empowering clients. Furthermore, they suggest that a closed-group format, where new members are not introduced every week, would be effective for substance abuse clients because it creates an atmosphere of stability. A closed-group format is appropriate for clients, such as substance abuse clients, whose lives lack predictability (Froerer et al., 2009). This study provides structured guidelines for implementing SFGT with HIV/AIDS clients.

SFGT is also a non-threatening and direct intervention that is both therapeutic and easy for clients with mental health problems to comprehend. Springer, Lynch, and Rubin (2000) conducted a quasi-experimental study to investigate the effect of SFGT on self-esteem among Hispanic children whose parents were incarcerated. The authors compare the results between the experimental group and the comparison group. Ten participants involved in the study, in which half were assigned to the SFGT experimental and the rest were assigned to no treatment control group (wait-list group). Six solution-focused group sessions were provided for six weeks and the outcomes were measured using the Hare Self-Esteem Scale (HSSS). The Wilcoxon Signed-Rank test showed that the scores were significantly improved between pretest and posttest on self-esteem in the experimental
group ($\alpha = .05, p = .005$) and no significant difference in the comparison group ($\alpha = .05, p = .08$).

Springer et al. (2000) report that direct interventions (scaling and miracle questions) create positive effects in clients and increase self-esteem. In their discussion, the authors point out that scaling questions provide quantitative measurement of the clients' progress. The small sample size ($n = 10$), however, limits the generalizability of the study’s results. The authors themselves suggest conducting another experiment with a larger sample size with randomized participants in order to assure internal validity (Springer et al., 2000).

Coe (2000) investigated the effects of SFGT for adults in a community mental health center using a quasi-experimental research design with one single group. SFGT was provided to forty adults with different mental health diagnoses such as mood and adjustment disorders. The researcher provided a structured SFGT with therapeutic interventions drawn from solution-focused therapy, specifically future-oriented questions, relationship-oriented questions, and scaling questions. Over a period of ninety days, three assessments were taken at different stages: pre-test, post-test, and follow-up test. The outcomes were measured using the Brief Symptom Inventory (BSI) and the Goal Attainment Scale (GAS).

Coe (2000) used a 2 (number of sessions attended) x 3 (time) MANOVA to analyze the main effect for the Time factor (pretest, post, and follow-up) on BSI. The results indicate significant reduction in clients' psychiatric symptoms at post-test and follow-up test ($F = 2.98, p < .05$), as well as significant improvements in goal attainment
When compared to pre-test measurement, the follow-up tests show significant decreases in the clients’ psychiatric symptoms when compared to pretest ($F = 115.01, p < .05$). However, the follow-up tests show no significant difference in the clients’ psychiatric symptoms when compared to posttest ($p > .05$). Coe also investigated the effect that the number of group sessions attended has on the reduction of psychiatric symptoms. The clients who attended four sessions or fewer were compared with clients who attended more than four sessions. He reports no significant difference between the groups in participants’ psychiatric symptoms based on number of sessions ($F = 1.589, p > .05$).

Coe (2000) concludes that because the clients were able to identify coping strategies and continued to use those strategies after treatment ended, psychiatric symptoms were effectively reduced. This suggests that change could be a long-term process even though the clients received short-term treatment (Coe, 2000). The study lacked a control group and did not select participants randomly; therefore, one cannot definitively conclude whether the clients' ability to attain their goals was due to the treatment or due to other confounding factors such as researcher bias.

Although SFGT has been widely studied across mental health issues, outcomes research on the efficacy of SFGT is minimal, particularly in treating substance abuse clients. The previous studies on SFGT for individuals with problems stemming from alcohol and drug addiction could be traced from 1996 until present (Froerer et al., 2009; LaFountain & Garner, 1996; Metcalf, 1998; Pichot & Dolan, 2003; Smock et al, 2008; Springer et al., 2000; Zimmerman, Prest, & Wetzel, 1997). Only a few SFGT studies,
however, produced empirical evidence (de Shazer & Isebaert, 2003; Li, Armstrong, Chaim, Kelly, & Shenfeld, 2007; Proudlock & Wellman, 2011; Smock et al., 2008).

McCollum et al. (2003) used a case study design to describe the use of SFGT in treating a group of substance abuse clients \((n = 4)\). The group’s purpose was to help the members develop motivation and create change by emphasizing their goals, identifying strategies through exception questions, and stressing commonalities among group members. The treatment provided was based on Pichot and Dolan's (2003) treatment guidelines. In the single session, they focused on clients' qualities and goals while using the clients' language and directions for change. They monitored the clients' progress with scaling measures taken at the end of the session. Scaling measures indicated that all the group members identified their score as above average, meaning that they were close to obtaining their desired goals. Like other studies mentioned here, there were no outcomes or empirical evidence to support SGFT’s efficacy (McCollum et al., 2003).

McCollum et al. (2003) argue for the usefulness of a competence-based approach like SFBT in group format. Developing group therapy is considered "culturally sensitive" for treatment agencies that emphasize change in group settings. The treatment providers in different agencies are already familiar with group work and have the necessary skills to conduct group sessions. Thus, a group format will not require significant adjustments from the agency staff who truly value their role in treating clients. The suggestion also offers a good rationale for conducting SFGT in residential settings, which is congruent with the present study that is designed to be conducted in a residential setting in a multi-ethnic country (Malaysia).
Previous researchers (e.g., Metcalf, 1998; de Shazer & Isebaert, 2003) have highlighted the benefits of using SFBT in group-formats, in which mutual goals are developed in order to elicit group members’ resources and strengths. Li et al. (2007) supported this suggestion by conducting an experimental research design to compare individuals participating in multiple couples group treatment with individuals receiving individual couple treatment among clients with substance abuse issues and related mental health concerns. Twenty-seven couples \( (n = 54) \) involved in the study, in which twelve couples were randomly assigned to individual couple treatment and fifteen couples to multiple couples group treatment.

A structured SFGT was provided for couples with various substance abuse issues (a group of up to four couples) over the course of eight weeks. Solution-focused techniques were used to assist the participants to identify and reduce problems associated with substance abuse. To do that, the researchers emphasized constructing concrete and attainable goals among the group members, including the utilizing of miracle questions. The outcomes were assessed using the Brief Symptom Inventory (BSI) and the Adverse Consequences of Drug Use Scale (ACDU) at pretreatment and 6-month follow-up.

The authors report that, only twenty couples completed all treatment sessions \( (n = 40) \); 7 couples were in individual couple treatment and thirteen couples were in multiple couples group treatment. Both groups showed a significant improvement in BSI \( (F = 16.24, p < .001) \) and in ACDU \( (F = 8.85, p < .01) \) at a 6-month follow-up measurement. Of 40 participants, 18 chose abstinence, 10 chose reduction of substance use, three were undecided, and the rest had already abstained from drug use at intake. At a 6-month
follow-up measurement, 67% had achieved their goals to be abstinent or to reduce substance consumption. Even though there were no significant differences in two treatment conditions, in their discussion, the authors report that using SFBT in a group-formats has a better retention rate than individual couple treatment and suggest that group formats have more advantages in constructing goals attainment by couples working in a group versus individual couples (Li et al., 2007). The study however, used a small sample size that prohibited more in-depth analysis to control for effects of variables, such as therapist attributes.

Proudlock and Wellman (2011) presented a mixed-method evaluation pertaining to the application of SFGT in increasing overall functioning among adults with severe and enduring mental health difficulties. The sample was drawn from clients who received care under the Crisis Resolution and Home Treatment Team ($n = 8$). The authors provided 6-sessions of therapy with outcomes measured using the Mental Health Recovery Measure (MHRM) at pre- and post-treatment points. The results indicate that clients’ functioning increased above average ($Z = -2.24, p = .025$). With respect to qualitative data, the researchers report that the group cohesiveness was derived from the desire of the group members to search for solutions and resources rather than their shared experiences of problems and diagnoses. Their findings illustrate that SFGT is appropriately employed in a group where the primary focus is to provide support, identify strengths, and resources that simultaneously increase the likelihood of decreasing problematic symptoms (Proudlock & Wellman, 2011). In discussing the limitation of the study, the small sample size limits internal validity of the study.
The findings suggest that the use of SFGT can be expanded in many areas of mental health concerns including substance abuse. SFGT is appropriately applied to substance abuse clients as they come with different substance abuse histories and associated issues. In SFGT, the clients’ similarities in prior experience of problems play a small role in developing group cohesiveness. The group members’ desire to construct the solutions forms a therapeutic relationship that directs them toward change (Proudlock & Wellman, 2011).

Substance abuse clients who receive SFGT are provided flexibility to develop goals of their choice. De Shazer and Isebaert (2003) described a treatment program that was based on solution-focused approach used in a hospital to treat clients with alcohol dependence. The treatment program consisted of solution-focused individual therapy and couple or family solution-focused therapy provided for in-patient and out-patient. One hundred and eighteen inpatients ($N = 118$) and fifty-nine outpatients ($N = 59$) received the treatment program. In the treatment program, the clients’ goals were developed from solution-focused interventions (exception, miracle questions, and scaling etc.). Although clients were diagnosed with alcohol dependence, their goals that were not related to abstinence were accepted in therapy (e.g., saving marriage, keeping a job). Measurements through face-to-face and telephone interviews were conducted at four-years follow-up after the clients completed an 18-month period treatment (de Shazer & Isebaert, 2003).

The follow-up measurements indicate that 50% of inpatients ($n = 60$) reported being abstinent, 34% ($n = 40$) reported being successful at controlled drinking, and a
small percentage at 15% \((n = 18)\) reported had not reached either their goal of abstinence or controlled drinking. Meanwhile, 50% of outpatients \((n = 36)\) reported being abstinent and twenty-three outpatients reported success at controlled drinking. With respect to outpatients’ results, the authors report that 9 \((12.5\%)\) of these thirty-six abstinent clients had originally chosen controlled drinking as their first goal. This suggests that when the first goal was developed based on the clients’ choice, it was sufficient to warrant some optimism and would lead to other goals that included changing alcohol patterns or being abstinent \(\text{de Shazer & Isebaert, 2003}\). The findings of the study illustrate the importance of honoring clients’ choice of goals. Nevertheless, as the outcomes were based on client self-reports and telephone interviews, there was a lack of standardized or psychological measures of alcohol use. Specificity of the outcomes \(\text{e.g.},\) symptoms reduction, goal attainment\) is more relevant to outcomes measurement than generic success in the field of addiction \(\text{Spokas et al., 2007}\).

Trepper, Dolan, McCollum, and Nelson \(2006\), in their review of the future of solution-focused therapy, agree that the main weakness of solution-focused therapy is the lack of standardized tools that determines which techniques should be used in sessions and how the techniques are comparably distinguished from other approaches. Therefore, they recommend researchers pay more attention to treatment fidelity for future studies. This includes implementing specific guidelines and peer supervision.

Smock et al. \(2008\) emphasize details of treatment fidelity in their study. They investigated the effects of SFGT in substance abuse level 1 clients, who were referred to a community and family therapy clinic. SFGT was compared with Hezelden model of
treatment (a traditional problem-centered group approach). Fifty-six participants were recruited for the study, in which 27 participants were randomly assigned to the treatment group and 29 to the control group with measurements taken before and after treatment. However, post-treatment measurements were limited to the 38 participants (19 in the treatment group and 19 in the control group) who completed all 6 weeks of study sessions.

The outcomes were measured using the Beck Depression Inventory (BDI), the Substance Abuse Subtle Screening Inventory, and the Outcome Questionnaire. With respect to treatment fidelity, the researchers employed the Family Therapist Rating Scale to assess therapists’ adherence to SFGT framework. Moreover, each therapist was assessed by three independent evaluators to ensure the treatment provided was in fact SFGT (Smock et al., 2008).

Results indicate that clients in both treatment conditions improved overall and there were no significant differences between groups at posttreatment. However, only clients in the treatment group showed significant differences in BDI scores ($p = .002$) and in treatment outcomes ($p = .002$) and no significant differences were found in the control group for BDI scores ($p = 0.86$) and treatment outcomes ($p = .27$). These results suggest that only clients in SFGT indicated significant decrease in depression and significant improvement in treatment outcomes when comparing pre- and posttest data. Moreover, results indicate medium effect size for BDI (Cohen’s $d = .64$) and symptom distress subscale of treatment outcomes (Cohen’s $d = .61$) (Smock et al., 2008).
The authors conclude that, SFGT significantly improved treatment outcomes in participants and decreased the level of comorbid factors of substance abuse including depression and symptom distress. It is assumed that improved co-occurring symptoms of psychological distress in substance abusers who undergo drug treatment programs will allow for other aspects of recovery to emerge (Smock et al., 2008). In discussing the limitation of the study, the participants not completing the experimental group were not described or accounted for in the analysis. This limits the discussion on solution-focused approach in regards to clients’ retention rate in treatment. However, the findings from Smock’s et al study are consistent with Drake, O’Neal, & Wallach’s (2008) review of psychosocial interventions for clients with co-occurring mental health and substance use disorders. They point out that counseling interventions implemented in group therapy have positive effects on both substance use outcomes and other outcomes (non-symptom).

**Outcomes in Substance Abuse Treatment**

In reviewing treatment outcomes in substance abuse treatment, previous studies have investigated many variables that interact with treatment to predict outcomes in substance abuse that include drug of choice (Nazar et al., 2006), client motivation (McCollum et al., 2003; Hayes et al., 2010), prior treatment history (Wright & Devine, 1995), and severity of psychiatric symptoms (Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003).

In Malaysia, Ghani, Brown, Khan, Wickersham, Lim, Dhaliwal, Kamarulzaman, & Altice (2015) investigated outcomes of substance abuse programs by evaluating the
perspectives and satisfaction of clients enrolled in the Cure and Care drug treatment program. The researchers used a qualitative study for that purpose and twenty participants were interviewed ($n = 22$). The participants consisted of in-patient and out-patient clients who reported their drug of choice was opioids and amphetamine and had been receiving drug treatment for eleven months at the time of the interview. Ghani et al. report that two major themes emerged that indicate treatment outcomes in participants: diminished withdrawal symptoms and craving for drugs (drug abstinence). Moreover, they report that four components of the Cure and Care treatment program that positively contribute to outcome are methadone maintenance treatment, group therapy, religious instruction, and recreation.

With regard to group therapy components of the treatment program, the participants of the study reported that components focused on drug trigger management and behavioral change were helpful in contributing to outcomes. Focus on behavioral changes includes negative emotions management to avoid triggers for drug use relapse (e.g., anger, depression, and trauma) and aids in avoidance of legal actions. The authors conclude that an integrative drug treatment program is important in treating substance abuse issues. Moreover, they suggest that addressing psychiatric comorbidity in substance abuse clients by integrating mental health services (e.g., group therapy and peer group support) would result in increased drug treatment program retention. Although there were positive results in treatment outcomes, the researchers provide less elaboration on which approaches were used in the group therapy given to the participants in the Cure and Care treatment program and to what extent the therapy contributed to
outcomes and progress toward treatment goals. Due to the qualitative study design, how and to what extent the group therapy was helpful at contributing to treatment outcomes is difficult to determine.

Findings from Ghani et al.’s (2015) study suggest that addressing psychiatric symptoms in substance abuse clients in Malaysia (e.g., depression, anxiety, post-traumatic symptoms, adjustment disorder etc.) is worthy of effort, considering substance abuse recovery is a complex situation. Prior studies conducted in Malaysia also suggest that psychiatric symptoms affect clients’ coping strategies to manage relapse (Matshah, Halik, Kimong, Ayub, Sam Mee, & Su Kiong, 2014) and play a major role in substance abuse treatment outcomes (Khan, Sulaiman, & Hassali, 2012).

As such, previous studies have emphasized the importance of addressing psychiatric symptoms in treating substance abuse in order to produce better outcomes, such as increased treatment retention (Simpson, Joe, & Rowan-Szal, 1997), decreased chances of relapse (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004), and prolonged abstinence (Sigmon, Steingard, Badger, Anthony, & Higgins, 2000; Higgins, Sigmon, Wong, Heil, Badger, Donham, Dantona, & Anthony, 2003).

Compton et al. (2003) investigated the role of psychiatric symptoms in predicting drug treatment outcomes in substance abuse clients. They conducted an interview with substance dependent clients newly admitted to treatment using the Diagnostic Interview Schedule (DIS) and re-interviewed them at 12-month follow-up to assess the outcomes ($n = 401$). The outcomes were assessed based on the number of illicit drugs used, number of illicit substance dependence criteria met, and number of illicit substance dependence
diagnoses at one-year follow-up. The researchers used multivariate regression model to test whether psychiatric symptoms would predict outcomes.

They report that major depression has the most consistent impact on treatment outcomes, in which the mean number of clients with major depression were different as compared to clients without major depression for all three outcomes: illicit drugs used ($p < 0.02$), substance dependence criteria ($p < 0.01$), and dependence diagnoses ($p < 0.05$). Similarly, the mean number of clients with generalized anxiety was different when compared to clients without generalized anxiety for dependence diagnoses outcomes ($p < 0.05$). The findings from Compton et al’s study confirm the impact of depression and anxiety on substance abuse treatment outcomes (Compton et al., 2003). However, despite its statistically significant results in predicting the outcomes, the researchers did not address to what extent the success of the treatment of psychiatric symptoms affects substance abuse treatment outcomes.

Wright and Devine (1995) contend that conclusions with respect to overall treatment outcomes overlook a great deal of individual variation in response to treatment that includes social circumstances (e.g., unemployment, homelessness experience), drug of choice, addiction propensity and severity, prior treatment history, race, and other factors. It is important to consider client variation in order to understand their responsiveness to drug treatment. In their study, they used early childhood and adolescent experience (e.g., when the client first started using hard drugs, psychiatric problems, childhood abuse etc.), prior treatment history, race, education, and
psychological problems as independent variables to predict treatment outcomes in substance abuse treatment programs \(n = 152\).

Wright and Devine report that the regression model for all variables found significance for education level, prior treatment history, and psychological problems in predicting treatment outcomes (i.e., substance-free days, employment, total good day, and days in treatment) as compared to clients with less education. Moreover, prior treatment histories were significant predictors of outcomes in employment and total good day. However, clients with mild psychological problems indicated better outcomes only in employment and no other outcomes. The authors conclude that education is more important than prior treatment history and psychological problems in predicting outcomes. They indicate that education levels often go unnoted in treatment literature and suggest future studies to explore other individual variation in factors contributing to treatment outcome. Wright and Devine’s study provides insights into using individual variation to examine outcomes in substance abuse treatment.

Taking into account individual variation, the present study uses period of sobriety and experience of receiving treatment in substance abuse clients, in addition to psychological symptoms, to understand its impact on treatment outcomes. According to Miller and Berg (1995), in using a solution-focused approach, it is essential for the therapist to identify any period of abstinence or cutting down on substance use in clients, in order for the therapist to discover clients’ resources and strengths that took place within the period.
Summary

Review of the literature provides preliminary support for the efficacy of SFGT. Previous literature illustrates several commonalities supporting the utility of SFGT in mental health and substance abuse treatment. First, SFGT techniques (miracle questions and exception questions) are important in goal development, in which clients are provided with the flexibility to develop desired goals rather than restricted to abstinence (Coe, 2000; Hayes et al., 2010; Spilsbury, 2012). Second, focusing on changes that will take place in the future creates hope and positive emotions in clients (Froerer et al., 2009 & Springer et al., 2000). Finally, techniques in solution-focused therapy are better implemented in group formats (Li et al., 2007; McCollum et al., 2003; Smock et al., 2008; Proudlock & Wellman, 2011).

However, as previous literature has studied the utility of SFGT in western populations, the conclusions do not permit definitive generalization to non-western populations. Given SFGT’s potential to offer briefer and less intrusive therapy, it is reasonable to further examine the efficacy of SFGT for clients with substance abuse issues in Malaysia. Thus, the present study seeks to investigate the outcomes of SFGT in a residential care setting conducted in Malaysia. The study employs a quasi-experimental research design in examining the treatment outcomes and psychological well-being in substance abuse clients. The application of this methodology is further explained in chapter 2.
CHAPTER II

METHODOLOGY

This study employs a quasi-experimental research design using non-randomized pre-test and post-test single group design. A quasi-experimental design is appropriate when it will be difficult to randomly assign subjects to a group due to the nature of the study which involves social implications; policy and safety regulations; and costs in terms of time, money, and effort (Dimitrov & Rumrill, 2003). For this study, the treatment militates against the random assignment of subjects due to several factors. First, male and female clients are not placed in the same treatment center in Malaysia; thus this study only had male subjects. The second factor involves practicality and accessibility; the treatment center used in this study was located in a community in central Malaysia accessible to, and convenient for, substance abuse clients.

Other studies have also used a quasi-experimental research design to investigate drug treatment outcomes. Non-randomized pre-test and post-test design were specifically used to assess the outcomes of solution-focused group therapy (SFGT) (e.g., de Shazer & Isebaert, 2003; Smock et al., 2008; Proudlock & Wellman, 2011). In the current study, changes in the dependent variables (treatment outcomes and psychological well-being in participants) were measured by collecting data before and after treatment is administered. This method of measurement allows the researcher to examine the effects of treatment.

According to Dimitrov and Rumrill (2003), pre- and post-test research design is primarily used for measuring changes resulting from an experimental treatment.
Based on previous studies, it is considered practical for this study to employ a quasi-experimental research design that uses non-randomized pre-test and post-test single group design to investigate treatment outcomes. A single group design is considered appropriate to obtain primary data pertaining to the use of SFGT in Malaysian culture.

