Group psychological treatments: a therapeutic tool for change in people with substance addiction

Los tratamientos psicológicos grupales: una herramienta terapéutica para el cambio en personas con adicción a sustancias

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Received: 04/09/2025 · Accepted: 10/12/2025

Cómo citar este artículo/citation: Sierra Serrano, R., Palau Muñoz, C., Orengo Caus, T. & Sánchez Mañez, A. (2025). Group psychological treatments: a therapeutic tool for change in people with substance addiction. *Revista Española de Drogodependencias*, *50*(4), 104-121. https://doi.org/10.54108/10125

Abstract

This article describes two experiences of group psychological treatment (Matrix and Marlatt & Gordon) carried out in two Addictive Behavior Units within the public addiction network of the Valencian Community. Both units share common characteristics, such as the composition of the therapeutic team, and both have the necessary and appropriate infrastructure to implement this type of treatment.

In the context of addictions, group psychological interventions are a highly powerful therapeutic tool in change processes. The text reviews the fundamental psychological components of group therapies in general, and of the specific models presented. The combined use of group interventions with individual therapy and pharmacological treatments is considered the optimal multicomponent treatment option. Our review aims to support and recommend the development and implementation of group therapies in all Addictive Behavior Units.

Keywords

Group therapy, psychological treatment, relapse prevention, change processes, detoxification.

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Resumen

En este artículo, describiremos dos experiencias de tratamiento psicológico grupal (Matrix y Marlat y Gordon) llevadas a cabo en sendas Unidades de Conductas Adictivas de la red pública de adicciones de la Comunidad Valenciana. Ambas unidades comparten características comunes, como el personal que forma el equipo terapéutico, y ambas disponen de la infraestructura necesaria y adecuada para llevar a cabo este tipo de tratamientos.

En el contexto de las adicciones, las intervenciones psicológicas grupales son una herramienta terapéutica muy poderosa en los procesos de cambio. Se revisan en el texto los componentes psicológicos fundamentales de las terapias de grupo en general y de los modelos que se presentan en particular. Se considera el uso simultáneo de los grupos con las intervenciones individuales y los tratamientos farmacológicos como la opción óptima de tratamiento multicomponente. Nuestra revisión pretende refrendar y recomendar el desarrollo y aplicación de las terapias grupales en todas las Unidades de Conductas Adictivas.

Palabras clave

Terapia grupal, tratamiento psicológico, prevención de recaídas, procesos de cambio, deshabituación.

INTRODUCTION

Group psychological interventions have a long-standing tradition in the treatment of addictions. Groups influence the behavior of their members in various ways, ranging from providing social support across multiple levels of interaction to facilitating vicarious learning, which is especially relevant in the rehabilitation process of individuals with addiction.

The group setting for addiction treatment offers a unique context that shapes participants' behavior. As Yalom and Leszcz (2020) state: "Group therapy is the only therapy that offers clients the opportunity to benefit others. In addition, it fosters role versatility by asking clients to shift between the roles of help recipient and help provider."

Group therapies have demonstrated high effectiveness in addiction treatment. The interactive experience among group members is the primary vehicle for learning (MacKenzie, 1994). Abstinence rates are higher among those who participate in group therapies. This is because group treatment reduces the tendency to drop out, enhances the perception of self-efficacy through identification with others' progress (those considered peers), and increases insight through identification processes (Pascual et al., 2014). Moreover, group therapies are highly efficient interventions that save time and staff resources (Markus & King, 2003).

Throughout this article, we describe the empirical models underlying the clinical practice of two Addictive Behavior Units (UCA) in the province of Valencia. In both UCA, group therapies were implemented for individuals with addiction to various substances, following the principles of ef-

fective treatment and best practices proposed by NIDA. This group intervention model has become an essential component of our service portfolio.

The UCA Padre Porta has implemented the Marlatt and Gordon Relapse Prevention (RP) Program since its establishment. Meanwhile, the UCA Paterna–La Coma uses the Matrix Intensive Program for stimulant and alcohol cessation, developed by Rawson and Obert.

The psychological models used in addiction treatment provide a solid conceptual framework to address the fundamental needs of addiction treatment. These models focus on enhancing user motivation, recognizing psychological diversity, and reducing relapses. It is important to emphasize that psychological treatments are part of comprehensive, multidisciplinary therapeutic approaches that may include pharmacological and social interventions. This combination is currently considered the most effective therapeutic strategy (Carroll, 2004; NIDA, 2001, 2009).

The National Institute on Drug Abuse (NIDA) recommended several psychological treatments for stimulant addiction in 2001 and 2009. One of these is the Matrix model, which integrates evidence-based psychological therapies to effectively treat addictions. Since its creation, the empirical trajectory of the Matrix model has been repeatedly evaluated and validated (Rawson, 2009). The Marlatt and Gordon model, developed in 1985, serves as the theoretical framework for Relapse Prevention (RP). It focuses on identifying and managing the factors that may lead to relapse after initiating addiction treatment. Marlatt and Gordon emphasize that relapses are not the end of treatment or a failure, but part of the recovery journey. Recovery involves psychological work on situational, cognitive, and emotional factors. Both the Marlatt & Gordon Relapse Prevention Model and the Matrix Model, when applied in a group format, follow NIDA's principles of effective treatment and best practices (2001, 2009).

Both models view addiction as a chronic mental disorder that requires intensive, multicomponent treatment. Relapses are seen as part of the recovery process and as opportunities for patients to learn and self-observe.

The models include individualized treatment plans with a multidisciplinary approach. They address the complexity of patients' various life areas, such as health, family, emotional and cognitive state, and employment. They do not consider detoxification alone —the first step in treatment— to be an effective long-term intervention.

A strength of both models is that they offer an open group format. Individuals can begin the process without waiting for a group to end or a new one to start. This facilitates accessibility and availability of treatment. Both the Marlatt & Gordon model and the Matrix Model last more than three months and include a follow-up phase. They are also intensive or high-frequency programs.

Both models are multidimensional and allow the integration of medical-pharmacological treatments. They also consider, in both assessment and intervention, the co-occurrence and comorbidity of other primary and/or substance-induced mental disorders. Both the Matrix Model and the Marlatt

& Gordon Model are effective regardless of the origin of the patient's motivation. Throughout treatment, voluntary monitoring of substance use is conducted either randomly or systematically.

The Matrix Model was developed by Rawson and Obert in the early 1980s in Southern California, coinciding with the first wave of cocaine users in the United States. Initially referred to as a neurobiological model (Rawson, 1986; Rawson, 1989; Rawson, 1990), its distinctive feature is the integration of clinical and empirical dimensions.

Before its implementation in Spain, training on the Matrix Model was conducted in 2008, led by Zarza and Obert, and aimed at addiction professionals who would develop and pilot the model in the country. The training included observing real therapy sessions and an intensive course for clinical supervisors.

The first pilot study of the Matrix Model in Spain was carried out in 2009, focusing on individuals addicted to cocaine and other substances (Zarza, 2009). The results indicated that the model is easily adaptable and effective, consistent with findings from Rawson's research group (Rawson, 2009).

The Marlatt and Gordon Relapse Prevention model began to be applied in Spain in various institutions and specialized centers in the early 1990s, following its widespread dissemination among professionals of the cognitive-behavioral strategies it proposes. Specifically, at the UCA Grao Padre Porta, the model has been used in group format since the unit opened in 2001.

I. MATRIX MODEL

The Matrix model is based on cognitive–behavioral theories, relapse-prevention techniques, motivational therapy, social support, and parallel education for both the patient and their family. The model emphasizes the importance of continuity in addiction treatment and frequent, intensive contact.

A. Main Psychological Components of the Matrix Model

1. Establishing a positive, collaborative, and motivating therapeutic relationship

The Matrix model stresses the importance of building a positive, collaborative, and motivating therapeutic alliance with the patient. It relies on motivational techniques, such as Motivational Interviewing (MI) developed by Miller and Rollnick (2002), which have proven beneficial throughout treatment, especially during the early weeks. Therapists must treat patients with the utmost respect, even when their decisions differ from those of the therapist, and should avoid imposing value judgments.