The dependent variables for this study are treatment outcomes and psychological well-being in participants. By examining treatment outcomes and the psychological well-being of the participants, this study hopes to be able to assess the effect of SFGT for substance abusers in a residential care setting in Malaysia.

**Research Questions**

The following research questions guided the present study:

1. What effect does solution-focused group therapy have on treatment outcomes as assessed by Outcome Questionnaire?

2. How does solution-focused group therapy increase psychological well-being of the participants immediately post-treatment as assessed by Clinical Outcome in Routine Evaluation?

3. Are there differences in indication of abuse as assessed by UNCOPE on treatment outcomes as assessed by Outcome Questionnaire?

4. Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?
5. Is there a relationship between psychological well-being of the participants as assessed by Clinical Outcome in Routine Evaluation and treatment outcomes as assessed by Outcome Questionnaire in post-treatment?

6. Which aspects of psychological well-being as assessed by Clinical Outcome in Routine Evaluation are most predictive of treatment outcomes as assessed by Outcome Questionnaire?

**Participants**

**Demographic**

The target population of the study was individuals who (a) had a history of abusing substances, (b) had relapsed as they were in recovery, and (c) were currently undergoing drug treatment in a residential care setting. It is government policy in Malaysia that male and female substance abusers are not placed in the same treatment center (Tanguay, 2011). Therefore, this study involved only male subjects. The Substance Abuse and Mental Health Services and Administration (SAMHSA, 1997) states that having a homogeneous group membership by gender is acceptable when the group members have similar cultures, even though their substance abuse issues are different.

The drug treatment center involved in this study was Cure and Care 1Malaysia Clinic, a government-assisted treatment and rehabilitation center in Malaysia. The center was located in Sungai Besi Kuala Lumpur in the Central Zone of Peninsular Malaysia. The clinic employed the alternative approach of drug treatment (ambulatory care programs). That is, individuals with substance abuse issues entered the treatment
program voluntarily through self-referral or walk-in, and not because of a court order or due to a social welfare referral. The clinic provided open-access services to treat individuals with substance abuse issues, their families, and other individuals acquainted with the substance abuser, such as employers and community leaders, who might also have been affected by his or her drug issues.

The clinic provided a 30-day, 60-day, and 90-day residential treatment program. The clients must have first gone through a detoxification process designed to alleviate their withdrawal symptoms, before continuing on to the treatment program that would help them overcome physical and psychosocial addiction to drugs. The clinic’s drug treatment program provided psychosocial modalities including early recovery, relapse prevention, spiritual guidance, and group and individual therapy. The clinic also provided the following medical care services: HIV and TB screening, regular medical check-ups, detoxification, and methadone maintenance therapy (MMT). Abstinent clients were given vocational therapy including job training and job allocation assistance (National Anti Drug Agency, 2014, para. 2).

Once this researcher received permission from the Institutional Review Board (IRB) of the university and from the research site to conduct the study, information on the target population was obtained from the NADA’s treatment and rehabilitation division. At the time of the study, there were 97 substance abusers in the treatment program. The center was run by 20 personnel including the reserve police forces and support staff. The target population consisted of Malay male clients from 19 to 60 years old from several different Malaysian states.
Power Analysis

A priori analysis was conducted using a statistical software of G*Power (Erdfelder, Faul, & Buchner, 1996) to determine the number of participants in this study to represent an adequate sample size. The analysis yielded a recommended size of 54 with a predetermined medium effect size of $r = .30$ with an alpha level at .05 and a statistical power of .80. A desired power of .80 is commonly used in education and the behavioral science research (Lomax & Hahs-Vaughn, 2013). The researcher anticipated an attrition rate of 10% of the participants. Accordingly, the study’s sample size of 57 was sufficient to perform statistical analysis.

Inclusion and Exclusion Criteria

The participants were screened for inclusion in the study and were invited to give their informed consent. The inclusion criteria of the participants were: (a) subjects had had a history of abusing substances (opiate, marijuana, hallucinogen, benzodiazepine, tobacco, alcohol, inhalant, and ATS) that had had an impact on their normal functions; (b) subjects had undergone the detoxification process to remove and stabilize the withdrawal symptoms prior to participating in the treatment program; (c) subjects had experienced relapse at least once during their recovery; and (d) subjects would be able to stay in the center for at least four weeks to fully participate in group therapy.

The exclusion criteria included the following: (a) subjects exhibiting psychosis symptoms and in need of long-term treatment, e.g., hospitalization; (b) subjects who had not experienced a relapse during recovery; (c) subjects whose sole addiction was alcohol; (d) subjects who abused methadone or suboxone; and (e) subjects who exhibited organic
brain syndrome. Organic brain syndrome refers to decreased mental functioning due to brain injury or cardiovascular disorder; that is, there are medical, not psychiatric reasons for the mental illness. The symptoms of organic brain syndrome include short-term loss of brain function and inability to interact with others.

**Procedures of Data Collection**

**Group Description**

IRB approval was obtained prior to conducting the study. In addition, a letter of approval was obtained from the treatment center before treatment administration. The approval letters permitted the researcher to access the subjects' record, to perform screening, and to provide SFGT for four weeks. The counselor at the Cure and Care 1Malaysia Clinic site provided the list of names and records of the individuals receiving drug treatment. The records contained information about their substance abuse history, the frequency of use, the substance abuse symptoms, the substance-related issues, and injection drug use. The subjects' information pertaining to their medical, psychiatric and psychological histories were also obtained from the records.

Based on the record information, the clinic counselor screened sixty potential participants for inclusion in the study based upon a document provided by the researcher that outlined the inclusion and exclusion criteria of the study. The clinic counselor then conducted observational assessments toward potential participants to ascertain that the participants exhibit symptoms indicating co-occurring issues in substance abuse. Length of time for observational assessments was two days that took place during the day. The determination of co-occurring symptoms in substance abusers was decided when their
conditions did not fulfill the symptoms set for other major disorders in DSM 5 (e.g., major depression or personality disorder) and conditions did not warrant further psychiatric and medical attention during the time of the study.

During the observational assessment period, the clinic counselor observed changes in the participants' mood and behavior, and determined whether the participants were minimizing or exaggerating their symptoms. The Treatment Improvement Protocol developed by the Substance Abuse and Mental Health Services and Administration (SAMHSA, 2005) discussed the importance of observation in determining co-occurring symptoms in substance abuse clients, in addition to self-reporting and clinical interview. The clinic counselor was a licensed counselor who observed the participants and met with them every day at the center.

Following completion of the screening and assessment process, the participants were invited to be scheduled for a pre-group session. The pre-group session was an introductory session during which the purpose of the study was explained to participants. The researcher, who was also the group therapist, introduced herself and shared her experience and qualifications with the group. Participants were advised that an audio recording would be used in the group session to capture the responses of the therapist. The participants were reminded that the recordings were used for therapist assessment; to ensure that treatment delivered to them was in fact solution-focused group therapy and the group members’ information would not be retrieved or transcribed from the recording. To minimize discomfort among group members, the recorder was placed
close to the therapist during the group therapy session and not pointing toward any
specific participant.

Of sixty potential participants, fifty-seven agreed to participate in the study and
they were informed that they would not have standard group therapy at the treatment
center. However, they could still continue to have other regular therapy sessions at the
center, such as individual counseling sessions, peer group sessions, and spiritual guidance
sessions. They were also informed that they were allowed to leave SFGT sessions at any
point in time if they so wished. The participants understood that their participation in the
study would not influence the length of their treatment.

Furthermore, the participants were informed that they would not be terminated
from SFGT if they missed one session. If they missed two consecutive sessions, they
would be contacted by the researcher in order to determine their intention to continue
participating in SFGT. The participants understood that if they decided to leave SFGT,
their data would be collected and included in the study and they would still have access to
the standard group therapy at the treatment center.

Confidentiality and safety were emphasized during the pre-group session.
Pertaining to the safety or potential risks to participants while participating in the study,
they were provided with contact information for the counselors at the center who were
accessible 24 hours per day. In addition, the participants would be able to reach out for
help to peer support members, who were also available 24 hours per day as they also live
in the center. Peer support was a group consisting of recovering addicts who had
achieved sobriety for more than 90 days. They were usually in the process of being reintegrated back to the community.

The participants who agreed to participate in the study would be asked to sign the Participants Statement of Consent (Appendix B). Following completion of the consent form, an instrument booklet consisting of demographic information, indication of abuse, the Outcome Questionnaire, and the Clinical Outcome in Routine Evaluation instrument was distributed to each participant. The instruments were administered in a suitable room with basic facilities, such as tables, chairs, and fan. The instructions for each instrument were read aloud by the researcher to ensure that participants understood how to complete the items. The participants were given 30 minutes to answer the questionnaires. They were provided assistance when they had questions or difficulties in responding to the items and additional time was given when more time to complete the questionnaire was needed.

After the pre-group session, the group comprised of fifty-seven participants was formed and scheduled to meet for 1.5 hours once weekly over the next four weeks. This was a homogeneous closed-group format where new members would not be admitted once the treatment has begun. The researcher led the group.

The data from two instruments: the Malay version of the Outcomes Questionnaire and the Clinical Outcome in Routine Evaluation were collected at the pre-group session and at the end of the group therapy at week four. The instruments measured treatment outcomes and psychological well-being in participants.
Treatment

The independent variable of this study was the treatment program consisting of SFGT as described by Pichot & Dolan (2003). Solution-focused therapy in a group format is based on the individual therapy format of solution-focused brief therapy (SFBT). Similar to SFBT, the SFGT treatment will include exception questions and miracle questions. The difference between solution-focused in individual and group sessions is that the therapist implements the techniques simultaneously with the members of a group instead of one-to-one with a client (Pichot & Smock, 2009). In the study of drug addiction, group work in treating substance abuse is considered a more powerful therapeutic tool than individual therapy (SAMHSA, 2005). In this study, a solution-based approach was utilized to facilitate the group members' progress through strategies outlined in SFGT.

Implementing the strategies simultaneously requires a skillful therapist to include all group members' goals and expectations so that each feels respected and understood. Pichot and Smock (2009) identify five key areas that make SFGT unique: (a) the group is treatment-plan driven; (b) clients are focused on themselves and their goals; (c) the group is seen as a place to work on individual miracles; (d) clients gain unique benefits from working in a group setting; and (e) the therapist takes a neutral and curious stance when addressing norms (p. 116).

A treatment manual was used as the guideline for this study to ensure that the interventions and strategies used were standardized across sessions. Three solution-focused manuals have been identified in previous studies pertaining to group work. First,
Pichot and Dolan (2003) describe steps and strategies of SFGT. Their manual was used in McCollum et al.’s study (2003) with substance abuse clients, in which interventions and strategies were utilized in a group format setting. Second, the manual for SFBT developed by the Research Committee of the Solution-Focused Brief Therapy Association (2013) was designed to work in individual formats and has been used widely in drug addiction problems in previous studies (Hayes et al., 2010; Spilsbury, 2012). The third manual, developed by Proudlock and Wellman (2011), outlines strategies and steps of solution-focused therapy focusing on a session-basis outline, which consisted of six sessions that involved subjects with mental health difficulties.

Considering the differences among the manuals, this study adopted Pichot and Dolan's manual of SFGT as it was specifically utilized to treat substance abuse clients (McCollum, Trepper, & Smock, 2003; Pichot & Smock, 2009; Smock et al., 2008). The manual consists of 12 steps of SFGT:

1. Ask Group Introduction Question. Invite group members to identify themselves when they answer the question.

2. The group therapist silently identifies common themes from group answers and finds a broader theme that includes all common themes.

3. The group therapist reflects out loud the theme of group.

4. The group therapist asks the group’s permission for the group to address the theme identified unless another issue (emergency) needs to be addressed.

5. Ask a future-oriented question based on the theme.

6. Get as many details as possible about the future-oriented question asked.
7. Listen for any exceptions mentioned by the group members and follow up any
exceptions by getting as many details as possible.

8. Ask scaling questions to determine clients’ current level of progress toward their
goal.

9. Find out what the clients have done to have reached and maintained their current
level of progress.

10. Find out where the client thinks other people in his or her life would rate him or
her and what the client is doing that would cause them to rate him or her there.

11. Ask group members what role the theme plays in working towards their miracles.

12. Give group members “feedback” from the theme. Invite the clients to assign
themselves homework by passing out homework sheets.

The major techniques of SFGT are drawn from the 12 steps described in the
previous studies (Meyer & Cottone, 2013; West, 2010; Smock et al., 2008; Coe, 2000),
which were used in the current study (Appendix D). In this study, the therapist took a
less structured approach in applying the solution-oriented techniques and strategies, in
facilitating activities, and in assigning tasks due to the closed membership and
homogenous composition of the group. That is, the group therapist provided flexibility
for the group members to address other issues that were not centered on a specific theme.
The focus was to encourage the group members to know what was important in order for
them to develop solutions to their problems.

In this study, the participants received four sessions of treatment consisting of
SFGT. The determination of the four-week treatment was based on the purpose of the
therapy, which was to promote change with brief interventions in a more cost-effective manner. Fewer sessions, which provide participants with active interactions and interventions, are useful since many substance abuse clients drop out after a few sessions due to other substance abuse-relations issues like relapse, acute withdrawal symptoms when the clients misuse substitution drugs (e.g., methadone, suboxone), and health problems (McCollum et al., 2003).

De Shazer (1991) reports that an average of five sessions is typical of solution-focused therapy. Previous studies show that even brief interventions with clients could be effective and produce long-lasting change (Miller & Willoughby, 1997; Miller, 1993). In drug addiction treatment, health care economics including managed care agencies prefer short-term treatment as long-term treatment is typically not feasible or practical due to multiple factors, such as funding constraints, limited number of professional mental health workers in a center, and the nature of the addiction disorder (West, 2010). However, Coe (2000) recommends an average of four sessions for SFGT in a community mental health setting. In his study, the scores of participants who attended two sessions were compared to the scores of participants attending four sessions. The results showed the length of the treatment program did not have a significant effect on the reduction of the participants’ variance in treatment effects on psychological symptoms (Coe, 2000).

**Treatment fidelity.** To ascertain that treatment delivered by the therapist in the group was in fact SFGT, two licensed counselors were appointed as evaluators to assess the therapist’s fidelity to the SFGT model. The evaluators were not present during group sessions, but recorded their observations from audiotaped SFGT sessions. Using the
audio recordings, the evaluators determined their judgment of SFGT techniques, phrases, and interventions they heard being employed during the session and recorded their observations on the session analysis form.

The evaluators used the SFGT manual (12 steps) and the solution-oriented group therapy analysis form attached to the treatment manual to assess how the therapist used the techniques, strategies, phrases, and interventions suggested in the manual during group sessions (see Appendix J). The therapy analysis form consists of illustrative solution-focused approach statements (e.g., *What is better since the last session? What will you be doing if you are not depressed?*). The evaluators tabulated each statement they considered to be solution-focused as a “Yes” and other statement as a “No” by placing a tally mark in the appropriate row. To calculate the analysis form, the responses were totaled and the scores were presented as a ratio of solution-focused interventions and interventions rated as being non-solution focused.

The evaluators conducted the evaluation at the end of every week’s session over the 4-weeks of the study period. To score the therapist, the analysis measures of fidelity issues in SFGT were adapted from Coe's (2000) wherein the score of 75% was established as a standard threshold to validate or invalidate the application of SFGT interventions and strategies in group treatment. The therapist, therefore, needed to attain an overall score of 75% or better in order to ensure that the participants actually received solution-focused interventions rather than other types of intervention.
Instrumentations

The treatment outcomes were assessed using two instruments; the Outcome Questionnaire -45.2 (OQ-45; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994) and the Clinical Outcome in Routine Evaluation (CORE; Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne, et al, 1998). The researcher prepared an instrument package that consisted of three sections.

Section A asked for client demographic information (i.e., age, race, marital status, and religion), substance abuse history (relapse experience, period of sobriety, types of drug, drug treatment, among others), readiness to change, and indication of abuse. In the “readiness of change” question in Section A, participants were asked to identify what level of readiness closely reflected their situation. These levels (recognition, ambivalence, and taking steps) were based on the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) by Miller and Tonigan (1996). Recognition refers to participants’ acknowledgment of their problem of drug addiction and demonstration of a desire to change, however they are not ready for change. Ambivalence, on the other hand, refers to participants’ doubt about making changes and uncertainty that their involvement in drug addiction can cause harm in their lives and affect other people. Taking steps refers to participants’ willingness to take action and expend the effort necessary for them to change toward recovery including participation in a drug treatment program and seeking a support group to maintain relapse prevention. This identification is helpful in assessing the compatibility of the participants’ levels of readiness prior to receiving SFGT.
The participants’ indication of abuse was assessed by UNCOPE question (Hoffmann, Hunt, Rhodes, & Riley, 2003). UNCOPE is comprised of six yes-or-no questions that assess the participants’ risk for substance abuse or dependency. Dependence in drug addiction is used to reflect the more chronic condition with greater expectation of continued problems (i.e., long-term treatment, referral, etc.) as opposed to abuse (less chronic condition with lesser expectation of continued problems such as short-term treatment, recovery under community supervision, etc.). A score of four or more positive UNCOPE items indicates dependence (Hoffmann et al., 2003) while less than four indicate abuse.

Section B was the Outcome Questionnaire-45.2, while Section C was the Clinical Outcome in Routine Evaluation. The sections below describe each of the instruments, as well as their reliability and validity.

**The Outcome Questionnaire - 45.2**

The Outcome Questionnaire- 45.2 (OQ) was used to address treatment outcomes that were measured during the pre-group session and after four-week group therapy sessions at the end of the study period. Lambert, Lunnen, Umphress, Hansen, and Burlingame (1994) were the original developers of the OQ. The OQ is a 45-item self-reporting scale used to measure the efficacy of clinical interventions in therapy, as well as to help enhance those interventions. The instrument is designed to be short, cost-effective and measure changes over time. The treatment outcome is assessed by evaluating three subscales: symptom distress (SD, 25 items), social role functioning (SR, 9 items), and interpersonal relationships (IR, 11 items). The subscales are used to
determine any problems in the patients’ everyday functions, and to assess how
interventions may be embedded in a treatment plan and tracked over time (Lambert et al.,

The symptom-distress dimension measures general emotional and lifestyle
stressors such as anxiety, depression, stress, substance abuse, and suicidality (e.g., "I feel
no interest in things"). The social role functioning dimension measures the participants'
social relations and leisure activities (e.g., "I find my work/school satisfying"). The
interpersonal relationships dimension assesses participants' satisfaction with marital,
family, and friendship relationships (e.g., "I feel unhappy in my marriage/significant
relationship"). Participants respond to the items using a 5-point Likert scale ranging from
0 (never) to 4 (always) based on their recollection of the preceding week (Lambert,
2012).

The OQ score is calculated by summing all values identified by the clients after
reverse scoring is conducted on nine items (1, 12, 13, 20, 21, 24, 31, 37, and 43). This
yields a total score ranging from 0 to 180, in which higher scores indicate poorer
outcomes, and inversely lower scores indicate better outcomes. The results were
analyzed based on the total mean score and the mean scores for each three subscales.
Scores for each subscale were calculated by taking the mean for each of the domain
areas, while the overall outcomes scores will be derived by taking the mean of all items.
In addition, the standard deviation was calculated for each subscale and overall outcome.

Lambert, Hansen, Umphress, Lunnen, Okiishi & Burlingame et al. (1996) report
an overall internal consistency and reliability of .93 in a clinical sample and reliabilities
of .91, .74, and .71 for SD, IR, and SR subscales respectively. In a recent study, Boswell, White, Sims, Harrist, and Romans (2013) conducted further psychometric analysis of OQ to provide additional support for the three subscales in OQ and the Total score. Boswell et al. investigated the internal consistency for each subscale and examined the underlying constructs by measuring the correlation between the clients' presenting concerns (e.g., relationship issues, sexual orientation, alcohol/drug problem, etc.) with the subscale scores and the Total score. Internal consistency for Total score was .94 and .93, .78, and .70 respectively for the SD, IR, and SR subscales. Presented concerns associated with anxiety, depression, and stress correlated the highest with Total score and SD subscale \( p < .05 \). The IR subscale was correlated significantly with presenting concerns of relationship and family issues, sexual orientation, and body image. The SR subscale was found to be significantly correlated with concerns about career indecision as the subscale measures social relations that include work/school satisfaction.

In addition to the high reliability and validity values of the OQ, the items of the questionnaire were determined to be highly sensitive to change and highly responsive (Vermeersch, Lambert, & Burlingame, 2000). Vermeersch et al. used hierarchical linear modeling to analyze the items’ sensitivity to change. They discovered that 37 items representing each subscale were sensitive to change, and therefore valid for measuring change, but that 8 items were less sensitive to change. Two possible explanations for the lower degree of sensitivity are: the symptoms measured by these items are static in nature; or the symptoms also tap into a physiological complaint that would need a longer period of treatment to see changes in the client (e.g., physiological complaint in symptom
distress subscale; "I have sore muscles"). Overall, the items of the OQ reliably measure long-term changes that occur following participation in therapy (Vermeeersch et al., 2000).

The OQ had been translated into numerous languages including Italian and Swedish (de Jong, Nugter, Polak, Wagenboorg, Spinhoven, & Haiser, 2007; Lo Coco, Chiappelli, Bensi, Gullo, Prestano, & Lambert, 2008; Wennberg, Philips, & de Jong, 2010). The OQ has also been validated across population groups that include college populations and substance abusers (Beretvas & Kearney, 2003; Wennberg et al., 2010). In addition, the OQ has also been tested across ethnicities including African American, Asian/Pacific Islander, Hispanic, and Native American clients (Beretvas & Kearney, 2003; Lambert, Smart, Campbell, Hawkins, Harmon, & Slade, 2006). Lambert et al. (2006) asserted the importance of using instruments in psychotherapy that had been tested and validated with ethnic minorities in order to meet their needs in mental health services.