Although the Matrix model promotes a directive approach aligned with cognitive–behavioral therapies, therapists must also maintain a patient-centered focus. Patients' goals may not necessarily involve complete abstinence. Therapists are responsible for sustaining a positive and collaborative relationship with both the patient and the family. Confrontation —pointing out errors, scolding, highlighting behavioral–cognitive contradictions, or using sarcasm—

should be avoided. Therapists must not impose their own treatment goals.

A collaborative, accepting environment fosters honesty and comfort in therapy, increasing patients' willingness to learn and listen. This allows patients to set their own therapeutic goals and increases the likelihood they will attend follow-up sessions, which is essential for maximizing therapeutic success. Addressing patients by their first name is highly recommended and beneficial.

Patients may express persistent ambivalence, which can be frustrating for therapists. Difficulties in adherence and continued substance use may indicate that goals are being imposed that the patient cannot or does not wish to meet. In such cases, it is crucial to reach a patient-therapist agreement to adjust goals to more realistic levels. As these goals are gradually achieved, more ambitious ones can be introduced—what motivational language refers to as "going with the flow."

2. Developing clear organization and realistic expectations

Organization and structure are crucial elements of any effective outpatient treatment program. Active involvement of the patient is key in creating a schedule, planning, and defining activities inside and outside the center. These activities include attending individual, family, and group therapies; participating in self-help groups; and implementing strategies to reduce exposure to high-risk situations that may trigger relapse (thought-planning, approach behaviors, and use). The aim is to establish a routine that minimizes stress and counteracts the lack of structure and chaos that often characterize the daily life of people with addiction.

These skills are developed in early recovery skills groups. Planning is recorded in agendas specifically designed for patients. The structured routine implemented during the first four months of intensive treatment helps define a "recovery map" consisting of the different phases the patient is expected to go through. This helps patients develop clearer and more realistic expectations about what to expect and how they may feel throughout the process.

3. Psychoeducation for patients and families

A fundamental component of the model is educating patients about the neurobiology of addiction and the conditioning processes related to substance use (Obert, London & Rawson, 2002). Accurate, updated, and simplified information helps patients and families understand addiction as a chronic mental disorder. It enables them to anticipate changes in cognitive and emotional processes as well as in social relationships throughout recovery.

This educational process also helps normalize symptoms such as acute and protracted withdrawal, as well as emotional and cognitive difficulties. It provides techniques for managing these symptoms. While psychoeducation is common in therapy, what distinguishes this model is its emphasis on teaching patients to understand their feelings and behaviors as they experience the chem-

ical and brain changes that occur during different phases of recovery.

4. Cognitive-behavioral foundations and practical application

The model is grounded in cognitive–behavioral theories and their application inside and outside therapy sessions. Work by Marlatt and Gordon (1985), Carroll and colleagues (1991, 1994a, 1994b), among others, has significantly influenced the content and group treatment activities in the Matrix model.

Cognitive–behavioral therapy teaches patients to self-monitor and use techniques to prevent relapse. Each Matrix session has a specific theme tailored to the patient's treatment phase (e.g., external and internal triggers). Patients receive worksheets in every session. Topics are introduced with a brief explanation by the therapist, followed by reading materials, completing exercises, and group discussion.

5. Positive reinforcement of desirable behaviors

Contingency Management (CM) techniques have proven effective in multiple rigorous scientific studies (Petry, 2000; Roll et al., 2006) for shaping and reinforcing abstinence and other therapy-consistent behaviors. The Matrix model incorporates CM strategies as an essential component of stimulant treatment (Rawson et al., 2006; Roll et al., 2006).

Positive reinforcement can be applied through verbal praise for attending therapy, obtaining negative urine and breathalyzer tests, using skills outside sessions, completing assignments, and actively participating in group therapy**.**

6. Family education

The model actively involves the family in the treatment program. Family includes close relatives, partners, and intimate friends who are significant in the patient's daily life. Active family involvement improves treatment retention and patient stabilization. Family education enables relatives to better understand the patient's recovery process, the difficulties they may encounter, and how they can support them.

7. Participation in self-help groups

In the United States, 12-step groups such as Alcoholics Anonymous (AA) are popular. Recent studies have demonstrated the effectiveness of these groups in maintaining abstinence (Humphreys et al., 2004). However, in countries like Spain, these programs are less widely accepted, which may generate resistance. Therapists should not pressure patients to attend these groups, as participation is voluntary.

In our case, we encountered challenges in encouraging attendance at AA. However, after establishing the Emotional Support Group (ASE) in Paterna, led by the UCA Therapeutic Team and composed of recovered patients, we successfully improved attendance and adherence.

8. Weekly monitoring of substance use

Urine drug screening and breathalyzer testing are the most reliable methods for monitoring substance use. These are not used as tools of control or surveillance but as aids to help patients main-

tain abstinence. Negative tests reinforce abstinence, while positive results provide an opportunity for patient and therapist to analyze the factors leading to relapse.

It is important to inform patients from the beginning that these tests are performed for all participants as part of standard procedure. The goal is to reward negative results (abstinence) and help patients understand relapse if it occurs. Additionally, negative results can be very reassuring for families, as they provide tangible evidence of treatment progress.

B. Structure of the Sessions

The model follows current trends in the psychological treatment of addictions (Rawson et al., 1990; Rawson et al., 1991) and is structured into the following components (Table 1):

1. **Individual sessions** vary depending on the version of the Matrix model. In the Hazelden version (both English and Spanish), there are ten sessions: seven individual and three family sessions. Topics include the use of alcohol and/or other drugs, withdrawal symptoms, emotions and cognitions, sexual behavior, and recovery. The patient's progress in applying cognitive–behavioral techniques is evaluated, and their status in various areas of life is reviewed.
2. **Family–joint sessions** involve working with the patient and their family, partner, and/or close friends in individual sessions. These sessions focus on discussing ways to provide support, such as creating a list of supportive actions. The three sessions take place throughout treatment in three phases, as goals and objectives evolve. Additionally, guidelines for family involvement are provided.
3. **The psychoeducational group offers** 12 sessions over 16 weeks of treatment. Patients and their families participate in these training group sessions. Information is delivered through oral presentations, graphic materials, and written materials. Topics include the neurobiology of addiction, conditioning, the medical and psychological effects of substance use, addiction and family, triggers and cravings, and the stages of recovery.
4. **Early Recovery Skills Groups** consist of eight one-hour sessions, held twice a week during the first month of treatment. These sessions teach cognitive coping skills, such as thought-stopping and stress inoculation, and behavioral skills, such as stimulus control and alternative activities, to help patients maintain their initial sobriety. The structured format includes therapist-led education and exercises to help patients understand and recognize their addiction and addictive patterns.
5. **Relapse Prevention Groups** consist of 32 one-and-a-half-hour sessions based on the relapse prevention literature and adapted for stimulant and other substance use. Each session is divided into three parts: 1) reviewing recent events, 2) evaluating weekly schedule plans to improve them and detect potential triggers for use, and 3) reading

Table 1. Type and Number of Sessions Throughout Intensive Treatment (0–4 Months) and Continuing Care

Matrix Treatment Phase	Type of Sessions	Minimum Number of Sessions	TOTAL
Intensive Treatment (0–4 months)	Individual sessions	7	58
	Patient–family sessions	3	
	Group sessions (early recovery skills phase)	8	
	Group sessions (relapse prevention phase)	32	
	Educational group sessions for patients and families	12	
	External sessions (ASE, AVEX, AA groups)	2 per week	32
	Relapse analysis sessions (individual)	open	open
	Urine tests / Breathalyzer	weekly (random)	16
Continuing Care (indefinite) From month 4 onwards	Social support group session	1 per week	
	Individual sessions / Patient–family sessions	open	open
	External sessions (AA groups, occupational therapy, etc.)	open	
	Relapse analysis sessions (individual)	open	open
	Urine tests / Breathalyzer	weekly (random)	open

the corresponding topic, supplemented with exercises and discussions. Relapse analysis is a reflective exercise examining the factors (external and internal triggers, reinforcements, etc.) that led to the relapse situation.

6. **Social Support Group**: After the four-month intensive treatment, patients may join a weekly social support group. This group helps maintain connections that support ongoing recovery. As part of the second phase of treatment, this group consists of 36 one-and-a-half-hour sessions, which may be extended as needed. Table 1 shows the timeline distribution and the main components and sessions of the model.