Because the OQ -45.2 has been tested in multiple languages and cultures and has been shown to reliably assess the participants' progress, the instrument was considered to be appropriate for translation into Malay language and tested with a Malaysian population. The OQ was translated into Malay language using back translation procedures (see Appendix I for a complete back translation flow). A pilot study using the Malay version of the OQ was conducted for reliability measurement. The pilot study was conducted with forty individuals with substance abuse issues: who were undergoing a drug treatment program at Malaysia Prison and Correctional Facility. The Malay version of the OQ obtained an overall internal consistency value of Cronbach's alpha .91, which
is considered acceptable reliability as reported in the previous studies (e.g., Boswell et al., 2013; Lambert et al., 1996).

The Clinical Outcome in Routine Evaluation

The Clinical Outcome in Routine Measure - Outcome Evaluation (CORE - OM; Mellor-Clark, Barkham, Connell & Evans, 1999) was used to assess the status of the participants' psychological well-being over the course of treatment. The assessment was conducted during the pre-group session and at the end of the group therapy sessions (at week 4). The CORE - OM consist of 34 items that measures four subscales of psychological well-being: symptoms that includes depression, anxiety, and trauma (12 items); general well-being (4 items); life functioning (12 items); and risk/harm to self (6 items). The items are presented in a 5-point Likert scale (0 = not at all to 4 = most all the time).

The CORE-OM is calculated by adding the response values of all items, which produces scores ranging from 0 to 136. The higher score indicates the more distressed the clients are. The results were analyzed based on the total mean score and the mean scores for each of the four subscales. In addition, the standard deviation was calculated for each subscale and total score (Mellor-Clark et al., 1999).

Mellor-Clark et al. (1999) developed the CORE - OM as an outcome evaluation tool to address the need for a standardized evaluation and routine outcomes assessment in order to provide appropriate and effective treatments. The development of the CORE - OM was based on the model for evidence-based practice proposed by the National Health Service Executive (NHSE) of the United Kingdom. The instrument has been widely
examined for its reliability, validity, convergent validity in relation to other measures, and sensitivity to changes in values.

Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark, and Audin (2002) investigated those values in clinical and non-clinical samples. The authors used data from college students \((n = 1106)\) drawn from a university and from clinical sample \((n = 890)\) drawn from twenty-three clinical sites. The authors reported the Cronbach alpha as \(\alpha = .94\) for both groups. Additionally, 55 sample from non-clinical group \((n = 1106)\) was used for test-retest stability. The correlations were highest within the CORE - OM subscales ranging from 0.87 to 0.88 except for the risk subscale (0.64). The authors concluded that these results were unsurprising in view of the reactive nature of the items. Furthermore, the CORE - OM was found significantly correlated with other psychological instruments that measure the same variables, such as Symptom Checklist - 90-Revised \((r = .88)\) (Evans et al., 2002).

Ming (2001) also conducted a study using the CORE - OM in a sample drawn from the Chinese community in Britain to investigate the generalizability of the measurement with a multi-ethnic society. The author had 133 participants from the Chinese community who responded to either the CORE-OM original version (English) or Chinese translated version. Several nationalities were included in the study – 51.9% of the participants were British, 21.7% were Chinese, 6.2% were Hong Kongese, 11% were Malaysian, and the rest were Singaporean and Taiwanese. Chinese was the first language for a majority, or 64.7%, while the rest of the participants had English as their first
language. According to the authors, coefficients for the CORE-OM were reported as $\alpha = .93$ and $\alpha = .88$, for the original CORE and Chinese CORE, respectively (Ming, 2001).

Skre, Fribog, Elgaroy, Evans, Myklebust, and Lillevoll et al. (2013) reported a similar coefficient ($\alpha = .94$) with a diverse clinical sample using the Norwegian language version of the CORE-OM. Test-retest reliabilities were reported to be adequate over a period of two weeks for the Norwegian version with $r = .76$, and $r = .87$ for the English version. Scores on the CORE-OM confirmed that the scale was able to examine changes in the clients’ routine outcomes assessment (Skre et al., 2013). In another study, Joseph, Lewis, and Olsen (1996) examined the convergent validity of the CORE-OM with other measures of outcomes assessment with findings that suggested that the internal reliability of the CORE-OM compared favorably with three measures of depressive symptomology, namely, Beck Depression Inventory, Self-Rating Depression Scale, and the Center for Epidemiological Studies Depression Scale.

CORE-OM is considered appropriate for translation into the Malay language and for testing with a Malaysian population because CORE-OM has been tested using several languages, tested across different cultures, and has demonstrated its ability to assess the participants' progress in routine settings. The CORE-OM was translated into Malay language using back translation procedures (see Appendix I for a complete back translation flow). A pilot study using the Malay version of the CORE-OM was conducted for reliability measurement. The pilot study was conducted with forty individuals with substance abuse issues: who were undergoing drug treatment at Malaysia Prison and Correctional Facility. The Malay version of the CORE-OM
obtained overall internal consistency value of Cronbach's alpha .83. The alpha value was in the range consistent with reliability scores by the previous studies (e.g., Ming, 2001; Skre et al., 2013).

**Confounding Variables Management**

Previous studies have identified extraneous factors that could influence variation in treatment outcomes (e.g., Smock et al., 2008). For substance abuse research that uses an outcome study design, confounding variables are associated with the therapist and participants of the study, such as the therapist’s adherence to solution-focused approach and the participants’ differences in personal characteristics (e.g., extrovert, introvert, etc.). It is imperative, therefore, that the researcher addresses and manages these issues in order to produce a quality outcome study (Wiersma & Jurs, 2009).

The research can deal with potential confounding variables either at the study design stage or at the analysis stage. This study opted for the first option as recommended by the previous study that applied quasi-experimental design in SFGT (Coe, 2000 & Smock et al., 2008). The SFGT analysis form that was used in addressing treatment fidelity of the study was also used to represent therapist adherence to solution-focused methods. According to Coe (2000), the SFGT analysis form consists of main tenets of solution-focused therapy (e.g., scaling questions, identifying exceptions, and discovering solutions, etc.) with the therapist’s score of 75% or more required to ensure therapist adherence to solution-focused assumed.

Holding factors constant was used to control and minimize confounding variables associated with the participants' ability of change. First, the same therapist delivered the
treatment and the length of treatment for the group was built into the research design. Second, the participants involved in the study were restricted to substance abusers who had experienced a relapse at least once prior to the beginning of group therapy treatment. The purpose of the restriction was to group the individuals who have had similar characteristics in relation to the confounder. Therefore, any potential confounding effects coming from the first-time client will be eliminated. Because the group being treated in this study was homogeneous by gender, the generalizability of the study’s results might be limited and may reduce its external validity.

**Data Analysis**

The determination of data analysis procedures was guided by the research questions of the study. Descriptive statistics that involved percentages, frequencies, means, and standard deviations were applied to explain the participants’ demographic information. Paired t-tests were also used to compare the effect of SFGT on treatment outcomes as well as psychological well-being of the participants at pre- and post-test. Moreover, independent t-tests were performed to compare mean scores between substance abuse and substance dependence indications on treatment outcomes of participants at post-treatment.

Simple linear regression was used to analyze the relation between period of sobriety and treatment outcomes, while a Pearson correlation was utilized to examine the relationship, the direction, and the strength of the relationship between treatment outcomes and psychological well-being. However, the relationship identified does not equate to causation between variables. A multiple linear regression model was used to
further explore whether participants’ psychological well-being could predict treatment outcomes. The data were processed using Statistical Package for Social Science (SPSS) Version 23.

Summary

In this chapter, the research questions of the current study were presented and the study’s design, methods, and data analysis were described. The treatment procedures, instruments used, and data collection for the study were also described. In Chapter 3, the findings of the current study are presented.
CHAPTER III
RESULTS

The previous chapter outlined the specific methodology of this study and the results of data analysis are presented in this chapter. This study investigated the effect of solution-focused group therapy (SFGT) for substance abusers in a residential care setting conducted in Malaysia as assessed by the Outcome Questionnaire (OQ) and the Clinical Outcome in Routine Evaluation (CORE). The researcher used a quasi-experimental, pre- and post-test single group research design to answer the following questions:

1. What effect does solution-focused group therapy have on treatment outcomes as assessed by Outcome Questionnaire?

2. How does solution-focused group therapy increase psychological well-being of the participants immediately post-treatment as assessed by Clinical Outcome in Routine Evaluation?

3. Are there differences in indication of abuse as assessed by UNCOPE on treatment outcomes as assessed by Outcome Questionnaire?

4. Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?

5. Is there a relationship between psychological well-being of the participants as assessed by Clinical Outcome in Routine Evaluation and treatment outcomes as assessed by Outcome Questionnaire in post-treatment?
6. Which aspects of psychological well-being as assessed by Clinical Outcome in Routine Evaluation are most predictive of treatment outcomes as assessed by Outcome Questionnaire?

This chapter outlines the results of the investigation. It is divided into three sections; participant demographics, a review of the statistical quantitative data analysis, and a summary of the findings.

**Participant Demographics**

A total of 97 clients who received residential treatment at Cure and Care Malaysia Clinic were eligible for this study. Fifty-seven clients met participant inclusion criteria; agreed to participate in the study and completed pre- and post-test measurements of the study. The participants had gone through the detoxification process to remove withdrawal symptoms and had been in treatment for at least 30 days. From the total \( n = 57 \), six groups of solution-focused group therapy (SFGT) were formed and scheduled to meet once per week for over four weeks. With respect to attendance, 57 participants came to the session consistently for four weeks.

All participants were males of Malay ethnicity, who identified their religion as Islam \( n = 57 \). Their ages ranged from 19- to 60-years-old with a mean age of 33. The majority of participants (45.6%) were below the age of 30, 33.3% were below the age of 40, while the remainder (21.1%) ranged in age from 40- to 60-years-old. With respect to participants’ marital status, a majority (71.9%) were single, 19.3% were married, and the remainder (8.8%) were divorced. A full representation of participant demographics data can be found in Table 1.
Table 1

*Distribution of Participants by Demographic Characteristics (n = 57)*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malay Group</td>
<td>57</td>
<td>100</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>57</td>
<td>100</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 to 30</td>
<td>26</td>
<td>45.6</td>
</tr>
<tr>
<td>31 to 40</td>
<td>19</td>
<td>33.3</td>
</tr>
<tr>
<td>41 to 60</td>
<td>12</td>
<td>21.1</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>41</td>
<td>71.9</td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td>19.3</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>8.8</td>
</tr>
</tbody>
</table>

**Substance Abuse History**

This section presents the distribution of the participants’ demographics by substance abuse history that includes number of relapse episodes, types of drug used, experience of receiving drug treatment in the past, period of sobriety, indication of abuse, and readiness for change. Data analysis indicated that 33.3% participants had experienced relapse episodes at least once, fewer participants (29.8%) had relapsed twice, 19.3% had relapsed three times, while the remainder of participants (17.5%) of the participants had experienced four or more times relapse episodes.
In terms of types of substance used, 12 participants (21.1%) reported amphetamine-type stimulants (ATS; e.g., ice, meth, crystal, etc.) as their drug of choice, meanwhile nine participants (15.8%) reported heroin as their drug of choice. However, most participants (63.7%) reported using more than one substance: 15.8% reported using heroin and ATS; 19.3% reported using heroin, ATS, and marijuana; and 14.0% reported using heroin, cocaine, ATS, marijuana, and another substance (e.g., ecstasy, LSD, etc.).

The participants’ experience in receiving drug treatment at other centers prior to entrance to the current residential treatment program (Cure and Care 1Malaysia Clinic) was also analyzed in demographic information. With respect to treatment experience, the majority of participants (66.7%) had previously received drug treatment one time, 12.3% of participants had been in drug treatment twice, two participants (3.5%) with three prior treatment experiences, and 10.5% of the participants had gone through drug treatment experiences four or more times. Despite having had at least one relapse event (an inclusion criterion), four participants (7.0%) had never had any drug treatment experience in the past.

With respect to period of sobriety, data analysis indicated that the longest period the participants had lived in sobriety prior to entrance to the current residential treatment (Cure and Care 1Malaysia Clinic) was 12 years and the shortest period was six days. More participants reported having previously maintained sobriety for two months ($n = 11$) and three months ($n = 11$) than any other length of time reported. Five participants reported a maximum period of five months, and nine participants reported periods of over one year. Specifically, two participants reported one year, two reported one year and two
months, one reported five years, two reported ten years, and one participant reported 12 years of sobriety. A specific distribution of participant periods of sobriety can be found in Table 2.

With respect to indication of abuse, data analysis indicated the participants’ risk for substance abuse or substance dependence. Dependence in drug addiction is used to reflect a more chronic condition with greater expectation of continued problems that needs long-term treatment and intensive care as opposed to abuse. Data showed that 44 participants (77.2%) were identified as substance dependent, while 13 participants (21.7%) were classified as substance abuse. A distribution of participant demographics by substance abuse history is presented in Table 2.

Although not specified as a variable to answer research questions in this study, participants’ level of readiness to change was identified to examine the comparability prior to receiving SFGT. Data analysis showed that 33 participants (57.4%) were at recognition level of readiness to change, while 24 participants (42.6%) were at ambivalence level. These two levels indicate different levels of readiness to change, however individuals share some similarities in the way in which they acknowledge their problem of drug addiction and have doubt about making changes. Thus, the results suggest that participants’ level of readiness to change was comparable prior to receiving SFGT.
Table 2

Distribution of Participants by Substance Abuse History (n = 57)

<table>
<thead>
<tr>
<th>Substance Abuse History</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Relapsing Episodes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>19</td>
<td>33.3</td>
</tr>
<tr>
<td>Twice</td>
<td>17</td>
<td>29.8</td>
</tr>
<tr>
<td>Three times</td>
<td>11</td>
<td>19.3</td>
</tr>
<tr>
<td>Four or more times</td>
<td>10</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Type of Substance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin, only</td>
<td>9</td>
<td>15.8</td>
</tr>
<tr>
<td>ATS/Ice/&quot;Syabu,&quot; only</td>
<td>12</td>
<td>21.1</td>
</tr>
<tr>
<td>Heroin and ATS</td>
<td>9</td>
<td>15.8</td>
</tr>
<tr>
<td>Cocaine, ATS and marijuana</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Heroine, cocaine, ATS, marijuana, and another substance (e.g., ecstasy, LSD)</td>
<td>8</td>
<td>14.0</td>
</tr>
<tr>
<td>ATS and marijuana</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Heroine, ATS, and marijuana</td>
<td>11</td>
<td>19.3</td>
</tr>
<tr>
<td>Heroine, ATS, marijuana, and alcohol</td>
<td>5</td>
<td>8.8</td>
</tr>
<tr>
<td><strong>Experience of Receiving Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>One time</td>
<td>38</td>
<td>66.7</td>
</tr>
<tr>
<td>Two times</td>
<td>7</td>
<td>12.3</td>
</tr>
<tr>
<td>Three times</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Four or more times</td>
<td>6</td>
<td>10.5</td>
</tr>
<tr>
<td><strong>Period of Sobriety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 days</td>
<td>3</td>
<td>5.6</td>
</tr>
<tr>
<td>1 month 8 days</td>
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<td>1.9</td>
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<tr>
<td>1 month 15 days</td>
<td>1</td>
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<tr>
<td>1 month 25 days</td>
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<td>1.9</td>
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<tr>
<td>2 months</td>
<td>11</td>
<td>20.4</td>
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<td>3 months</td>
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<td>4 months</td>
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<td>3.7</td>
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<td>1.9</td>
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<tr>
<td><strong>Indication of Abuse</strong></td>
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</tr>
<tr>
<td>Substance Abuse</td>
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<td>22.8</td>
</tr>
<tr>
<td>Substance Dependence</td>
<td>44</td>
<td>77.2</td>
</tr>
</tbody>
</table>

\(^a n = 54. Three participants did not complete information on period of sobriety\)
Missing Data

A total of three participants were excluded from analysis research question four (Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?), failing to complete the period of sobriety information.

According to Treiman (2009), listwise deletion is the most commonly used method for dealing with missing data. He asserts that the listwise method is more robust than other methods (e.g., mean substitution, proxy method, etc.) for regression analysis. In addition, according to Enders (2010), listwise deletion should be used when the proportion of the missing data is small. This procedure allows for a conservative approach. Thus, the researcher chose to drop three cases with missing data points from period of sobriety. This resulted in a total of 54 participants to investigate the relationship between the period of sobriety and treatment outcomes. Even after deletion, the total of 54 participants was sufficient to perform statistical analysis as a priori analysis of G*Power recommended size of 54.

Instrument Reliability

Chapter 2 presented the initial reliability values established by Lambert et al. (1996) for the Outcome Questionnaire – 45.2 (OQ) and Evans et al. (2002) for the Clinical Outcome in Routine Evaluation (CORE). The internal consistency values obtained from the pilot study for the Malay version of OQ and CORE were also presented in chapter two.

In this study, the Malay version of OQ and CORE obtained overall internal consistency values of Cronbach’s alpha .93 and .87 respectively. Reliability scores for
the instruments in this study were in the range consistent with the initial reliability scores established by the authors of the instrument.

**Confounding Variables Management**

The current study used an outcome study design to investigate the effects of SFGT on substance abuse clients conducted in Malaysia. Previous studies have identified that treatment fidelity of SFGT or the therapist’s adherence to a solution-focused approach is an extraneous factor that influences variation in the treatment outcomes (e.g., Coe, 2000; Smock et al., 2008). Therefore, the researcher used the SFGT Analysis Form (see Appendix J) to reduce and minimize improbable confounders from this source on treatment outcomes. In this study, the researcher was the therapist.

Two licensed counselors were appointed as evaluators to evaluate the therapist, who each listened to six audiotaped recordings of SFGT sessions at the end of every week over 4-weeks sessions (24 recordings). While listening to audiotaped sessions, they rated items on the session analysis form by tallying in the appropriate column their judgment of whether SFGT techniques, phrases, and interventions they heard being employed during the session. The ratio of the session analysis is presented in Table 3.

The data indicated that 90.84% of the interventions used by the researcher in the group sessions were considered by the evaluators to be solution-focused. This meets the criterion 75% cutoff score selected prior to the study (Coe, 2004) to confirm the treatment fidelity of the study. The result also suggests that the main tenets of
Table 3

*The Ratio of the Session Analysis*

<table>
<thead>
<tr>
<th>Week</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E1</td>
<td>E2</td>
<td>E1</td>
<td>E2</td>
<td>E1</td>
<td>E2</td>
<td>E1</td>
</tr>
<tr>
<td>One</td>
<td>142/12</td>
<td>140/14</td>
<td>109/8</td>
<td>99/10</td>
<td>104/9</td>
<td>101/11</td>
<td>121/8</td>
</tr>
<tr>
<td>Two</td>
<td>95/9</td>
<td>80/15</td>
<td>99/8</td>
<td>86/12</td>
<td>97/7</td>
<td>94/11</td>
<td>101/9</td>
</tr>
<tr>
<td>Three</td>
<td>92/8</td>
<td>82/14</td>
<td>81/7</td>
<td>77/11</td>
<td>87/5</td>
<td>80/9</td>
<td>91/7</td>
</tr>
<tr>
<td>Four</td>
<td>82/6</td>
<td>78/10</td>
<td>79/8</td>
<td>75/12</td>
<td>81/5</td>
<td>79/11</td>
<td>89/6</td>
</tr>
<tr>
<td>Total</td>
<td>791/88</td>
<td>705/76</td>
<td>723/68</td>
<td>772/78</td>
<td>781/73</td>
<td>769/73</td>
<td>4541/456</td>
</tr>
</tbody>
</table>

*Note.* All scores are represented as a ratio of solution-focused interventions and interventions rated as being non-solution-focused. The top figure in each ratio is solution-focused; the bottom one is non-solution-focused. R1 = Recording 1; R2 = Recording 2; R3 = Recording 3; R4 = Recording 4; R5 = Recording 5; R6 = Recording 6; E1 = Evaluator 1; E2 = Evaluator 2.
solution-focused interventions (e.g., scaling questions, identifying exceptions, and discovering solutions, etc.) were consistently applied by the researcher in group sessions. Thus, researcher adherence to solution-focused therapy guidelines was confirmed.

**Statistical Analysis**

The statistical analysis of the present study is guided by six research questions. Paired t-test was used to analyze the effects of SFGT on participant treatment outcome and psychological well-being. This statistical technique was chosen because it allows the researcher to compare participants’ differences on the treatment outcomes and psychological well-being results at pre- and post-treatment.

The dependent variable, or scores on treatment outcomes (OQ), was calculated by summing up all the values of 45 Likert items pertaining to mental health functioning among participants. Nine items were reverse scored (*Never* = 4, *Rarely* = 3, *Sometimes* = 2, *Frequently* = 1, *Almost always* = 0). Higher scores indicate poorer outcomes. The scores for the present study ranged from 108 to 133 and 42 to 146, respectively for pre-test and post-test. A score of 146 represented the highest among study participants. In addition, scores on OQ were analyzed on its three subscales: symptom distress (SD), social relation (SR), and interpersonal relationship (IR). Analyzing three subscales allowed the researcher to examine which subscale contributed most to participant treatment outcome.

Psychological well-being was calculated using Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM). This instrument evaluates four aspects of participants’ psychological well-being: symptoms (depression, anxiety, and trauma), life
functioning, harm to self, and general well-being. The CORE-OM was calculated by summing all values of 34 items with higher scores indicating more severe, unhealthy psychological well-being. In this study, the scores ranged from 102 to 131 and 32 to 102, respectively at pre- and post-testing.