C. Implementation of the Model in an Addictive Behaviors Unit

The model was first implemented in the public addictions network at the Addictive Behaviors Unit of Paterna, belonging to the Valencia Arnau de Vilanova–Lliria Health Department, in 2010.

The team that led the initial implementation of the model in Spain, specifically in the Valencian Community (Zarza, Perelló, Palau, Cortell, and Sánchez), identified several key aspects of the model considered important for its regional application, including the existence of an explicit structure, detailed working materials (sessions, videos, workbooks for patients and therapists), and strict training oversight for therapists, including supervision and fidelity assessment.

This team validated the model in a private healthcare setting. After achieving positive results, the therapeutic team at the UCA Paterna–La Coma decided to adapt the Matrix model for use in the public addictions network. In 2010, it was incorporated into their service portfolio.

At this Unit, patients enrolled in Matrix received detailed information about the program from the psychologist. The strengths of the model were emphasized, and participation was positively encouraged. Sufficient time for this pre-program motivational task is recommended.

The timeline and number of sessions were adapted to clinical reality, socio-demographic characteristics, and the available therapeutic team, based on the results of the applicability and validation of the original Rawson and Obert model in the Spanish population (Zarza, 2009). It is worth noting that the therapeutic team at UCA Paterna participated in the first pilot Matrix sessions in Spain.

The final structure of the model was organized so that group sessions take place one afternoon per week, lasting 6–7 hours. During this period, the following sessions are conducted sequentially:

1. **Four Early Recovery Skills Sessions**, which provide patients with detailed guidance on the steps needed to halt substance use and develop strategies to begin the deshabituation process. These one-and-a-half-hour group sessions are designed exclusively for patients.
2. **Twelve Family Psychoeducation Sessions** involve the patient and their family or close contacts in learning about the addictive disease, its characteristics, and the recovery process. These sessions foster a common language for understanding the phases of addiction and stages of recovery. Patients are empowered by gaining knowledge about the neurobiological aspects of the disease and behavioral changes during active use, detoxification, and deshabituation. Family participation in these one-and-a-half-hour sessions allows them to remove blame and become valuable co-therapists, facilitating recovery.
3. The final part of the afternoon is dedicated to **Relapse Prevention Sessions**, which address various aspects related to identifying, anticipating, and managing high-risk situations for substance use. These weekly two-hour sessions provide a safe, nonjudgmental

space for open discussions. Through identification with group members, patients participate in change processes. While abstinence is a primary goal, ensuring attendance at the next session is crucial. This is achieved by providing support, motivation, and honest, realistic feedback. Effective time management ensures active participation of all group members.

Therapeutic groups are conducted in an **open format**. After the four Early Recovery Skills sessions and the twelve Family Psychoeducation sessions, these are repeated until completing the thirty-two Relapse Prevention sessions. This prevents waiting lists and allows patients to join group therapy at any point in the therapeutic process.

2. MARLATT AND GORDON RELAPSE PREVENTION MODEL

Group psychological interventions have a long tradition in the treatment of addictions. In the therapeutic model used in our UCA, they have been a fundamental tool since the creation of the service. The group context serves as a foundation to influence the behavior of its members through multiple levels of interaction—something impossible in individual therapy. Within the group, real-life experiences can be simulated in a safe environment, with feedback from fellow members. In this way, the group is always more than the sum of its parts.

Irvin D. Yalom referred to **Group Therapeutic Factors** (Yalom, 1996) to describe those elements that occur in group therapy through the intervention of the therapist, the patient, or both, which contribute to patient improvement. Among these factors, according to Yalom, are the group's ability to foster hope, its universality, and vicarious learning. Other relevant factors in the group's therapeutic power include explicitness (the ability to name what is happening), validation (being seen), a positive image of change, the contrast of beliefs, mutual support, and the group as a source of commitment.

The **Relapse Prevention (RP) model**, created by G. Alan Marlatt and Judith Gordon in the 1980s and framed within cognitive-behavioral approaches in psychology, represented a conceptual shift from previous interventions in addiction treatment and has been one of the most widely used models since then (Larimer, Palmer, & Marlatt, 1999). Traditional psychological treatment models in addiction, dominant until the 1990s, relied mainly on behavioral interventions using aversive stimuli, fostering guilt, and promoting "willpower" as the intrinsic driver of change. Detoxification and abstinence were emphasized as the final goal of the process.