The independent variable of indication of abuse was calculated using UNCOPE questions. UNCOPE is a yes-no-question dichotomous instrument consisting of 6 items to assess the tendency of participants to experience substance dependency. UNCOPE was calculated by creating two categories of results (0 = substance abuse and 1 = substance dependence). The participants would be assigned 0 when they indicated less than four yes of UNCOPE items and assigned 1 when they indicated four or more yes of UNCOPE items. Independent t-test was chosen to interpret the UNCOPE results as it allowed the researcher to compare the means between the two categories on treatment outcomes.

In addition, information on period of sobriety of participants was used as an independent variable to investigate the relationship between period of sobriety and treatment outcomes. The period of sobriety consisted of how long the participants used to be sober in months (e.g., three weeks of period of sobriety was recoded to 0.7 months, 4 weeks was recoded to one month, and one month fifteen days was recoded to 1.5 months, etc.). In the present study, simple linear regression allowed the researcher to examine whether participants’ differences in treatment outcomes were explained by differences in sobriety period.
A Pearson’s correlation ($r$) was used to assess the correlation between psychological well-being (CORE) and treatment outcomes (OQ) of participants at post-treatment. In addition, the coefficient of determination ($r^2$) was used to determine the degree to which participant differences in psychological well-being may be associated with the participant differences in treatment outcomes. The square of the correlation coefficient value was computed for this purpose. Furthermore, the four subscales of psychological well-being, namely symptoms (depression, anxiety, and trauma), life functioning, harm to self, and general well-being were used as independent variables (predictors) to investigate relationships with treatment outcomes. In the present study, multiple linear regression allowed the researcher to examine whether participants’ psychological well-being could predict treatment outcomes.

**Results for Research Question One**

*What effect does solution-focused group therapy have on treatment outcomes as assessed by Outcome Questionnaire-45.2 (OQ)?*

A paired t-test was computed to assess the means differences between pre- and post-test measures on treatment outcomes of the participants ($n = 57$). Results showed a statistically significant differences between pre-test ($M = 117.91$, $SD = 6.23$) and post-test ($M = 104.55$, $SD = 24.05$) on treatment outcomes, $t = 4.16$, $df = 56$, $95\%CI = (6.93, 19.77)$, and $p = .001$. These results suggest that SFGT had an effect on treatment outcomes. Specifically, the treatment outcomes significantly increased after participating SFGT sessions. To estimate the magnitude of the pretest-posttest increased in treatment outcomes, the researcher constructed the 95% confidence interval (CI) for the
differences. The 95%CI = (6.93, 19.77) of the present study indicated that treatment outcomes in participants increased over the period of SFGT sessions by a magnitude from 6.93 to 19.77 points on the treatment outcomes scale.

In addition, significant differences found between pretest and posttest on symptom distress, \( t = 9.10 \) (56), \( p = .001 \) and interpersonal relationship subscale, \( t = -3.50 \) (56), \( p = .001 \). There was no significant difference between pretest and posttest on social relation subscale. The results answered the research question, indicating that SFGT have effects on treatment outcomes in participants. Specifically, the treatment outcomes can be seen in a significant increased of symptom distress in participants at post-treatment. The results of paired t-test are presented in Table 4.

The assumption of normality was tested using Kolmogorov-Smirnov test of normality on treatment outcomes for pretest and post-test. The analysis indicated that the assumption would hold \( (p > .05) \). Furthermore, a normal probability plot was analyzed on treatment outcomes for pre- and post-test and the the plot indicated normal distribution. The result of the assumption of treatment outcome for pretest and posttest can be found in Figure 1 and Figure 2 respectively.
Table 4

Results of Paired T-Test Between Pretest and Post-test on Treatment Outcomes (OQ) and Subscales (n = 57)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest M</th>
<th>Pretest SD</th>
<th>Post-test M</th>
<th>Post-test SD</th>
<th>n</th>
<th>95% CI</th>
<th>t (df)</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQ</td>
<td>118.00</td>
<td>6.14</td>
<td>105.18</td>
<td>24.10</td>
<td>57</td>
<td>(6.93,19.77)</td>
<td>4.16</td>
<td>.001</td>
</tr>
<tr>
<td>Symptom Distress</td>
<td>74.56</td>
<td>3.86</td>
<td>55.84</td>
<td>15.68</td>
<td>57</td>
<td>(14.60,22.84)</td>
<td>9.10</td>
<td>.001</td>
</tr>
<tr>
<td>Social Relation</td>
<td>23.59</td>
<td>1.54</td>
<td>22.70</td>
<td>5.54</td>
<td>57</td>
<td>(-.95,2.25)</td>
<td>.81</td>
<td>.42</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>23.20</td>
<td>1.98</td>
<td>26.01</td>
<td>6.10</td>
<td>57</td>
<td>(-4.43,-1.20)</td>
<td>-3.50</td>
<td>.001</td>
</tr>
</tbody>
</table>

*p < .01*
Figure 1. Normal Q-Q Plot for the Distribution of the Treatment Outcomes Pretest
Results for Research Question Two

How does solution-focused group therapy increase psychological well-being of the participants immediately post-treatment as assessed by Clinical Outcome in Routine Evaluation (CORE)?

A paired samples t-test was conducted to compare psychological well-being in pretest and post-test. Results showed a statistically significant difference between pretest ($M = 119.71$, $SD = 6.12$) and post-test ($M = 72.68$, $SD = 18.52$) on psychological well-
beings scores, \( t = 20.28, df = 56, 95\%CI = (42.39, 51.68), \) and \( p = .001 \). These results suggest that CORE scores, or participants’ psychological well-being significantly increase immediately post-treatment. To estimate the magnitude of the pretest-posttest increase in participants’ psychological well-being, the researcher constructs the 95% confidence interval (CI) for the differences. The 95%CI = (42.39, 51.68) of the present study indicated that participants’ psychological well-being increased over the period of SFGT sessions by a magnitude from 42.39 to 51.68 points on the psychological well-being scale.

In addition, a significant difference was found between pre- and post-test on each of four subscales of psychological well-being scale: symptoms \( (t(56) = 15.86, p = .001) \), life functioning \( (t(56) = 16.30, p = .001) \), harm to self \( (t(56) = 9.96, p = .001) \) and well-being \( (t(56) = 10.21, p = .001) \). The results answered the research question, suggesting that SFGT significantly increased psychological well-being in participants immediately post-treatment. It appears that the participants’ psychological well-being increased by a magnitude from 42.39 to 81.68 points on the CORE scale over the period of four weeks of SFGT session. The results of the paired t-test may be found in Table 5.

The assumption of normality was tested using Kolmogorov-Smirnov test of normality on psychological well-being for pre-test and post-test. The analysis indicated that the assumption would hold \( (p > .05) \). Moreover, a normal probability plot was analyzed on psychological well-being for pre- and post-test and the plot indicated normal distribution. The result of the assumption normality of psychological well-being for pre- and post-test may be found in Figure 3 and Figure 4 respectively.
Table 5

*Paired T-Test Between Pretest and Post-test on Psychological Well-Being (CORE) and Subscales (n = 57)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest M</th>
<th>Pretest SD</th>
<th>Post-test M</th>
<th>Post-test SD</th>
<th>95% CI</th>
<th>t (df)</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE</td>
<td>119.71</td>
<td>6.12</td>
<td>72.68</td>
<td>18.52</td>
<td>(42.38,81.68)</td>
<td>20.28 (56)</td>
<td>.001</td>
</tr>
<tr>
<td>Symptom</td>
<td>43.15</td>
<td>3.36</td>
<td>25.84</td>
<td>8.88</td>
<td>(15.12,19.50)</td>
<td>15.86 (56)</td>
<td>.001</td>
</tr>
<tr>
<td>Life Functioning</td>
<td>43.00</td>
<td>2.40</td>
<td>29.79</td>
<td>6.04</td>
<td>(11.58,14.83)</td>
<td>16.30 (56)</td>
<td>.001</td>
</tr>
<tr>
<td>Harm</td>
<td>14.31</td>
<td>1.120</td>
<td>6.10</td>
<td>5.90</td>
<td>(6.55,9.86)</td>
<td>9.96 (56)</td>
<td>.001</td>
</tr>
<tr>
<td>Well-Being</td>
<td>14.31</td>
<td>1.20</td>
<td>10.95</td>
<td>2.32</td>
<td>(2.70,4.03)</td>
<td>10.21 (56)</td>
<td>.001</td>
</tr>
</tbody>
</table>

p < .01
Figure 3. Normal Q-Q Plot for the Distribution of Psychological Well-Being Pretest
Results for Research Question Three

Are there differences in indication of abuse as assessed by UNCOPE on treatment outcomes as assessed by Outcome Questionnaire?

Independent t-test was computed to compare treatment outcomes between participants with substance abuse indication and participants with substance dependence indication. Results showed a significant difference between participants with substance abuse indication \((M = 96.30, SD = 34.00)\) and participants with substance dependence indication \((M = 107.00, SD = 20.12)\) on treatment outcomes scores, \(t(55) = -1.08, p = \)
.004, suggesting that participants with substance abuse indication scored better in treatment outcomes.

The results suggest that there were differences in participants with substance abuse indication and participants with substance dependence indication on treatment outcomes scores. A summary of the t-test results is presented in Table 6.

Table 6

*Independent T-test for Treatment Outcomes by Indication of Abuse (n = 57)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Indication of Abuse</th>
<th></th>
<th></th>
<th>95% CI</th>
<th>t (df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Abuse</td>
<td>96.30</td>
<td>13</td>
<td>107.00 (20.12)</td>
<td>-1.08</td>
<td>.004</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Dependence</td>
<td>34.00</td>
<td>44</td>
<td>-31.83,10.43</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p > .01

**Results for Research Question Four**

*Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?*

The period of sobriety consisted of how long the participants had previously been able to maintain sobriety, in months. A simple linear regression was conducted to assess if period of sobriety predicted treatment outcomes. The results showed a significant negative correlation between the independent variable, period of sobriety and dependent variable, treatment outcomes (R = -.38). The correlation coefficient of .38 indicated a
medium effect size. The analysis of variance (ANOVA) results from the regression equation were statistically significant, $F(1,52) = 9.06, p = .004$. The model summary from the regression analysis gives the $R^2 = .148$. Thus, this model showed that period of sobriety accounted for 14.8% of the variance in the dependent variable, treatment outcomes, with a medium effect size (adjusted $R^2 = .132$). This indicates that 14.8% of the variance in the treatment outcomes was explained by the model.

The results answered the research question, indicating that there was a negative relationship between period of sobriety and treatment outcomes. This suggests that as the period of sobriety increased, scores on the treatment outcomes tended to decrease (i.e., better treatment outcomes) and conversely, as the period of sobriety decreased, scores on the treatment outcomes tended to increase (i.e., poorer treatment outcomes). Moreover, treatment outcomes can be predicted from the period of sobriety. This is supported by the ANOVA result that indicated the participants’ differences on treatment outcomes are explained by their differences in period of sobriety. The results of the simple linear regression are presented in Table 7.

The assumptions of linearity and homoscedasticity were checked and met. The residual scatterplot indicated that the independent variable (period of sobriety) was generally linearly related to the dependent variable of treatment outcomes. Furthermore, the scatterplot matrix showed that residuals (the errors) were normally distributed and the residuals were relatively uncorrelated with the linear predictor. The results of these assumptions can be found in Figure 5 and Figure 6 respectively.
Table 7

**Simple Linear Regression Predicting Treatment Outcomes from the Period of Sobriety (n = 54)**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>121.08</td>
<td>6.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Period of Sobriety</td>
<td>-1.57</td>
<td>.523</td>
<td>-.38</td>
<td>.004</td>
</tr>
</tbody>
</table>

*Note. R^2 = .148; F (1, 52) = 9.06, p = .004*

Figure 5. Residual Scatterplot of Normally Distributed Errors of Treatment Outcomes and Period of Sobriety
Figure 6. Scatterplot Matrix Linearity and Homoscedasticity Assumption of Treatment Outcomes and Period Sobriety

Results for Research Question Five

Is there a relationship between psychological well-being of the participants as measured by Clinical Outcome in Routine Evaluation (CORE) and treatment outcomes as measured by Outcome Questionnaire (OQ) in post-treatment?

A Pearson’ correlation \((r)\) was computed to assess the relationship between scores of psychological well-being (CORE) and treatment outcomes (OQ). There was a statistically significant relationship between treatment outcomes and psychological well-
being ($r = .719, p = .001$). The correlation is significant at the 0.01 level. Based on the correlation value, it indicated that 52% of the participants’ differences in treatment outcomes score is associated with their differences in psychological well-being ($r^2 = 0.52$).

The results suggest that there is a significant positive relationship between scores on psychological well-being and treatment outcomes, indicating that as the scores psychological well-being increased, scores on the treatment outcomes also tended to increase and conversely, as the scores on psychological well-being decreased, scores on the treatment outcomes also tended to decrease. The results of the correlation may be found in Table 8.

Table 8

*Means, Standard Deviation, and Intercorrelation for Psychological Well-Being and Treatment Outcomes (n = 57)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$M$</th>
<th>$SD$</th>
<th>Treatment Outcomes</th>
<th>Psychological Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Outcomes</td>
<td>104.56</td>
<td>24.05</td>
<td>-</td>
<td>.719**</td>
</tr>
<tr>
<td>Psychological Well-Being</td>
<td>72.70</td>
<td>18.52</td>
<td>.719**</td>
<td>-</td>
</tr>
</tbody>
</table>

**p < .01**
Results for Research Question Six

*Which aspects of psychological well-being as assessed by Clinical Outcome in Routine Evaluation are most predictive of treatment outcomes as assessed by Outcome Questionnaire?*

This research question attempts to investigate which aspects of psychological well-being are most predictive of treatment outcomes. Psychological well-being consisted of four aspects: symptoms (depression, anxiety, and trauma), life functioning, harm to self, and general well-being were used as independent variables (predictors). Multiple regression was conducted to assess if this set of predictors could predict treatment outcomes.

The correlation between the four predictors and treatment outcomes were statistically significant at the 0.01 level. The correlation between treatment outcomes and symptoms of psychological well-being was statistically significant, $R^2 = .828$, $p = .000$, suggesting that 68.5% of the variance in treatment outcomes is explained by the variance in symptoms. The correlation between treatment outcomes and life functioning of psychological well-being was statistically significant, $R^2 = .465$, $p = .000$, indicating that 21.65% of the variance in treatment outcomes is explained by the variance in life functioning. The correlation between treatment outcomes and harm to self of psychological well-being was statistically significant, $R^2 = .425$, $p = .001$, suggesting that 18.0% of the variance in treatment outcomes is explained by the variance in harm to self. Finally, the correlation between treatment outcomes and general well-being of psychological well-being was statistically significant, $R^2 = .280$, $p = .035$, indicating that
7.8% of the variance in treatment outcomes is explained by the variance in general well-being. The results of the correlation can be found in Table 9.

Table 9

*Means, Standard Deviation, and Intercorrelation for Treatment Outcomes and Symptoms, Life Functioning, Harm, and General Well-Being of Psychological Well-Being (n = 57)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Treatment</th>
<th>Symptoms</th>
<th>Life</th>
<th>Harm</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Outcomes</td>
<td>104.55</td>
<td>24.05</td>
<td>-</td>
<td>.828**</td>
<td>.465**</td>
<td>.425**</td>
<td>.280*</td>
</tr>
<tr>
<td>Symptoms</td>
<td>25.84</td>
<td>8.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Functioning</td>
<td>29.79</td>
<td>6.04</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm</td>
<td>6.10</td>
<td>5.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Well-Being</td>
<td>10.95</td>
<td>2.32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** p < .01; * p < .05

Furthermore, the results showed a significant positive correlation between the four predictors and the dependent variable, treatment outcomes ($r = .85$). The correlation coefficient of .85 indicated a large effect size. The analysis of variance (ANOVA) results from the regression equation were statistically significant, $F(4, 52) = 33.10, p = .001$. The model summary from the regression analysis gives $R^2 = .718$. Thus, this model showed that 71.8% of the participants’ differences in treatment outcomes is accounted for by their differences in symptoms, life functioning, harm to self, and general well-being of psychological well-being, with a large effect size (adjusted $R^2 = .696$).
With respect to examining the statistical significance of the regression coefficients for each predictor, symptoms was statistically significant at the 0.01 level, \( p = .001 \). However, the results indicated no statistical significance for life functioning \( (p = .067) \), harm to self \( (p = .397) \), and general well-being \( (p = .191) \). These results suggest that symptoms was the predictor that most contributed to predicting treatment outcomes.

When analyzing the percentage for each predictor’s contribution to the variance in the dependent variable, treatment outcomes, the results from the part correlation between treatment outcomes and the four predictors from the regression analysis were used for that purpose.

The results from the part correlation indicated \( r = .642, r^2 = 0.412 \) for symptoms, suggesting that 41.2% of the variance in treatment outcomes is accounted for by the variance in symptoms. Additionally, the \( r = -.138, r^2 = 0.019 \) for life functioning suggests that 1.9% of the variance in treatment outcomes is accounted for by the variance in life functioning and the \( r = -.063, r^2 = 0.0039 \) for harm to self suggests that .0039% of the variance in treatment outcomes is accounted for by the variance in harm to self.

Moreover, the results from the part correlation showed \( r = .098, r^2 = 0.0096 \) for general well-being, suggesting that .0096% of the variance in treatment outcomes is accounted for by the variance in general well-being. From the results, symptoms is a relatively more important predictor than life functioning, harm to self, and general well-being for predicting treatment outcomes.

The results suggest there was a significant positive relationship between symptoms, life functioning, harm to self, and general well-being of psychological well-
being and treatment outcomes. This suggests that as these four aspects of psychological wellbeing increase, scores on the treatment outcomes also tend to increase and conversely, as these four aspects of psychological well-being decrease, scores on the treatment outcomes also tend to decrease. Moreover, treatment outcomes can be predicted from symptoms, life functioning, harm to self, and general well-being of psychological well-being and symptoms is the most predictive of treatment outcomes. The results of the multiple regression are presented in Table 10.

Table 10

*Multiple Regression Predicting Treatment Outcomes from Symptoms, Life Functioning, Harm to Self, and General Well-Being of Psychological Well-being (n = 57)*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
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<td>10.44</td>
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<td></td>
</tr>
<tr>
<td>Symptoms</td>
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<td>.305</td>
<td>.982</td>
<td>.001</td>
</tr>
<tr>
<td>Life Functioning</td>
<td>-.783</td>
<td>.419</td>
<td>-1.197</td>
<td>.067</td>
</tr>
<tr>
<td>Harm</td>
<td>-.336</td>
<td>.394</td>
<td>-0.083</td>
<td>.397</td>
</tr>
<tr>
<td>General Well-Being</td>
<td>1.14</td>
<td>.864</td>
<td>.110</td>
<td>.191</td>
</tr>
</tbody>
</table>

*Note.* $R^2 = .718; F (4, 52) = 33.10, p = .001$

The assumptions of linearity and homoscedasticity were checked and met. The residual scatterplot indicated that the independent variables, symptoms, life functioning, harm to self, and general well-being of psychological well-being were generally linearly
related to the dependent variable, treatment outcomes. Furthermore, the scatterplot matrix showed that residuals (the errors) were normally distributed and the residuals were relatively uncorrelated with the linear predictor. The results of these assumptions can be found in Figure 7 and Figure 8 respectively.

**Figure 7.** Residual Scatterplot of Normally Distributed Errors of Treatment Outcomes and Symptoms, Life Functioning, Harm to Self, and General Well-Being of Psychological Well-Being.
Multicollinearity was also checked by analyzing the Tolerance and variance inflation factor (VIF) values. The results indicated that the Tolerance values were close to 1 for all independent variables except symptoms and life functioning. Due to VIF values not greater than 10 for all independent variables, multicollinearity was not a concern in the analysis for the independent variables. Results may be found in Table 11.

Figure 8. Scatterplot Matrix Linearity and Homoscedasticity Assumption of Treatment Outcomes and Symptoms, Life Functioning, Harm to Self, and General Well-Being of Psychological Well-Being
Table 11

*Multicollinearity Statistics of Independent Variable (n = 57)*

<table>
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<tr>
<th>Regression Model</th>
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<th>VIF</th>
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**Summary**

This chapter reviewed the findings from quantitative analysis of the investigation on the outcomes of solution-focused group therapy among individuals with substance abuse issues in a residential care setting conducted in Malaysia. The researcher used a quasi-experimental research design single group to investigate the outcomes measured using the Malay version of Outcome Questionnaire and Clinical Outcomes in Routine Evaluation instrument. Participants reported low scores on both instruments at post-test, indicating their overall treatment outcomes and psychological well-being increased with SFGT. In addition, when using the participants’ period of sobriety and psychological well-being in regression analysis, linear regression was statistically significant in predicting the dependent variable, treatment outcomes, and symptoms (depression, anxiety, and trauma) was the most predictive of treatment outcomes.

The next chapter explores these findings and relates them to the existing literature regarding the outcome studies of solution-focused group therapy in addiction counseling.
The limitations of this research are also presented. Finally, the researcher discusses the implications of solution-focused group therapy for the field of counselor education and clinical practice in general and in Malaysia specifically.
CHAPTER IV

DISCUSSION

This study investigated the effect of solution-focused group therapy (SFGT) on substance abusers who are in a residential care setting in Malaysia. Previous studies have urged the conduct of more quantitative research to test the efficacy of SFGT in different treatment settings, specifically in-patient or out-patient settings, hospital long-term care, and community settings (Gingerich & Eisengart, 2000; Kim, 2008; Smock et al., 2008; Proudlock & Wellman, 2011) as well as its efficacy in different cultures (De Jong & Berg, 1998).

This study addresses this gap in the literature by examining the treatment outcomes and psychological well-being of Malaysian substance abuse clients who received SFGT in their country. This study seeks to explore the efficacy of SFGT in Malaysia and within Malay culture specifically, and to increase awareness among addiction counselors concerning the use of the SFGT framework in the psychotherapy component of treatment for substance abuse. Moreover, this study hopes to give educators and professional psychotherapists a better understanding about Malaysian culture as the addiction counseling field moves toward multicultural therapy.

This chapter begins with a summary of the major findings for each research question, followed by a section discussing the study’s limitations. This study’s findings are then related to the current literature on (a) SFGT in substance abuse treatment and (b)
substance abuse treatment in Malaysia. Finally, this chapter discusses the considerations of the findings, the implications for practice, and recommendations for future research.

**Summary of Results**

The results of the study provide preliminary support for the efficacy of SFGT in treating substance abuse clients in a residential care setting in Malaysia. In order to examine the effect of SFGT on the participants, the Malay versions of Outcome Questionnaire (OQ) and the Clinical Outcome in Routine Evaluation (CORE) were administered during the pre-group session and immediately following the termination of treatment at week 4.

Research has demonstrated the efficacy of SFGT for treating individuals with substance abuse issues. Specifically, SFGT has been shown to improve treatment outcomes (Coe, 2000; Smock et al., 2008), increase overall functioning (Proudlock & Wellman, 2011), and decrease psychiatric symptoms (Li et al., 2007; Spilsbury, 2012). Few studies on SFGT, however, have examined its efficacy in non-western populations, thereby raising questions about its applicability to non-western populations. Because this study was the first to use SFGT for substance abuse treatment in a residential care setting in Malaysia, it was important to assess the preliminary support for its efficacy in Malaysian culture by assessing the participants' treatment outcomes (OQ) and psychological well-being (CORE).

The results of the present study support the hypothesis that SFGT does have an effect on treatment outcomes in substance abuse clients in a residential care setting in
Malaysia. Specifically, there are significant differences in the participants' treatment outcomes and psychological well-being as seen in the immediate post-treatment assessment. Furthermore, there was a significant positive relationship between treatment outcomes and psychological well-being. That is, participants who scored higher on treatment outcomes also scored higher on psychological well-being and, conversely, participants who scored lower on treatment outcomes also scored lower on psychological well-being.

In addition, when the four aspects of psychological well-being – namely symptoms (depression, anxiety, and trauma), life functioning, risk/harm to self, and general well-being – were used as independent variables to predict treatment outcomes, the regression model was significant. In other words, in this sample, psychological well-being did contribute to predicting treatment outcomes. The four aspects of psychological well-being contributed to explaining 71.8% of the variance in predicting treatment outcomes in the present study. This initial evidence supports a relationship between treatment outcomes and symptoms, life functioning, harm to self, and general well-being. Furthermore, when the regression coefficient for each predictor was analyzed, “symptoms” emerged as best predictor for treatment outcomes; in other words, “symptoms” had the biggest impact on treatment outcomes.

Aside from psychological well-being, the participants' period of sobriety was also used as an independent variable to predict treatment outcomes. There was a significant negative relationship between period of sobriety and treatment outcomes in participants.
More specifically, participants who reported longer periods of sobriety tended to report better treatment outcomes. When the regression coefficient for the period of sobriety was analyzed, the model was statistically significant. Period of sobriety contributed to explaining 14.8% of the variance in predicting treatment outcomes in the present sample.

Finally, significant differences existed with respect to substance abuse indication between substance abuse and substance dependence on treatment outcomes. The results of the independent t-test suggest that indication of abuse in substance abuse clients has an effect on the treatment outcomes. That indication of abuse was associated with more favorable outcomes, while improvements in outcomes were less for dependence.

Research Question 1

What effect does solution-focused group therapy have on treatment outcomes as assessed by Outcome Questionnaire?

The present study has shown that SFGT does have an effect on treatment outcomes. More specifically, significant differences in treatment outcomes were found in participants at post-treatment as compared to pre-treatment, indicating that participants scored better in treatment outcomes. This finding is consistent with previous research. SFGT has been shown to increase treatment outcomes when comparing pre- and post-test data among individuals with substance abuse issues (de Shazer & Isebaert, 2003; Smock et al., 2008) and to increase overall functioning (Proudlock & Wellman, 2011). This finding supports the use of SFGT in a group format for substance abusers in a residential care setting in Malaysia. In the present study, SFGT was conducted in Cure and Care
Malaysia Clinic resulting in changes in group settings. This finding is congruent with the study of McCollum et al. (2003) that argued for the utility of a competence-based approach like SFGT in group format as being "culturally sensitive" for residential treatment agencies.

It is important to discuss the specific, rather than general, outcomes (e.g., symptoms reduction) in presenting the overall treatment outcomes in substance abuse therapy (Spokas et al., 2007). The Outcome Questionnaire (OQ) was found to be a reliable measure of client's outcomes even if they have only received brief periods of treatment. To operationalize what constitutes an outcome in the present study, the researcher used the subscales of the Malay version of the OQ. These subscales, which represent the overall treatment outcomes in participants, are symptom distress, social relations, and interpersonal relationships. The symptom distress subscale measures general emotional and lifestyle stressors. This domain was included in treatment outcomes measure because emotional problems and substance abuse tend to be comorbid conditions. The other two domains – social relations and interpersonal relationships – were included because the literature states that a person’s satisfaction with his or her social role is correlated with overall life satisfaction in individuals with substance abuse issues (Lambert et al., 1998).

Although the present study found a significant difference in overall treatment outcomes, only symptom distress and interpersonal relationships indicated significant differences in post-test versus the pretest. The pretest and post-test results for the social
relations subscale did not have significant differences. These results suggest that the participants’ symptom distress significantly decreased at post-treatment. This finding is consistent with the Smock et al. study (2008) that used the OQ to assess clients' outcomes from SFGT. They reported that only SFGT had a moderate effect on symptoms distress among level 1 substance abuse clients at post-treatment. The authors concluded that SFGT is useful in reducing symptoms distress experienced by individuals with substance abuse issues. Other previous studies have also indicated that clients who received solution-focused brief therapy (SFBT) scored lower in the Depression Anxiety Stress Scale (Spilsbury, 2012) and were able to maintain their abstinence (Hayes et al., 2010). This finding suggests that SFGT is more likely to be useful in symptoms reductions than in social relations among substance abuse clients.

In the present study, the lack of significant difference in the pretest and post-test results on social relations could be due to the tendency of the participants to describe behavioral changes that were related to reducing emotional problems accompanying substance abuse. When they were asked miracle questions in the session, the participants tended to focus on situations where they were able to manage emotional problems while in recovery (e.g., less depressed thinking about future recovery) rather than situations where they were able to improve their social relations with significant others and friends. When the participants' attention focused on reducing emotional problems, the solutions would be oriented toward reducing those problems, such as depression and anxiety. Participants' progress in reducing the symptoms of emotional problems became clearer as
they were asked scaling questions throughout the session. The purpose of these scaling questions was to assist participants in assessing their progress towards goals that reflected their response to the miracle question (i.e., when depression was gone or was experienced less often). This could explain a significant difference on symptom distress in the present study and less significant effect for social relations. De Shazer and Isebaert (2003) reported that the participants' response to the miracle questions became the focus of change in the participants who constructed solutions and developed goals.

Since there was a significant difference in treatment outcomes at post-treatment and the OQ measures emotional problems associated with substance abuse such as depression, this study can conclude that clients with substance abuse issues in a residential care setting in Malaysia significantly benefitted from SFGT. These findings provide preliminary support for using a solution-focused approach as a less time-consuming psychotherapeutic approach for mental health treatment for clients with substance abuse issues than traditional or existing treatment approaches in Malaysia.

The efficient use of time is aligned with the current concepts of the ambulatory care program utilized by Cure and Care 1Malaysia Clinic. The concepts of this program revolve around open voluntary concept that is less-time consuming and at a lower intensity with the maximum period of treatment limited to 90 days. Kamarulzaman (2012) argues that because the ambulatory care program gives little attention to the mental health care components, co-occurring symptoms in substance abuse (e.g., depression, anxiety, trauma, among others) often go unrecognized and untreated. The
findings for the research question in this study lead to the conclusion that SFGT was useful in treating symptoms distress and thus, improved the overall treatment outcomes for participants in Malaysia.

**Research Question 2**

*How does SFGT increase the psychological well-being of participants immediately post-treatment as assessed by Clinical Outcome in Routine Evaluation?*

The present study found that SFGT significantly increased psychological well-being in participants immediately post-treatment at week four. This improved psychological well-being was seen in all four aspects of psychological well-being: symptoms (depression, anxiety, and trauma), life functioning, harm to self, and general well-being. This finding is consistent with previous research showing that SFGT increased psychological well-being based on a comparison of pre- and post-test data from clients with substance abuse issues (Li et al., 2007; Proudlock & Wellman, 2011).

Moreover, the increase in psychological well-being at post-treatment evaluation has been correlated with alcohol abstinence (de Shazer & Isebaert, 2003) and significant improvements in goal attainment, such as keeping jobs and saving marriages (Coe, 2000; McCollum et al., 2003). These findings suggest that clients with substance abuse issues in a residential care setting in Malaysia significantly benefit from SFGT to increase their psychological well-being.

Moreover, since this study used SFGT in a residential care setting, these findings also suggest that a solution-focused approach is potentially appropriate to be utilized for
substance abuse clients in residential settings. James et al. (2013) stated that a solution-focused approach is not designed for delivery in residential settings and more studies are needed to test its utilization in those settings. The findings of the present study support expanding the utilization of solution-focused approach to residential settings, besides in-patient and out-patient settings (Gingerich & Eisengart, 2000; Smock et al., 2008), hospital long-term care (de Shazer & Isebaert, 2003; Kim, 2008), and community settings (Coe, 2000; Proudlock & Wellman, 2011). The appropriateness of a solution-focused approach used in residential settings may be attributed to the values that SFGT adds to residential treatment programs. For instance, SFGT emphasizes identifying solutions, raising exceptions questions that stress periods of success, and having hope for the future. This was also asserted by Froerer et al. (2009), who studied how SFGT added value to treating drug users with human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS). They showed that therapy that focuses on the clients' desired future rather than on what had gone wrong in the past, empowers the clients to change and increase their chances of success despite the disease. This then helps to empower clients to take charge of their life.

In the present study, the treatment guidelines of SFGT were adopted from Pichot and Dolan's (2003) manual of solution-focused therapy. The guidelines of the treatment emphasize future-oriented questions (e.g., the use of miracle questions), soliciting clients' coping and resources (e.g., the use of exception questions), and encouraging and assessing changes (e.g., the use of scaling questions). These values added by SFGT to
treatment in residential settings are beneficial for substance abuse clients. For instance, the concept of projecting solutions into the future instills hope and a sense of purpose for clients because they have already planned what they will do once they leave residential treatment and return to their everyday life. This explanation is congruent with Mott and Gysin's (2003) work on the catalyst of change in clients who receive solution-focused brief therapy (SFBT). The authors reported that soliciting the details of changes in the future serves as a mechanism of change in a solution-focused approach.

The findings of the study provide preliminary support for utilizing SFGT for substance abuse clients in residential care settings in Malaysia. There are few studies that look at how psychotherapy in drug treatment programs may increase the psychological well-being of clients with substance abuse issues in Malaysia. One reason for this situation is the kinds of indicators that the National-Anti Drug Agency Malaysia (NADA) uses to determine the success of drug recovery. These indicators are the new and relapsing client cases each year, drug use reduction, and how the money is spent by the Malaysia government for drug treatment programs (Ibrahim et al., 2009; Narayanan et al., 2011). It was not until 2008 that NADA Malaysia began to look at the clients' quality life functions, which includes psychological well-being, as one of the measures for drug treatment outcomes. Nazar, Zakaria, and Salleh (2009) used the World Health Organization’s “Quality of Life” as indicators for drug recovery success in order to assess the effectiveness of the matrix model of drug treatment for out-patient clients. They reported that the clients who received the matrix model of drug treatment showed
improvements in quality life functioning in social functioning, keeping a full-time job, and family relationships.

The present study is a first step toward suggesting that it is crucial to consider psychological well-being, which includes life functioning, symptoms, and general well-being components as measured by the Clinical Outcome in Routine Evaluation, as one of the indicators for treatment outcomes measures. Based on the findings for the second research question in this study, it can be concluded that SFGT is useful in increasing psychological well-being among substance abuse clients in a residential setting in Malaysia.

**Research Question 3**

*Are there differences in indication of abuse as assessed by UNCOPE on treatment outcomes as assessed by Outcome Questionnaire?*

In the present study, this research question attempts to examine how differences in substance abuse indication affect treatment outcomes at post-test. The research question was investigated by creating two categories of abuse indication: substance abuse and substance dependence. The study found significant differences in indication of abuse on treatment outcomes. That is, the treatment outcomes were significantly different between participants with substance abuse indication and participants with substance dependence indication. However, participants with substance abuse indication scored slightly better in treatment outcomes than substance dependence indication (at 10-point mean score difference). Despite the difference being marginal, this finding suggests that
abuse and dependence affect treatment outcomes in substance abuse clients. This finding is consistent with previous research that reported the degree of severity in substance abuse affect treatment outcomes that requires a specific evaluation for each category (Conway, Levy, Vanyukov, Chandler, Rutter, Swan, & Neale, 2010).

It is important to examine substance abuse indication on treatment outcomes as substance abuse and substance dependence consist of diagnostic differentiation of drug use and criteria. The Diagnostic Statistical Manual 5 (DSM 5, 2013) points out that substance dependence at least meets these three criteria: tolerance and withdrawal to indicate neurologic adaptation and compulsive use of the drug; while substance abuse at least meets the criterion of recurrent use despite adverse consequences in the absence of neurologic adaptation criteria (American Psychological Association [APA], 2013). To summarize the diagnostic differentiation, dependence is used to reflect a more chronic condition that produces significant and lasting changes in brain chemistry and function that would affect recovery strategies (i.e., long-term treatment, referral, etc.) as opposed to abuse (Hoffmann et al., 2003).

The diagnostic differentiation of abuse and dependence suggests that each category carries different constructs of addiction severity that includes behavioral and social consequences, use patterns, and number of symptoms. Hence, these two levels of addiction severity (abuse and dependence) warrant a specific evaluation for each as well as psychotherapy treatment plan that tailor to the severity of addiction including length of
treatment, types of intervention, medication necessity, cut-off score for estimating the significant change, and others (Conway et al., 2010).

As such, in the present study, a possible factor that could have impacted the significant differences on treatment outcomes between abuse and dependence is the length of treatment (SFGT) of the participants. This study involved four weeks of treatment of SFGT. The intent of the present study was to see whether SFGT has an effect on treatment outcomes in a relatively brief period of time in substance abuse clients in Malaysia. According to de Shazer (1991), an average of five sessions is typical of solution-focused therapy. In the field of mental health and substance abuse treatment, previous research reported providing six weeks of treatment of solution-focused therapy for individuals with substance dependence (Hayes et al., 2010; Proudlock & Wellman, 2011) and substance abuse (Smock et al., 2008), and others reported three weeks of treatment (Spilsbury, 2012). Some researchers (e.g., Miller & Willoughby, 1997; Coe, 2000) argue for an average of four weeks of treatment using a solution-focused approach, as solution-focused therapy has been proven to be a brief intervention that produces long-lasting change in clients. For example, Coe (2000) reported that length of solution-focused therapy did not have a significant effect on psychological symptoms when the score of participants who attended two sessions were compared to the scores of participants who attended four sessions.

Given the variation regarding length of treatment in solution-focused therapy for abuse and dependence, it may be helpful to explore how length of treatment in SFGT
impacts treatment outcomes, specifically for substance abuse and substance dependence. Knowing the length could facilitate the therapist to develop an appropriate treatment plan for clients based on the severity of addiction. Considering dependence is used to reflect a more chronic condition of addiction (Hoffmann et al., 2003), is it possible that those with substance dependence indication require longer treatment of solution-focused therapy than substance abuse.

Some researchers relate substance abuse indication with readiness to change for treatment in substance abuse clients (e.g., Miller and Tonigan, 1996). They assert that substance abuse clients go through systematic stages of change in drug treatment, namely recognition, ambivalence, and taking steps that would affect treatment outcomes. In other words, the treatment outcomes reflect where the clients are regarding level of readiness to change. This notion of change is not compatible with a solution-focused approach, which suggests that change is constant and clients already demonstrate a desire to change when they seek treatment (Walter & Peller, 1992; West, 2010). The concept of change in a solution-focused approach stems from the philosophy of social construction, which believes clients construct the reality of change in recovery (i.e., through scaling questions), and the therapist focuses on building solutions (Anderson, 1997; Pichot & Smock, 2009).

To acknowledge this concept of change in a solution-focused approach, this study did not include readiness to change as a variable for analysis; instead, the participants' level of readiness to change was assessed to see the compatibility prior to receiving the
Lewis and Osborn (2004) reported that it would be useful to determine the compatibility of the clients' level of readiness to change prior to treatment to provide some understanding for the therapist of why clients chose a certain number on scaling questions to represent their current situation.

In Malaysia, abuse and dependence are used interchangeably to reflect individuals with substance abuse issues (Mazlan et al., 2006). According to Mazlan et al., (2006), relapse rates are similar across abuse and dependence. Substance abuse indication or the severity of addiction is partially determined by the types of drugs abused by the individuals. Mazlan et al. reported that the epidemic of ATS abuse among individuals with heroin abuse created severe substance dependency in Malaysia since 2000. In addition, Singh et al. (2013) reported that concurrent ATS and opioid abuse has become highly prevalent among individuals with substance abuse in Malaysia. This is evident when drug recovery success decreased among methadone users when they also abused ATS (Singh et al., 2013).

This description corresponds with the participants' information in the present study, in which the highest percentage of the participants (20%) reported ATS as their drug of choice, followed by percentage of the participants (19.3%) who reported concurrent abuse of heroin, ATS, and marijuana. While this finding did not generalize to all Malaysian individuals with substance abuse issues, this finding certainly supports previous research conducted in Malaysia, suggesting that the ATS epidemic and types of drugs in Malaysia impact the way addiction severity is viewed.
Given the significant differences on treatment outcomes between abuse and dependence in this study, it may be helpful for future studies on linkage and interaction among psychological well-being and treatment outcomes to compare solution-focused approach outcomes based on types of drugs in Malaysia. The outcomes comparison may provide insight for the therapist to know which component of outcomes need to be emphasized for each substance and substance combination. The findings from research question three of this study conclude that SFGT is useful for participants with substance abuse and substance dependence indication in Malaysia.

**Research Question 4**

*Is there a relationship between period of sobriety and treatment outcomes as assessed by Outcome Questionnaire?*

In the present study, period of sobriety, the period the participants had previously been able to maintain sobriety, was used in linear regression to analyze its contribution toward predicting treatment outcomes. The statistical findings of this study provide support for this hypothesis of a relationship between period of sobriety and treatment outcomes. More specifically, there was a significant negative relationship between period of sobriety and treatment outcomes at post-treatment, suggesting that the longer the period of sobriety that participants had previously been able to maintain, the better treatment outcomes would be. Moreover, when the period of sobriety was used as an independent variable to assess its impact on treatment outcomes, the regression model was significant, indicating 14.8% of the variance in treatment outcomes is explained by
the participants' differences in period of sobriety. This finding suggests that period of sobriety has an impact on treatment outcomes in substance abuse clients at post-treatment. Previous researchers who specifically used period of sobriety as a predictor of drug treatment outcomes is limited, as many of them emphasized psychiatric symptoms as predictors of drug treatment outcomes (Simpson et al., 1997; Sigmon et al., 2000; Campton et al., 2003; Sacks et al., 2004; Ghani et al., 2015). This is reasonable, as the focus on treating psychiatric symptoms in substance abuse clients has become important particularly in emotional problems such as major depression, anxiety, trauma, and substance abuse, which tend to develop comorbid conditions (Lambert et al., 1998).

Nevertheless, it is important to consider client variation and demographic characteristics in order to understand their impact on treatment outcomes. Wright and Devine (1995) reported that the conclusion of overall treatment outcomes overlooked a great deal of individual variation in response to treatment that includes social circumstances (e.g., unemployment, homelessness experience, drug of choice, client education, prior treatment history, race, and other factors). Wright and Devine studied treatment outcomes in terms of substance-free days, employment, total good days, and days in treatment. They found education level was a significant predictor of treatment outcomes in substance-free days, employment, total good days, and days in treatment, while prior treatment history was only significant in employment and total good days. Their study was conducted in a western population, and replication of these findings with a non-western population is needed.
In the present study, client variation in terms of their period of sobriety was used as an independent variable to predict treatment outcomes. Identifying the clients' period of sobriety in a solution-focused approach is essential to acknowledge the exception to the participants' substance abuse problems (period of success). The basic idea of exception technique, which is one of the focal points in a solution-focused approach, is to discover the clients' resources and strengths to cope with their problems. It is possible to discover this in clients, as solution-focused therapists believe that problems do not happen all the time and there is exception when the problems are gone or less severe. As Miller and Berg note, almost every substance abuse client has had some period of abstinence that may have lasted months or years (Miller & Berg, 1995).

In this study, knowing the participants' history of period of sobriety assisted the researcher (therapist) in directing the participants' attention to periods when they were abstaining from substances. For example, in the therapy, participants discussed how they maintained a period of sobriety in order to pass a drug test for a new job. The participants were reminded that they had done this in the past, which would encourage them to repeat the behavior and help the participants perceive their own efficacy to change.

In the present study, most recruited participants had previous success in maintaining abstinence, in which 26 of them had been sober for more than four months and up to 12 years. Within this period, they experienced relapse more than once and multiple treatment histories. This information is evident when the majority of participants
reported that they had experienced relapse in their journey of drug recovery more than once \((n = 38)\), and they had prior treatment histories at least once \((n = 53)\). Given a significant relationship between period of sobriety and treatment outcomes, this finding suggests that substance abuse clients with a longer period of sobriety might reflect their ability to maintain abstinence and the effectiveness of their coping strategies. That is, they might have a wider repertoire of coping strategies to select from, to deal with life stressors as compared to substance abuse clients with a shorter period of sobriety. In other words, substance abuse clients with a longer period of sobriety are more likely to know what kind of coping strategies worked best for them in the past and are more likely to repeat them in drug treatment. The finding of this study support a recommendation for future studies to examine coping strategies and drug abstinence to encourage an extended discussion on coping strategies and treatment outcomes in substance abuse programs.

In Malaysia, client variation in terms of period of sobriety is overlooked in discussing treatment outcomes in substance abuse programs. Instead, client variation in terms of amount of relapse and drug of choice were used to explain treatment outcomes (Ibrahim et al., 2009; Narayanan et al., 2011). Nazar et al. (2006) reported that the effectiveness of substance abuse treatment programs largely depends upon types of drug used by the individuals, as each type of substance affects drug recovery rates and chances for relapse. For example, Matshah et al. (2014) reported that clients whose drug of choice was methamphetamines indicated high chances for relapse.
In the present study, the majority of participants reported that they had used more than one substance ($n = 36$), meanwhile twelve participants reported amphetamine-type stimulants (ATS) as their drug of choice, and there were only a small number representing heroin abusers ($n = 9$). The information on substance abuse history of the participants in this study is consistent with previous research on drug trends in Malaysia: the abuse of ATS has increased to become just as problematic as heroin abuse problems (Chawarski et al., 2006; McKetin et al., 2008; Scorzelli, 2009; Ghani et al., 2015). Hence, it may be helpful to explore drug types and their impacts on period of sobriety and treatment outcomes. Ghani et al. (2015) reported that opioid dependents showed better treatment outcomes than methamphetamine dependents in terms of diminished withdrawal symptoms and craving for drugs. However, the researchers indicated that they had limited information on the content of the group therapy received by the participants and to what extent the therapy contributed to outcomes. In future studies, a more thorough investigation on psychotherapy utilized by substance abuse treatment may provide a greater understanding of the relationship between drug types and period of sobriety, and how those factors interact to impact treatment outcomes in substance abuse treatment in Malaysia.

**Research Question 5**

*Is there a relationship between psychological well-being of the participants as assessed by Clinical Outcome in Routine Evaluation and treatment outcomes as assessed by Outcome Questionnaire in post-treatment?*
In the present study, the statistical findings supported the hypothesis of a relationship between psychological well-being of the participants and treatment outcomes. In fact, there was a significant positive relationship between psychological well-being and treatment outcomes in participants at post-treatment. More specifically, treatment outcomes tended to increase as the participants' psychological well-being increased and conversely, treatment outcomes tended to decrease as the participants' psychological well-being decrease. In the preceding research questions, the statistical findings indicated that SFGT did significantly affect treatment outcomes and increased psychological well-being of participants in this study at post-treatment. The statistical analysis of this study further supports these findings by indicating a significant positive relationship between psychological well-being and treatment outcomes. This finding is consistent with previous research. SFGT has been shown to reduce psychological symptoms in substance abuse clients and has a significant relationship with improved treatment outcomes (Coe, 2000; Li et al., 2007; Smock et al., 2008). Moreover, the increase in psychological well-being in substance abuse clients has been correlated with better treatment outcomes in treatment retention (Simpson et al., 1997), decreased chances of relapse (Sacks et al., 2004), and prolonged abstinence (Sigmon et al., 2000). This finding suggests that treatment outcomes are associated with the psychological well-being of substance abuse clients.

Additionally, the finding supports previous research on the utilization of SFGT in non-western population on better treatment outcomes among substance abuse clients.
(Lee, 2003; Meyer & Cottone, 2013). The solution-focused approach is a branch of social construction philosophy of knowledge, according to which an understanding of reality is socially construed based on one's perspective through language (Anderson, 1997). That is, in solution-focused therapy, the counselor adopts the client's language and understands his or her problem and solution based on his or her words. In other words, the client's frame of reference is utilized throughout the counseling process (Miller & Berg, 1995); some researchers call it client-identified solutions (Meyer & Cottone, 2003). Hence, solution-focused therapy allows the counselor to work with the client to define a mutually agreeable reality. According to Ho, Tsui, Chu, & Chan (2003), because the counselor uses the client's language to understand his or her problems and uses the client's worldview when interpreting meaning in the client's language, solution-focused therapy is a culturally sensitive approach.

Therefore, in using solution-focused therapy with substance abuse clients in the Malaysian population, clients are not only constructing the reality of drug recovery, but Malaysian cultural values can also be utilized to put meaning in the reality of recovery in therapy. In the present study, a four-week SFGT was given to Malaysian participants who belonged to the Malay ethnic group. Malay cultural values were utilized to imbue meaning to the realities of recovery, i.e. to reduce or to lessen distress symptoms. For instance, in one session, participants reported feeling upset about how their substance abuse problems created difficulties for their significant others (e.g., families, close relatives). They also reported feeling anxious regarding whether their families or
communities would accept or reject them when they left residential treatment. The participants also expressed anxiety about how such acceptance or rejection might affect their drug recovery, i.e. to maintain sobriety.

Relationship-oriented questions, one of the techniques used in a solution-focused approach, were used throughout the session to create a solution-oriented story in participants. For instance, the researcher (therapist) asked the question "What would your families say when they see changes in you?" This question facilitated the participants’ identification of future solutions. According to de Shazer (1991), relationship-oriented questions in a solution-focused approach help a client to discover what changes might look like, as well help the client perceive his or her efficacy to change. Response to this question could help in creating the sense of a close relationship with the families and the sense that the clients are not burdens to their families, which ultimately could help lessen distress symptoms. This is reasonable as Malaysia is a Southeast Asian country that espouses collectivist values that prioritize family and group relationship about the individual’s needs (Ming, 2001). In the present study, the reality of recovery in a collectivist culture took the form of "I want to stay sober so that I would not have to be a burden to my family." This is very different from individualistic cultures where recovery is expressed as "I want to stay sober, so that I could have good life and move on." According to Ming (2001), although psychological well-being is a general concept, cultural values play a role in determining the behavioral and contextual manifestations of psychological well-being. As such, while this study acknowledges that
sobriety has a common meaning across populations (that is, sobriety means leading a drug-free life), collectivist values determine the contextual manifestations of being sober wherein sobriety is also interpreted as not being a burden to one’s family.

The aforementioned example in this study is congruent with the arguments made by cross-cultural psychologists (e.g., Berry et al., 2011) that psychological symptoms can only be understood within the cultural context in which they occur. This study’s findings suggest that cultural contexts are important in understanding the solutions for psychological problems; specifically, how such approaches can reduce or lessen psychological symptoms. This concept aligns with the solution-focused approach, which emphasizes client-identified solutions that allow clients to construct their reality of solutions. Hence, the findings of this study suggest that a solution-focused approach is a culturally-sensitive approach for the Malaysian population.

Despite such compelling findings, applying SFGT will need to address some cross-cultural issues, such as language barriers, before it is implemented in a drug treatment program for non-western populations such as Malaysians. This study delivered SFGT in the Malay language and participants in the program were Malaysian men, who belonged to the Malay ethnic group. Another consideration in applying SFGT is the time orientation of different cultures. A solution-focused approach utilizes future-time orientation in the sentence structure in order to project changes or solutions that may occur in the future. For example, the miracle question, "How will you know things have become better?," is focused on the future and requires participants to do a virtual
rehearsal of their preferred future. This is contrary to the past-time orientation of many
Malaysians (Hofstede, 1991; Gong, 2001). The Malay ethnic group in Malaysia favors
traditions as they bring inspiration, motivation, hope, and direction for change in the
present-time orientation (Gong, 2001).

For this study, the miracle questions occasionally had to be rephrased to focus on
a time when the participants experienced harmony with all people and things or when
things were better back then. The miracle question then became: “How would you
describe a time when things were better or you were in harmony with your families?”
Such a question encouraged the participants to do a virtual rehearsal of their preferred
past and utilized the significant past experience as the source of hope for change.
Rewording some of the miracle questions allowed the researcher (therapist) to explore
more exceptions to participants' substance abuse problems.

Rewording the miracle questions in this study is congruent with the practice of
other researchers, such as Meyer and Cottone (2003) who restructured the miracle
question to a present-time orientation when they worked with American Indian clients.
They reported that future-oriented questions may not be compatible with clients such as
American Indians who come from a present-oriented culture. The researchers concluded
that it is important for the therapist to work with the client's time orientation to explore
more potential resources that the client can use to create a solution story in therapy.
Furthermore, the solution-focused therapist needs to educate himself or herself about the
client’s culture to ensure that the client's frame of reference is used (Meyer & Cottone, 2003).

This study’s finding that there is a significant relationship between psychological well-being and treatment outcomes in substance abuse clients who received SFGT suggests the need for more exploratory studies on using solution-focused approaches in non-Western populations. These exploratory studies should take into account the nature of collectivistic cultures and the language barriers.

**Research Question 6**

*Which aspects of psychological well-being as assessed by Clinical Outcome in Routine Evaluation are most predictive of treatment outcomes as assessed by Outcome Questionnaire?*

In the present study, psychological well-being consisted of four aspects: symptoms (depression, symptoms, and trauma), life functioning, risk/harm to self, and general well-being were assessed with a Clinical Outcome in Routine Evaluation. The results were then used in a multiple regression analysis model to determine which aspects of psychological well-being best predict the participants’ treatment outcomes. The statistical findings of the study support the hypothesis that aspects of psychological well-being would best predict treatment outcomes. Specifically, psychological well-being accounted for 71.8% of the participants' differences in treatment outcomes (adjusted $R^2 = .696$). This finding is consistent with previous research showing that the psychological well-being of substance abuse clients (e.g., major depression, generalized anxiety
disorder, among others) significantly predicts drug treatment outcomes in terms of diminishing withdrawal symptoms and supporting drug abstinence (Ghani et al., 2015), reducing the number of substance dependence criteria (Compton et al., 2003), and improved employment (Wright & Devine, 1995).

This study’s finding supports previous research on the positive relationship between psychological well-being and treatment outcomes among substance abuse clients. Furthermore, when the regression coefficient was analyzed for each aspect of psychological well-being, it was found that “symptoms” best predicts treatment outcomes. In other words, addressing symptoms in substance abuse clients is more important than addressing life functioning, risk/harm to self, and general well-being in predicting treatment outcomes. These four aspects of psychological well-being were important to consider if they contributed to predicting treatment outcomes.

**Symptoms and treatment outcomes.** Psychological symptoms, such as depression, anxiety, and trauma, that are frequently expressed in affective disorder symptoms also tend to be comorbid conditions of substance abuse. Previous researchers used affective disorder symptoms as indicators for treatment outcomes in substance abuse treatment. For example, McLellan, Lewis, O’Brien, and Kleber (2000) reported that substance abuse treatment outcomes may be improved in clients with mild to moderate levels of the beginnings of psychopathology and decreased in patients with more severe psychiatric impairment. Compton et al., 2003, however, argued that clients should not be given a psychological assessment upon entry to treatment (detoxification) because many
affective disorder symptoms will subside upon abstinence. In the present study, in order to address affective disorder symptoms and their relationship with treatment outcomes while reducing the likelihood of including withdrawal-associated symptoms, the participants' went through the detoxification process to eliminate withdrawal symptoms and they had been in treatment for at least 30 days by the time of assessment.

In the present study, “symptoms” was found to be a significant predictor of treatment outcomes even when other aspects of psychological well-being (life-functioning, risk/harm to self, and general-well-being) were held constant; specifically, symptoms accounts for 41.2% of the variance in treatment outcomes. Thus, this study’s finding supports previous research on the role of symptoms (i.e., depression, general anxiety, and trauma) in predicting treatment outcomes among substance abuse clients (Compton et al., 2003; Smock et al., 2008). Similar to previous research, this study’s finding suggests that there is a relationship between symptoms – specifically affective disorder symptoms – and treatment outcomes in individuals with substance abuse issues.

Despite compelling findings, cross-cultural issues still need to be considered when interpreting symptoms of psychological well-being in order to reach solid conclusions. One cross-cultural issue is the difference in symptomatology expression across cultures. Malaysia is one of the Southeast Asian countries that have been shown to have higher rates of expressed symptomatology (Cheng et al., 1993). Narayen (1995) reported that the Asian population is more likely to demonstrate affective forms of symptoms that indicate emotional problems. Asian cultural groups are also more likely
to report extreme feelings of worthlessness and guilt-related symptoms and the affective form of symptoms is more salient than the somatic forms (e.g., headache, pains, and other physical aches) when culturally-meaningful values are attached to those symptoms (Narayen, 1995).

This study’s findings correspond with the findings of previous studies about the expressed symptomology among Southeast Asians. In the present study, the participants' collectivist culture, which values one’s family might have attached to their symptoms (i.e., depression and anxiety) related to their substance abuse problems. The tendency of the Malay ethnic cultural group to manifest the affective form in expressed symptomology and the emphasis on collectivist culture, could explain why “symptoms” was a significant predictor of treatment outcomes. Future research might use these aspects in drug treatment recovery. Understanding how cultural differences (e.g., collectivism versus individualism, past-time orientation versus future-time orientation) affect mental health concerns in Malay individuals with substance abuse issues is helpful in developing appropriate interventions.

**Life functioning and treatment outcomes.** Life functioning is another indicator used to predict treatment outcomes in substance abuse treatment. According to Laudet (2011), outcome measures in substance abuse treatment is a multi-factorial process and measuring life functioning in substance abuse clients can provide a clear picture of outcomes. Life functioning includes level of involvement with the legal system, employment, medical care or hospitalization associated with substance used, and the
clients' overall satisfaction with their life. Life functioning also measures the clients' experiences in aspects of functioning that are important to them but are not captured by traditional symptoms assessment. Despite its importance, the concept of life functioning in predicting outcomes in substance abuse treatment is underutilized (Laudet, 2011; Srivastava & Bhatia, 2013).

In the substance abuse field, life functioning is often assessed by measuring the clients' quality of life (QoL). Srivastava and Bhatia (2013) reported that QoL among clients with alcohol dependence significantly improved over a three-month period of abstinence. The researchers also found that quality of life for substance abuse clients did not improve immediately after they stopped using substances; instead, quality of life gradually improved throughout abstinence. This improvement could be explained by several factors that include complete abstinence, effective control of withdrawal symptoms, regular presence of a close family member during medical follow-up visits, and effective management of psychiatric comorbidity and medical complications (Srivastava & Bhatia, 2013). Furthermore, Tiffany et al. (2011) reported that it is important to incorporate life functioning into measures for treatment outcomes. Reducing substance abuse is not the only primary outcome; life functioning provides therapists and researchers important information about the mechanisms responsible for treatment efficacy and effectiveness.

In Malaysia, Nazar et al. (2009) operationalized life functioning as increased improvement in social functioning, maintaining a full-time job, residing in a stable
residence, and family relationships. These were used as indicators to determine the outcomes of substance abuse treatment among out-patient clients. The researchers reported that these aspects of life functioning were appropriate indicators of treatment outcomes among out-patient clients as they experience the "real life" (e.g., employment, a stable residence, among others) while trying to maintain sobriety, unlike in-patient clients who are focused mainly on sobriety and have limited exposure to “real life.” This rationale corresponds with the finding of the current study.

This study found that post-treatment assessments showed life functioning as having significantly improved. Nevertheless, life functioning did not significantly contribute to predicting treatment outcomes when other aspects of psychological well-being (symptoms, harm to self, and general well-being) were held constant. Only 1.9% of the variance in treatment outcomes is accounted for by the variance in life functioning. A possible factor that could explain this result is the study’s treatment setting. The study’s participants were substance abuse clients in a residential setting conducted in Malaysia, i.e. the participants lived in the treatment center (Cure and Care 1Malaysia clinic) for substance treatment. Their life functioning focused on coping in a residential setting, such as how well they follow rules of the center and how well they get along with their peers in that setting, rather than functioning associated with holding a full-time job outside of the treatment center.

Moreover, life functioning is positively correlated with the length of the abstinence period (Srivastava & Bhatia, 2013). Most of the clients who participated in
this study had only been in the treatment for 44 days, out of which 14 days were spent in detoxification. Future research could explore how substance abuse clients in residential settings experience their life functioning and how those experiences are related to treatment outcomes. Although this study did not find life functioning as a significant independent contributor to predicting treatment outcomes, life functioning was found to be more useful when combined with other aspects of psychological well-being such as symptoms, harm to self, and general well-being. The results of the present study support the inclusion of life functioning in futures models of psychological well-being and treatment outcomes for substance abuse.

**Harm to self and treatment outcomes.** Self-harm is often incorporated with other indicators in predicting treatment outcomes. Prior research has shown that harm to self is associated with the adverse psychological well-being of substance abuse clients (Donovan, Mattson, Cisler, Longabaugh, & Zweben, 2005). The harm to self aspect of psychological well-being refers to the safety of substance abuse clients and their immediate social circle, that is they are a "risk" to themselves or others because they may have suicidal thoughts and/or thoughts to physically harm another person. According to Tiffany et al. (2011), the self-harm aspect of psychological well-being addresses issues of safety that cannot be assessed simply by reducing emotional symptoms and should be a clinical indicator for therapists to address immediately (Tiffany et al., 2011).

This present study found in the post-treatment assessment that avoiding self-harm was significantly improved. However, self-harm did not significantly contribute to
predicting treatment outcomes when other aspects of psychological well-being (symptoms, life functioning, and general-well-being) were held constant. A possible explanation for this finding is the study’s participants did not have major disorders. One of the inclusion criteria of participants of this study was substance abuse clients exhibiting mild to moderate psychological problems. The degree of these problems do not fulfill the symptoms for other major disorders in DSM 5 (e.g., borderline personality disorder, bipolar disorder, among other) and did not warrant further psychiatric attention during the conduct of the study.

In Malaysia, Khan et al. (2012) reported that individuals with substance abuse issues comorbid with major psychotic or personality disorder are at higher risk for committing harm to self and to other persons, and the presence of multiple major disorders is associated with more elevated risk. The researchers found that Malaysian ethnic Chinese females were at increased risk. Other researcher (e.g., Maniam, 1994) reported that Malaysian ethnic Indian males were at increased risk. Even though the harm to self aspect of psychological well-being in the present study did not significantly predict treatment outcomes in substance abuse clients, the finding of the study warrants future studies on culture and self-harm among individuals with substance abuse issues in Malaysia. For example, Khan et al. (2012) reported in their study that cultural epidemiology of self-harm among Malays ethnic was underreported in Malaysian society due to factors including religion, fear of psychiatric hospitalization, loss of face, and sense of dishonor to their families.
**General well-being and treatment outcomes.** In this study, general well-being is measured by the Malay version of the Clinical Outcome in Routine Evaluation. This evaluation illustrates the affective tone of the participants and assesses the participants' current state of mind. Some of the items that illustrate affective tone are "I have felt OK about myself" or "I have felt like crying." Understanding the clients' affective tone at the current moment corresponds with the phase model for psychotherapy change. This phase begins with improving well-being followed by the reduction in psychological symptoms and, ultimately, enhancing life functioning (Mellor-Clark et al., 1999).

In the present study, general well-being showed significant improvement at post-treatment assessment. General well-being, however, did not significantly contribute to predicting treatment outcomes when other aspects of psychological well-being – namely symptoms, life functioning, and harm to self – were held constant. This finding contradicts previous studies (Higgins et al., 2003; Sacks et al., 2004) that assessed the well-being and treatment outcomes for outpatients who had cocaine dependency.

Differences in treatment settings may explain why this study’s results differ from previous research. Freeman (2003) shows that opiate abusers who favored community programs, such as methadone maintenance programs, were more likely to sustain improvements in well-being than opiate abusers who favored total abstinence or residential treatment. This might be explained in part by the treatment regimen in community programs wherein methadone-dependent clients received pharmacotherapy treatment that help increase general well-being on a daily basis (Freeman, 2003).
Another reason why this study had different results may be the degree severity of psychological symptoms, which were the participants’ major concern. According to Skre et al. (2013), the reduction of psychological symptoms appears adequate for producing significant treatment outcomes and very useful for the therapist to create significant changes in clients. Other researchers (e.g., Bedfort, Watson, Lyne, Tibbles, Davies, & Deary, 2010) reported that general well-being likely represents the clients’ traits which are unlikely to change over a brief period of psychotherapy. The four-week treatment wherein SFGT was used in this study might be inadequate to sustain the general well-being in participants. Exploring the time factor and its relationship to the general well-being of substance abuse clients can be the focus of future research.

To predict treatment outcomes, previous research often combined general well-being with other indicators such as health outcomes, employment, and social functioning (Lambert et al., 1998). Freeman (2003) reported overall improvement among opioid dependents when well-being was combined with measures of health, which include general health, mental health, physical and social functioning, and vitality. The present study found that the factor of general well-being did not, by itself, significantly predict treatment outcomes; however, when it was combined with other aspects of psychological well-being—symptoms, life-functioning, and harm to self—the model was statistically significant. Even though the present study indicated that general well-being was not a significant independent predictor of treatment outcomes, understanding the state of mind (the general well-being) of substance abuse clients as part of psychological well-being
provides therapists with useful hints about the problem profile of the clients that could, in turn, lead to exploring other concerns in their life such as affective disorder, living conditions, among others (Skre et al., 2013).

In Malaysia, Baharudin et al. (2013) reported that the etiology of general well-being among substance dependents was complex considering the bidirectional relationship between types of drugs and psychological well-being. They found that individuals who abused only cannabis were more likely to report major depression compared to individuals who abused poly-drugs, such as cannabis and cocaine or heroin. Ghani et al. (2015) reported that opioid dependents’ general well-being, which includes emotional problems, improved significantly even after the short period of treatment program. Other Malaysian researchers such as Matshah et al. (2014) reported that methamphetamine abusers need a longer treatment program to realize general well-being as they had high chances of relapse as compared to heroin or cocaine abusers.

This corresponds with Nazar et al.’s (2006) suggestion that in the Malaysian context, treatment outcomes indicators that include general well-being largely depend on the types of drug used by the individual because each type of substance affects drug recovery rates and the chances of relapse to drug use. Hence, it would be interesting to investigate the general well-being for each substance type and its relation to treatment outcomes for future studies. Knowing the types of substance before treatment is started may be helpful in addressing appropriate interventions for clients.
Considerations of the Findings

The results offer significant considerations that may be contributed to the overall findings of the study in general as well as in group, solution-focused approach, and cultural perspective.

First, in general, the findings lead to the conclusion that SFGT was useful in improving overall treatment outcomes as evident by the significant reduction in symptoms distress and significant increase in psychological well-being in participants. Increased psychological well-being was observed in all four aspects: symptoms, life functioning, harm to self, and general well-being. These findings are consistent with previous studies (Li et al., 2007; Smock et al., 2008; Proudlock & Wellman, 2011). The significant reduction in symptoms distress in treatment outcomes is seemingly explained by the tendency of the participants to describe behavioral changes that were related to reducing emotional problems accompanying substance abuse as a response to the miracle question. Considering the participants’ response to the miracle question in solution-focused approach is important as it becomes the focus of change in session (e.g., solutions will be oriented toward the response), the findings of this study can be interpreted as contradictory to the literature. For example, Coe (2000) operationally defined reduction in psychiatric symptoms as study outcomes and Li et al (2007) operationally defined behavioral changes associated with abstinence as study outcomes.

Second, group work within a solution-focused approach framework may be contributed to improved treatment outcomes as it provides substantial benefits for the
members including synergistic atmosphere in the group and mutual help and support between the group members in working together toward developing solutions (Froerer et al., 2009). The present study used a closed-group format of solution-focused approach. This group format is applicable to counseling substance abuse clients in a residential care setting in Malaysia, because it creates a sense of family or a community, where the participants can feel welcomed and that they belonged (Froerer et al., 2009). This sense of family is invaluable to participants of the present study, who already value family or group mission over the individual in collectivist culture. Being in a group and being supported by group members while working on individual changes contributes general wellness and helps with managing symptoms distress. The advantages of group work within a solution-focused approach in the present study are contrary to previous studies that report individual therapy enables the therapist to spend more time and attention focusing on a client and his or her perspectives and concerns, than in group (Li et al., 2007).

Next, the fundamental notions of solution-focused approach are based on the social construction philosophy of knowledge, according to which reality is socially constructed based on one’s perspective through language (Miller & Berg, 1995). The construction of the meaning of life or reality that includes living, social interaction, and development occur within one’s sociocultural context. A solution-focused therapist fosters changes in clients by opening up new perspectives of reality to the client with less emphasis on “right” or “wrong”, instead focusing on what works for the client (Ho et al.,
2003). The philosophy of knowledge of social construction inherent in solution-focused approach framework may be contributed to overall improved treatment outcomes in the present study and that philosophy is pertinent to addiction counseling. In doing so, substance abuse clients can construct their own reality of recovery using their own frame of reference (e.g., cultural background). A solution-focused therapist collaboratively works with a substance abuse client in a therapeutic conversation to develop solutions. Allowing the clients to utilize their own frame of reference contributes to enhance psychological well-being as solutions and alternatives are viable within the sociocultural context of the clients (Ho et al., 2003). Allowing clients to construct their own reality of recovery may be contrary to previous studies that concluded that this practice in counseling only strives for economic therapeutic, which is to obtain only desired therapeutic results (immediate interventions). Therefore, this practice may deprive clients who may need intensive counseling for long-term care (Ho et al., 2003).

Finally, because the present study was conducted in Malaysia, it is crucial to address cultural factor in discussing the outcomes. The Malay ethnic group’s being a collectivist culture and a past-time orientation society presents two cultural dimensions that need to be considered in understanding the Malay ethnic cognitive frame and its relation to the outcomes of the present study. From the findings, there were two focal points of solution-focused approach (relationship-oriented questions and identifying exceptions) found to be adapted easily with the participants to create a solution-oriented story throughout the session.
Relationship-oriented questions are more applicable to ask the ethnic Malay as those questions highlight the participants’ relationships with their family or groups as they making changes. This is aligned with the collectivist culture of the ethnic Malay that values family and group relationship (Hofstede, 1986, 1991). An example for a relationship-oriented question that highlights the centrality of the family while helping the client to change is “In what way could you tell that your families notice changes in you?” Using relationship-oriented questions to identify what changes would look like in participants could increase how they perceive their efficacy to change. Moreover, identifying exceptions correspond more to the past-time orientation of the Malay ethnic group. The main objective of using exceptions questions is to explore the participants’ strategies in times when a problem is not severe and its aim to identify the participants’ coping strategies that worked in the past (de Shazer, 1991). Exception questions allow the participants to identify their own significant past experience as the source of hope for change.

While relationship-oriented questions and identifying exceptions are used in general solution-focused therapy sessions across populations, the collectivist and past-time orientation culture of Malay ethnicity plays a role in determining contextual manifestation of changes in therapy. Response to relationship-oriented questions create the sense that the participants are not a burden to their families, which help to lessen psychological distress and ultimately contribute to general wellness. This is important as one not being a burden to his or her ingroup (e.g., family, relatives, and community)
defines self-reliance in collectivist culture (Tafarodi & Smith, 2001). Meanwhile, exception questions provide opportunity for the Malay ethnic group to use their own significant past experience that includes traditions, which suggests respect to their past-time orientation culture. The sense that they are not a burden to their families and that their traditions are respected by the therapist could explain the outcomes of the present study in participants.

Respecting past-time orientation is valued in the Malay ethnic group. This and the use of miracle questions and goal setting that project solutions into the future may conflict with the focal point of SFGT on strengths. De Shazer (1998) defined miracle questions as the "centerpiece of this approach" (p.366). This also contrary to previous studies that report that miracle questions were essential in solution-focused therapy session in dealing with clients presenting substance abuse issues (Hayes et al., 2010; Spilsbury, 2012) as well as emotional problems (Springer et al., 2000).

A more culturally-sensitive approach may be to paraphrase the miracle questions that highlight past time, or when things were harmony “back then.” It is important for the therapist to paraphrase or restate the participants’ responses about their traditions and utilize them as source of inspiration and hope for change. This will ensure that the therapist is respecting the traditions shared by the participants. In addition, scaling questions may be adapted easily with the participants to track their changes toward obtaining goals that not only focus on their progress on scaling individually, but also includes specific behaviors the participants believe their family or group would like them
to accomplish. This is important to consider when utilizing this technique with the Malay ethnic group as self-acceptance is largely a reflection of family or social acceptance (Tafarodi & Smith, 2001). By incorporating the participants’ family or group in scaling questions, together the therapist and the participants may identify components that are needed to measure progress without neglecting the participants’ values regarding family and traditions.

**Implications for the Counseling Field**

The conclusions from this study offer significant insight into the utilization of solution-focused approach in non-Western populations and the relationship between psychological well-being and treatment outcomes for substance abuse clients in Malaysia. Most important, the findings provide foundations that can be used by professionals providing addiction counseling education and by professionals providing substance abuse treatment in Malaysia.

**Addiction Counseling Education**

This study found that using SFGT resulted in statistically significant improvements in treatment outcomes and psychological well-being at post-treatment. As such, there are several implications for addiction counseling education. First, the fundamental ideas of the solution-focused approach that emphasize multiple truths in constructing a reality based on one's frame of reference and an individual’s potentials and strengths are useful for treating individuals with substance abuse issues in addiction counseling. De Shazer (1990) reported that helping substance abuse clients with SFGT is
useful because of its unique approach whereby clients determine their own goals and outcomes for therapy. In other words, clients can develop their goals and outcomes in the context of their culture and value system, rather than simply following the dictates of the therapist.

The findings of this study provide initial support to the idea that educators teaching addiction counseling courses need to emphasize solution-focused approaches as much as traditional approaches, such as the cognitive-behavioral approach where therapists are considered the expert in the course of therapy. For instance, educators can incorporate a solution-focused approach as one of the course assignments. Incorporating solution-focused approaches will provide students with more resources so that, by the end of the course, the students would have a wider repertoire from which to draw when evaluating their clients. Saleebey (1996) argued that most psychotherapists in the United States adopt psychotherapy approaches that are based on a pathological view of their clients. For instance, the social model of addiction focuses on negative aspects or deficiencies, such as destructive behavior and poor socialization skills of the clients (SAMHSA, 1997). Although it has been demonstrated that SFGT brings about improved outcomes in treating substance abuse clients, its effectiveness and efficacy needs to be established, so that it can stand alongside with other traditional psychotherapy approaches (Kim, 2008).

Second, educators may need to emphasize the utilization of solution-focused approaches in different cultural settings in their teaching. Even though the general
fundamentals of solution-focused approach (i.e., respecting client's worldview) are comprehensible and feasible to practice across cultural settings, understanding how cultural values impact its application is important to maximize the benefits for clients (Lee, 2003). For example, how can a solution-focused approach be used with clients who value collectivism? Lee (2003) states that although there is a discussion on the cross-cultural application of solution-focused approaches, there is relatively little discussion about how to use solution-focused fundamentals systematically to inform clinical practice.

Finally, this study’s findings also have implications for international students who are studying counseling in American universities. The solution-focused approach originated from the United States and, as such, certain values and premises embedded in the approach were tested on Caucasian American clients (Meyer & Cottone, 2013). International students may need to increase their awareness by taking their cultural values into consideration while learning a solution-focused approach. That is, international students who operate from strength perspectives like solution-focused approaches, should demonstrate curiosity about, and appreciation of, their own cultural values and resources and utilize them in the learning process of solution-focused approach (Lee, 2003). For example, international students who come from past-time orientation or present-time orientation may show curiosity about utilizing a solution-focused approach, which is future-time orientation. This curiosity may further lead to a broader discussion with instructors or peers, thereby creating a wider impact for ideas on solution-focused
approach learning. This may help international students prepare to utilize the approach in their respective cultural settings and may improve the education and clinical skills of instructors and other students.

Substance Abuse Treatment in Malaysia

This study provides additional support for calls to further investigate the use of the solution-focused approach in the Malaysia population. This study’s findings suggest that individuals with substance abuse issues significantly benefit from SFGT in terms of increasing treatment outcomes and psychological well-being. The positive significant relationship between treatment outcomes and psychological well-being suggests that participants who score higher on treatment outcomes also score higher on psychological well-being and, conversely, participants who score lower on treatment outcomes also score lower on psychological well-being. This study also explored to what extent psychological well-being contributes to predicting treatment outcomes in the present study’s participants. The regression model indicated that psychological well-being contributed 71.8% of the variance in predicting treatment outcomes. These findings have several implications in substance abuse treatment in Malaysia that includes National Anti-Drug Agency Malaysia (NADA) and the addiction counselors who are working with individuals with substance abuse issues in Malaysia.

First, the therapy process in SFGT is based on solution-focused brief therapy (SFBT), the intention of which is to promote change with brief interventions in a more cost-effective manner (McCollum et al., 2003). Prior studies on solution-focused
approaches have shown that brief interventions provide similar or better outcomes than more extensive interventions in substance abuse treatment (Miller & Willoughby, 1997; Smock et al., 2008). In Malaysia, the focus of drug treatment was transformed from compulsory drug detention programs that used traditional approaches (e.g., medical model, physical training, etc.) to ambulatory care programs, known as Cure and Care, that use voluntary care programs in 2010 (Kaur, 2012). The ambulatory care program is characterized as a less time-consuming and a less intensive treatment that incorporates day care, medical detoxification, drug substitution therapy, and psychotherapy in the treatment program. Even though the Cure and Care program has been shown to have positive results, there is still a need to investigate psychotherapy approaches and their efficacy for the mental health treatment component in the program (Kamarulzaman, 2012).

Given the statistically significant improved outcomes in the present study in utilizing solution-focused approach with substance abuse clients in Malaysia, NADA Malaysia may want to consider incorporating the fundamental notions of the solution-focused approach (i.e., solution building in therapy by focusing on exceptions to problems while respecting the client's frame of reference) into the current psychotherapy approach used in residential settings. The underlying theoretical rationale of solution-focused approaches, such as being a brief therapy and a focus on strengths, is aligned with the concept of the ambulatory care program in Malaysia. According to Smock et al. (2008), solution-focused approaches that emphasize brief interventions and the resiliency
of clients may be part of an effective and cost-efficient strategy to treat a population who demand a great deal of resources, such as individuals with substance abuse issues.

Second, with respect to the economic burden of treatment, the Cure and Care program may consider using group formats to reduce costs, while maintaining or improving standards of care to clients. This will not only benefit the group in terms of developing group cohesiveness and peer support that offer encouragement during the process of change (LaFountain & Garner, 1996), but it will also benefit the residential agencies which can then treat more than one client at a time. Smock et al. (2008) reported that because group therapy in general is an extremely cost-effective modality, it is often incorporated into treatment plans for substance abuse clients in mental health facilities. Furthermore, utilizing group formats in residential treatment settings does not require significant changes from the agencies’ staff who already value their role in promoting change in group settings. As McCollum et al. (2003) asserted, group therapy that is "culturally sensitive" can emphasize change in group settings.

Finally, there are clinical implications for addiction counselors in Malaysia. First the counselors may consider non-confrontational approaches in goal development when working with substance abuse clients. De Shazer and Isebaert (2003) reported that the main interventions of solution-focused approaches, such as miracle and exception questions, are non-confrontational and flexible ways by which clients may construct goals. Developing goals based on the clients’ choice is sufficient to create a degree of accountability in clients who can take ownership of their treatment. Smock et al. (2008)
stated that this factor is important, as it usually led to more cooperation and, ultimately, more successful outcomes.

Valuing clients' choice in determining the goals and solutions, instead of the therapist dictating the course of therapy, seems to be an ideal approach to incorporate in the psychotherapy approach in the Cure and Care program of substance abuse treatment in Malaysia. When using non-confrontational approaches (e.g., miracle and exception questions) in collectivist societies such as Malaysia, addiction counselors may need to help their clients find meanings to attach to the solutions and utilize those meaning as strengths in the course of therapy. For instance, the participants in the present study reported that they valued close relationships with their families and did not want to feel that they were a burden to their families who have been assisting them in reducing their distress symptoms. Hence, addiction counselors may need to utilize these values in therapy. Lee’s (2003) review of using solution-focused approaches among Asian populations found that some notable cultural strengths of collectivism society, such as the value of an extended family and saving-face, may be used in therapy in order to produce significant changes in clients. She further asserted that a major focus of therapy is to assist clients in identifying, expanding, and utilizing strengths that are rooted in their cultural context, rather than ignoring those contexts.

**Limitations**

Though the findings of this study provides important insights into the utilization of solution-focused approach in a Malaysian population and its effect on treatment
outcomes in substance abuse clients, this study is not without its limitations. First, the present study employed a quasi-experimental research design using non-randomized pre- and post-test single group design in a residential care setting in Malaysia. The lack of randomization in participant selection procedure limits the generalizability of this study’s findings. Furthermore, the present study only included male individuals from the Malay ethnic group. Hence, the findings of the present study may not be generalizable to female individuals with substance abuse issues.

Second, the sample size in this study was not large enough to obtain a definitive conclusion about the utilization of solution-focused approach in individuals with substance abuse issues in Malaysia. The small size is partly due to only one center being selected.

Third, despite the compelling findings of the study, no control groups were involved. Therefore, there no definitive conclusion regarding a solution-focused approach as better than other psychotherapy approaches in treating substance abuse clients with co-occurring symptoms in Malaysia may be drawn. The inclusion of control groups with which to compare may have provided much stronger findings and conclusions in using solution-focused approaches in Malaysia. However, the research design used in this study served the purpose of the study, which was to provide preliminary support for the efficacy of SFGT for substance abuse clients in a residential care setting conducted in Malaysia.
Finally, the use of self-report questionnaires for data collection in this study presents some potential for response bias, as participants may exaggerate or inaccurately report their symptoms. This is due to items on the instrument being subject to biased interpretation on the part of each participant. Considering that each participant is unique in terms of their drug history background, they might give different meaning to the items on the instrument.

**Recommendations for Future Research**

This study was the first to have explored the efficacy of solution-focused group therapy on substance abuse clients in a residential care setting conducted in Malaysia. Because this study was the first of its kind, it revealed several areas for future research. The researcher identified the following recommendations for future research investigating solution-focused approach on individuals with substance abuse issues in Malaysia.

First, it may be beneficial in future research studies to use experimental research design, where a control group and random assignment to groups may occur. In the presence of control groups, the findings may suggest comparisons of efficacy to be made between either solution-focused approaches, and no treatment or standard institutional services (Gingerich & Peterson, 2013). Results of randomized trials may permit more definitive conclusions on the effectiveness of SFGT, the results of which may benefit many groups of people involved in substance abuse treatment services, such as policy makers and funders, in decision making and planning to fund a treatment centers.
Additionally, therapists need to know the evidence base for the approach before implementing it with the clients, and the substance abuse clients themselves need to know whether the approach being recommended is effective (Gingerich & Peterson, 2013).

Second, conducting studies on SFGT in multiple residential settings to increase the sample size by recruiting more clients may be helpful in achieving better heterogeneity of the ethnic groups background of the study population, for instance, to include Chinese, Indians, and other minority ethnic groups in Malaysia. In the current study, all participants were from the Malay ethnic group. Including more diverse representation of participants in terms of ethnic groups will allow for ethnic comparisons in regards to treatment outcomes (Baharudin et al., 2013). Moreover, when samples are more representative of Malaysia’s multicultural population as a whole, the results may be generalizable within Malaysia.

Finally, conducting experimental research design in SFGT on female individuals with substance abuse issues may be helpful in understanding gender differences on treatment outcomes resulting from SFGT. In the current study, the all male participants reported that their reality of recovery was surrounded by the feeling of not wanting to be a burden to their families and having a close relationship with the them. While this is consistent with collectivist values in Asian culture (Lee, 2003), male individuals also are expected to be a “breadwinner” for the families as compared to their gender counterparts in Asian cultures, like Malaysia (Baharudin et al., 2013). Baharudin et al. (2013) suggested that gender-role expectations in collectivistic society could influence
depression among individuals with substance abuse history. It may be helpful to understand how gender-role expectations affect solutions building in drug recovery among individuals with substance abuse issues to target interventions that address these unique expectations in Malaysian population.

Conclusion

The purpose of this study was to explore the utility of SFGT in Malaysian culture by assessing its effect on the treatment outcomes and psychological well-being on substance abusers in a residential care setting in Malaysia. Moreover, this study used psychological well-being as a predictor of treatment outcomes. This particular study represents a first step toward utilizing solution-focused approaches in substance abuse treatment in Malaysian culture. The positive treatment outcomes and psychological well-being found in this study further suggest the use of a brief and strength-based therapy, which emphasizes clients’ potentials and resources within a Malaysian population. The fundamental notion of the solution-focused approach that values clients’ frame of reference in solution-building seems to be ideal for implementation in Malaysian culture. Cultural factors of Malaysian culture, such as collectivistic values and past-time orientation can be incorporated in solution-building and goal development in the course of therapy.

In addition, this study included data that were analyzed to assess for the strength of predictability scores on the Malay version of Outcome Questionnaire to measure the outcomes and scores on the Malay version of Clinical Outcome in Routine Evaluation to
measure psychological well-being. The findings of the present study suggest that substance abuse clients who score increased on psychological well-being tend to have a trajectory toward improved treatment outcomes. Furthermore, substance abuse clients with longer experience in period of sobriety tend to have a trajectory toward better treatment outcomes. While much further research is needed to explore and validate these findings, it appears that SFGT is appropriate to be utilized with substance abuse clients in Malaysian culture. With an understanding that the relationship between treatment outcomes and psychological well-being exists within the participants of this study, interventions may be developed to address aspects of client needs deserving attention in the journey of their drug recovery.
APPENDICES
APPENDIX A

IRB APPROVAL
Appendix A

IRB approval

11/15/2015 Kent State University Mail - IRB approval for protocol #15-381 - retain this email for your records

IRB approval for protocol #15-381 - retain this email for your records
RAGS Research Compliance <researchcompliance@kent.edu> Wed, Jun 24, 2015 at 2:07 PM To: "JENCIUS, MARTIN" <mjencius@kent.edu>  Cc: "fsabri@kent.edu" <fsabri@kent.edu>
RE: IRB # 15-381 entitled “Solution-Focused Group Therapy in a Residential Care Setting: An Outcome Study Conducted in Malaysia”
I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants. This protocol was reviewed at a fully convened board meeting on June 17, 2015. Approval is effective for a twelve- month period:

June 17, 2015 through June 16, 2016

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice by email as a courtesy. However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.
If you have any questions or concerns, please contact the Office of Research Compliance at Researchcompliance@kent.edu or 330-672-2704 or 330-672-8058. Kent State University Office of Research Compliance
APPENDIX B
INFORMED CONSENT
Appendix B

Informed Consent

Kent State University
Informed Consent to Participate in a Research Study

Study Title: Solution-Focused Group Therapy in A Residential Care Setting: An Outcome Study Conducted in Malaysia

Principal Investigator: Farhana Sabri
You being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participant in voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose
This study is focused on investigating the effects of Solution-Focused Group Therapy in a residential care setting. The effects will determine the outcomes of the techniques in SFGT.

Procedures
If you agree to participate in the study, you will be asked to participate in solution-focused group therapy and you will not have the standard group therapy at the residential treatment.
Solution-focused group therapy should take approximately 1.5 hours every week over four weeks period. You will be given an instrument booklet twice; in the pregroup session and at the end of group therapy (week 4).

Audio
Audio recording will be used to capture the response of the therapist. The recording session is used for the therapist assessment; to ensure that treatment deliver to you is in fact solution-focused group therapy. All recordings and related researchers notes will be discarded in a secure manner at the completion of the study. The content of the recording session is not used to report findings in writing and/or presentation. You have the right to review these recordings, if requested.

Benefits
The potential benefits of participating in this study may include attending group therapy. It is hope that through you participation, you will have an opportunity to explore your coping strategies and strengths that will help with the abstinence. Additionally, your
participation in this study will add to the counseling literature to better understand drug addiction counseling in Malaysia.

**Risks/Discomforts**
There are no anticipated risks beyond those encountered in everyday life. However, reflecting on substance abuse experience may be upsetting. Below is a list of resources you may call for support:
- Your local counselors at the center. Phone number 03-9056 2997/2945 or 03-9058 7267
- Your local peer support members at the center (24 hours)
- Group support for recovering addicts at Cure and Care Service Center (CCSC), Chow Kit, Address: No 24A & 24B, Level 1 and 1, Haji Taib Dr, 50300 Kuala Lumpur. Phone number 03-4041 0467

**Privacy and Confidentiality**
Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used.

**Compensation**
No financial or other compensation will be awarded for participation in this study.

**Voluntary Participation**
Taking part in this research study is entirely up to you. Your participation in this research will not influence the length of your treatment. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact information**
If you have any questions or concerns about this research, you may contact the investigator Farhana Sabri at 330-999-0145. You an also contact this researcher’s advisors, Dr. Marty Jencius at 330-672-2662, or Dr. Jason McGlobalhin at 330-672-0716. This project has been approved by the Kent State University Institutional review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330-672-2704.

**Consent Statement and Signature**
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that I can print a copy of this consent form for future reference.

Participant Signature: 
Date:
APPENDIX C

SOLUTION-FOCUSED GROUP THERAPY STEPS
Appendix C

Solution-Focused Group Therapy Steps and Strategies

The treatment flow is based on Pichot and Dolan's (2003) manual of SFGT.

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

A LIST OF MAJOR TECHNIQUES AND STRATEGIES
Appendix D

A List of Major Techniques and Strategies

The opening session focuses on the group members' progress since the last meeting as well as identify coping strategies through the exception questions. The following techniques and strategies are used within each group session and the length of group therapy is one hour-and-half over four weeks.

1. Opening Session
   Questions:
   a. What is better since we last met?
   b. How do you account for change?
   c. How did you do that?
   d. Are these the changes you would like to continue to have happen?

2. Setting Goals
   Questions:
   a. How will you know that you have gotten what you came for and that treatment will end?
   b. What will be the first sign indicated to you that things are moving in the right direction as you want?
   c. What will be the signs that things are continuing in the right direction?
   d. Do you think that if you continue to do more of what has been working, you will be on-track toward solving this problem?
   e. What action are you willing to do about this problem?

3. The Miracle Question
   Questions:
   a. Suppose you went to bed tonight and while you were asleep, a miracle happened, and your problem solved. You do not know that a miracle happened because you are asleep. What would you notice differently about yourself in the morning, which would tell you that your problem solved? – strategies using crystal ball or video tape might be included
   Working question:
   a. What else do you notice?
   b. Tell me more about that?
   c. What will you be doing if you are not..?
   d. What will you be doing if you are..?
   e. What will ……. notice about you when you ….?
   f. What will you notice about ……. when they ….?
   g. What will you be feeling when…?
   h. How will ….. know you are feeling ……..?
4. **Formula Every Session Task**
   Strategies: Between now and next session, I would like you to observe, what is already happening in your life (in relation to the goal area) that you would like to have continue to happen. You can report that to me next week and we will discuss.

5. **Do Something Different Task**
   Strategies: Between now and next session, I would like you to do something different than you normally would do, no matter how strange or weird what you do might seem.

6. **Predicting Relapse**
   Change is three steps forward and two steps back, but we are never back to square one.

7. **Identifying Exceptions**
   Questions:
   a. Tell me about times when this problem does not occur?
   b. Tell me more about how do you do that?
   c. Tell me about times when the miracle happens just a little bit?
   d. What is different about the times when the problem does not occur?
   e. What will have to happen for you to do it that way more often?
   f. If your significant other was here, what do you suppose they would say or notice different about you at those times when the problem does not occur?

   Strategies if the participants deny exceptions:
   Appropriate response: …hmm that is unusual..
   Questions:
   a. What is different about the times when..?
   b. When is the problem less severe, frequent, intense, or shorter in duration?
   c. C. Have you ever had … or when you have felt … in the past? How did you cope or resolve it then?

8. **Discovering Solutions**
   Questions:
   a. How did you get that to happen? (for instance how “good thing for you”, symptom reduction or disappearance happened)

   Strategy to elicit the solution:
   a. You must have done something, what could that have been?
9. **Relationship Questions (Expanding Solutions)**
   Questions:
   a. How does it make your day go differently when you…?
   b. Who else notices when …? In what way could you tell that …… noticed?
   c. How did you get …. to end or stop?
   d. How did you figure out that to solve …. or end …. you need to ……?
   e. How is that different from the way you might have handled ….. before?

10. **Coping Questions**
    Questions:
    Sound serious. How is it that things are not worse?
    What are you doing to keep going when things are so bad?
    What would tell you that things are getting a little better?
    What would it take to make that happen?

11. **Scaling Questions**
    Questions:
    a. On a scale of 1 to 10, with 10 indicating you have every confidence that this problem can be solved, and 1 indicating no confidence at all, where would you put yourself today?
    b. On the same scale, how realistic would you say it is that this problem can be solved?
    c. On the same scale, where would you say you have to be live with this problem?
    d. What would have to happen to move from …. to a ……?
    e. On the same scale, how confident are you that you will continue to make progress at the pace you have been at?
    f. What would others say they need to see you do to move from a …. to a ….?

12. **Relabeling**
    Strategy: Redefining client’s definition of the problem as something less pathological. For instance, “depression” is relabeled as “the blues.”

13. **Normalizing**
    Strategy: Therapist describes the problem definition as common through such techniques as completing the clients’ sentence, or telling a story about the problem. For instance, “…. and did you stay in bed all day too? Yeah, if I were doing a really good depression I wouldn’t eat either.”

14. **Reflecting Qualifiers**
    Strategy: If a client states an absolute wording, for instance always or never, the counselor reflects frequently or sometimes.
15. Cheerleading and Compliments
   Response: That is great. I am impressed with the way you ….
APPENDIX E

PERMISSION TO TRANSLATE THE OUTCOME QUESTIONNAIRE INTO MALAY LANGUAGE AND TO USE IT
Hello Farhana,
I have good news! You are authorized to translate the OQ®-45.2 into Malay. I have attached a research order form for you to complete and fax to our office. There is a section on your research so just copy and paste the information you sent to me into the order form. The license fee is $30 and $25 for shipping and handling. The licensure includes permission to use the OQ for the purpose of your study and to include a copy of the OQ in your dissertation write-up.

Also attached are our translation guidelines which you seem to be following but I wanted you to have a copy to keep with your records.

Thank you Farhana,
Shari

Shari Rosefelt, Sales Consultant
OQ Measures, LLC | Sales and Customer Support
Direct Line: (801) 649-3334 | Fax: (801) 747-6900
Toll Free: (888) 647-2673 Ext: 302
Email: shari.rosefelt@oqmeasures.com | Site: www.oqmeasures.com
APPENDIX F

THE OUTCOME QUESTIONNAIRE
**Appendix F**

**The Outcome Questionnaire**

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation.

<table>
<thead>
<tr>
<th>Items</th>
<th>0 Never</th>
<th>1 Rarely</th>
<th>2 Sometimes</th>
<th>3 Frequently</th>
<th>4 Almost Always</th>
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</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
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<td>2. I tire quickly.</td>
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<td>3. I feel no interest in things.</td>
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<td>4. I feel stressed at work/school</td>
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<td>5. I blame myself for things.</td>
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<td>6. I feel irritated.</td>
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<td>7. I feel unhappy in my marriage/significant relationship.</td>
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<td>8. I have thoughts of ending my life.</td>
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<td>9. I feel weak.</td>
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<td>10. I feel fearful.</td>
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<td>11. After heavy drinking, I need a drink the next morning to get going (if you don’t drink, mark “never”)</td>
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<td>12. I find my work/school satisfying.</td>
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<td>13. I am a happy person.</td>
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<td>14. I work/study too much.</td>
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<td>15. I feel worthless.</td>
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<td>16. I am concerned about family troubles.</td>
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<td>17. I have an unfulfilling sex life.</td>
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<td>18. I feel lonely.</td>
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<td>19. I have frequent arguments.</td>
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<td>20. I feel loved and wanted.</td>
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<td>21. I enjoy my spare time.</td>
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<td>22. I have difficulty concentrating.</td>
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<td>23. I feel hopeless about the future.</td>
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<td>24. I like myself.</td>
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<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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<td>26.</td>
<td>I feel annoy by people who criticize my drinking (or drug use) (if not applicable, mark never)</td>
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<td>27.</td>
<td>I have an upset stomach</td>
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<td>28.</td>
<td>I am not working/studying as well as I used to.</td>
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<td>29.</td>
<td>My heart pounds too much.</td>
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<td>30.</td>
<td>I have trouble getting along with friends and close acquaintances.</td>
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<td>31.</td>
<td>I am satisfied with my life.</td>
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<td>32.</td>
<td>I have trouble at work/school because of drinking or drug use.</td>
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<td>33.</td>
<td>I feel that something bad is going to happen.</td>
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<td>34.</td>
<td>I have sore muscles.</td>
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<td>35.</td>
<td>I feel afraid of open spaces, or of driving, or being on buses, subway, etc.</td>
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<td>36.</td>
<td>I feel nervous.</td>
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<td>37.</td>
<td>I feel my love relationships are full and complete.</td>
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<td>38.</td>
<td>I feel that I am not doing well at work/school.</td>
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<td>39.</td>
<td>I have too many disagreements at work/school.</td>
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<td>40.</td>
<td>I feel something is wrong with my mind.</td>
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<td>41.</td>
<td>I have trouble falling asleep or staying asleep.</td>
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<td>42.</td>
<td>I feel blue.</td>
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<tr>
<td>43.</td>
<td>I am satisfied with my relationship with others.</td>
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<tr>
<td>44.</td>
<td>I feel angry enough at work/school to do something I might regret.</td>
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<tr>
<td>45.</td>
<td>I have headaches.</td>
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</tbody>
</table>
APPENDIX G

PERMISSION TO TRANSLATE CLINICAL OUTCOME IN ROUTINE EVALUATION INTO MALAY LANGUAGE AND TO USE IT
Appendix G

Permission to Translate the Clinical Outcome in Routine Evaluation into Malay Language and to Use it

FRMargison@aol.com 9/11/14
to cst, M.Barkham, riche80, me, john.mellor-cl.

Thanks Farhana,

I am copying the other trustees and John into my reply.

The procedure you are following seems to me to follow the spirit and letter of the processes Chris has suggested, so on behalf of the CORE Trustees we are happy for you to undertake the translation into Malay and liaise with Chris Evans on progress as appropriate and following the conditions as you have laid them out. You also have permission to use the CORE for the purpose of your study and include a copy of the CORE in your dissertation write-up.

many thanks

Frank

Frank Margison
CORE Trustee
APPENDIX H

THE CLINICAL OUTCOME IN ROUTINE EVALUATION
Appendix H

The Clinical Outcome in Routine Evaluation

**Instructions:** This form has 34 statements about how you have been over the last week. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

<table>
<thead>
<tr>
<th>Statements</th>
<th>0 Not at all</th>
<th>1 Only Occasionally</th>
<th>2 Sometimes</th>
<th>3 Often</th>
<th>4 Most or all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have felt terribly alone and isolated.</td>
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<tr>
<td>2. I have felt tense, anxious, and nervous.</td>
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<td>3. I have felt I have someone to turn to for support when needed.</td>
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<td>4. I have felt OK about myself.</td>
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<td>5. I have felt totally lacking in energy and enthusiasm.</td>
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<tr>
<td>6. I have felt totally lacking in energy and enthusiasm.</td>
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<tr>
<td>7. I have felt able to cope when things go wrong.</td>
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<tr>
<td>8. I have been troubled by aches, pains or other physical problems.</td>
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<td>9. I have thought of hurting myself.</td>
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<td>10. Talking to people has felt too much for me.</td>
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<tr>
<td>11. Tension and anxiety have prevented me doing important things.</td>
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<tr>
<td>12. I have been happy with the things I have done.</td>
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<td>13. I have been disturbed by unwanted thoughts and feelings.</td>
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<td>14. I have felt like crying.</td>
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<td>15.</td>
<td>I have panic or terror.</td>
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<td>16.</td>
<td>I made plans to end my life.</td>
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<td>17.</td>
<td>I have felt optimistic about my future.</td>
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<td>18.</td>
<td>I have difficulty getting to sleep or staying asleep.</td>
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<td>19.</td>
<td>I have felt warmth and affection for someone.</td>
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<td>20.</td>
<td>My problems have been impossible to put one side.</td>
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<tr>
<td>21.</td>
<td>I have been able to do most things I needed to.</td>
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<td>22.</td>
<td>I have threatened or intimidated another person.</td>
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<td>23.</td>
<td>I have felt despairing and hopeless.</td>
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<td>24.</td>
<td>I have thought I would be better if I were dead.</td>
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<td>25.</td>
<td>I have felt criticized by other people.</td>
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<td>26.</td>
<td>I have thoughts I have no friends.</td>
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<td>27.</td>
<td>I have felt unhappy.</td>
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<td>28.</td>
<td>Unwanted images or memories have been distressing me.</td>
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<td>29.</td>
<td>I have been irritable when with other people.</td>
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<td>30.</td>
<td>I have thought I am to blame for my problems and difficulties.</td>
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<td>31.</td>
<td>I have felt overwhelmed by my problems.</td>
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<tr>
<td>32.</td>
<td>I have achieved the things I wanted to.</td>
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<tr>
<td>33.</td>
<td>I have felt humiliated or shamed by other people.</td>
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<tr>
<td>34.</td>
<td>I have hurt myself physically or taken dangerous risks with my health.</td>
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</tbody>
</table>
APPENDIX I

FLOW OF BACK TRANSLATION PROCEDURES FOR THE OUTCOME QUESTIONNAIRE AND THE CLINICAL OUTCOME IN ROUTINE EVALUATION
Appendix I

Flow of back Translation Procedures for the Outcome Questionnaire and the Clinical Outcome in Routine Evaluation


* The instruments were translated into Malay language by three bilingual professional with Teaching English as a Second Language (TESL) and psychological assessment background.

*Back translation was performed by three professional translators whom English is their main preference language with psychological assessment background.
APPENDIX J

SOLUTION-FOCUSED GROUP THERAPY ANALYSIS FORM
Appendix J

Solution-Focused Group Therapy Analysis Form

Evaluator: ___________________________   Session #: _____________    Date: ____________

Instructions: You are to record your observation of an audiotaped group counseling session. Below is a list of statements which might be used by the therapist. Review them carefully in advance, so that you will be able to collect the necessary information for your analysis. Then, as you listen to the tape, carefully consider each statement made by the counselor. Tabulate those you consider to be solution-focused as a "Yes" and other statements as a "No" by placing a tally mark in the appropriate row. Please total your responses.

<table>
<thead>
<tr>
<th>YES</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

Illustrative Solution-focused Statements:

Pre-session change
What is better since you first called, the last session etc..?
How do you account for ....(the change)?
How did you do that?
Are these the kinds of changes you would like to continue to have happen?

Setting Goals
How will you know that you've gotten what you came for and that treatment will end?
What will be the very first sign that things are moving in the right direction?
What will be a sign that things are continuing in the right direction?
Do you think that if you continue to do more of what has been working you will be on-track toward solving this problem?
What are you willing to do about this problem?

The miracle question
Suppose you went to bed tonight and while you were asleep a miracle happened, and the problems which brought you here are solved. But you're asleep and you don't know that a
miracle has occurred. What would you notice about yourself in the morning which would tell you that a miracle had occurred? (Variations on this may include crystal ball or video tape)

What else?
Tell me more about that.
What will you be doing if your are not ...?
What will you be doing if you are ...?
What will ... notice about you when you ...?
What will you notice about ... when they ...?
What will you be feeling when. ...?
How will ... know you are feeling ...?

Formula every session task
Between now and next session I would like you to observe, so that you can report back to me, what is already happening in you life (in relation to the goal area) that you would like to have continue to happen.

Do Something different task
Between now and next session, I would like you to do something different than you normally would do, no matter how strange or weird what you do might seem.

Predicting relapse
Change is three steps forward and two steps back, but we are never back to square one.

Identifying Exceptions
Tell me about times when this problem doesn't occur?
Tell me more about how you do that?
Tell me about times when the miracle happens just a little bit?
What's different about the times when the problem doesn't occur?
What will have to happen for you to do it that way more often?
If your husband/wife were here, what do you suppose they would say they notice different about your at those times when the problem doesn't occur?
If client denies exceptions - Hmm that's unusual
What is different about the times when...?
When is ... less severe, frequent, intense, or shorter in duration? When is it different in any way?
Have you ever had ... or when you have felt ... in the past, how did you resolve it then?
Discovering Solutions
How did you get that (i.e., "good" thing, symptom reduction or disappearance, etc.) to happen?
You must have done something, what could that have been?

Expanding or anchoring solutions
How does it make your day go differently when you ...?
Who else notices when ...? In what way could you tell that ... noticed?
How did you get ... to end or stop?
How did you figure out that to solve ... or end ... you needed to ...?
That's clever!
How is that different from the way you might have handled ... Before?

Coping Questions
Sounds serious. How is it that things are not worse?
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without permission.
What are you doing to keep going when things are so bad?
What would tell you that things are getting a little better?
What would it take to make that happen?

Scaling Questions
On a scale of 1 to 10, with 10 meaning you have every confidence that this problem can
be solved, and 1 meaning no confidence at all, where would you put yourself today?
On the same scale, how realistic would you say it is that this problem can be solved?
On the same scale where would you say you have to be to live with this problem?
What would have to happen to move to a ...?
On the same scale, how confident are you that you will continue to make progress at the
pace you have been at?
What would others say they need to see you do to move from a 4 to a 5?
Wow!! you rate yourself as a 2, 3 or 4 etc... That's impressive!

Relabeling: Redefining clients definition of the problem as something less pathological.
For example, "depression" is relabeled as "the blues."

Normalizing: Counselor describes the problem definition as common through such
techniques as completing the clients sentence, or telling a story about the problem. For
example, ...and did you stay in bed all day too?
Yeah, if I were doing a really good depression I wouldn't eat either.

Reflecting back qualifiers: If a client states an absolute i.e., always or never, the
counselor reflects back frequently or sometimes.
Cheerleading and Compliments
That's GREAT !!! or K E E P IT U P !!!
I'm impressed with the way you ....!
Appendix K

Demographic Information

Age : ______________       Race : __________
Marital Status : ______________       Religion : __________

Substance Abuse History

Number of relapse : 1) One time ____  2) Two times ____
                  3) Three times ____  4) Four times and more ____

Types of drug used : 1) Heroin ____  2) Cocaine ____
                     3) ATS/Syabu/Ice ____  4) Marijuana ____
                     5) Other ___________

How long have you been sober: ______________

Previous drug treatment : ___________________________________________

Readiness of Change

Instruction: The question illustrates three levels of readiness of change. You have to select one level of readiness that closely reflects your situation.

1) **Recognition**: I am experiencing problems related to my substance abuse. I have desire for change and see that I will continue to harm myself if I do not change.  
   _____

2) **Ambivalence**: I don’t think about whether I abuse substance too much. I tend not to think about how my behavior might be hurting others.  
   _____

3) **Taking steps**: I am doing things to make a positive change in my substance abuse. It is evident that change is underway and I may see out help to persists and prevent relapse.  
   _____
Indication of Abuse and Drug Dependence

1. Have you spent more time drinking or using than you intended to?   YES ___ NO ___
2. Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?   YES ___ NO ___
3. Have you felt you wanted or needed to cut down on your drinking or drug use in the last month?   YES ___ NO ___
4. Has anyone objected to your drinking or drug use?   YES ___ NO ___
5. Have you ever found yourself preoccupied with wanting to use alcohol or drugs?   YES ___ NO ___
6. Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?   YES ___ NO ___
REFERENCES
References