The paradigm shift of Marlatt and Gordon's model focused on **relapse prevention through self-knowledge and self-care**, removing blame from the patient while working on their self-concept to enhance self-efficacy. This conceptualization encouraged many professionals working in addiction services to train and implement the model, due to its attractive, efficient content and the high dropout rates of the previous model.

The core therapeutic focus of the Marlatt and Gordon model centers on **learning coping strategies** to help individuals man-

age situations that may trigger the risk of substance use. This includes emotional management, based on the premise that emotions are one of the main triggers for the desire to use substances. This learning process involves lifestyle changes, including the environment, interpersonal relationships, and beliefs about oneself, others, and the world. Adequate coping increases the likelihood of long-term success in maintaining abstinence. Lifestyle changes also help reduce relapse risk. The process involves identifying triggers, developing coping strategies, and rebuilding a social support network, always setting realistic goals.

The Relapse Prevention model posits that the likelihood of relapse increases if individuals have a **deficient repertoire of coping skills** or have low confidence in their ability to apply them—that is, if they have low perceived self-efficacy (Marlatt & Gordon, 1985).

In Marlatt's words: *"Relapse prevention work requires the involvement of the patient as a co-therapist."* Accordingly, it is essential that the patient assumes the necessary responsibilities to make behavioral changes. The therapist's role is to convey the need for shared responsibility in treatment through motivational interventions and work on self-concept. Addiction recovery thus becomes a programmed learning task involving the acquisition of new skills and, overall, the enhancement of self-efficacy.

A. Psychological Components of the Model

The Marlatt and Gordon model proposes **three phases in the recovery process**:

1. **Acquisition of commitment and motivation for change** – motivational interventions are essential in this phase.
2. **Implementation of change** – involves learning self-control strategies, including cognitive, emotional, and behavioral skills.
3. **Maintenance of change** – derives from lifestyle modifications and requires continued psychological work, particularly focusing on self-concept, perceived self-efficacy, and self-knowledge.

Conceptually, the model can be summarized as follows:

- It is a **cognitive-behavioral intervention** aimed primarily at helping individuals become aware of the dysfunctional thoughts involved in addiction. It includes cognitive restructuring and coping skills management as recovery strategies.
- **Relapse is conceptualized as a process, not an event**, and as part of the recovery process. It can be considered a learning opportunity.
- Relapse occurs when a person is exposed to a **high-risk situation** and cannot use coping skills to maintain abstinence. Conversely, effective coping generates positive expectations and enhances perceived self-efficacy, which supports abstinence maintenance (Marlatt, 1993; Marlatt & Gordon, 1985).
- **Risk factors for relapse** may be situational, emotional, cognitive, or a combination. Relapse is more likely in high-risk situations.

- Two categories of high risk are identified:
    - **Intrapersonal factors**: alleviating negative emotional or physiological states, enhancing positive emotional states, overestimating control capacity.
    - **Interpersonal factors**: interpersonal conflicts, social pressure (Marlatt, 1983). Negative emotional states, interpersonal conflict, and social pressure are associated with higher relapse rates (Cummings, Gordon & Marlatt, 1980).
- **Perceived self-efficacy** is fundamental: it is a person's belief in their ability to organize and execute actions necessary to achieve desired outcomes in specific situations (Bandura, 1977) and is crucial for managing situations, emotions, and preventing relapse. Low perceived self-efficacy is a relapse risk factor (Marlatt & Gordon, 1985).
- Learning focuses on recognizing **early warning signs of relapse** and taking action. This involves identifying internal and external triggers and developing strategies to prevent and manage them, including subsequent cravings. Relapse can be prevented by properly managing high-risk situations, and the individual learns to identify and handle personal triggers.
- **Cognitive intervention** fosters self-efficacy, explores expected outcomes of substance use, and examines causal attributions.
- **Self-knowledge, positive feedback, and social support** are essential for treatment and relapse prevention.
- The concept of the **Abstinence Violation Effect (EVA)** (Marlatt, 1985) introduces the idea of differentiating between a "lapse" (a single use after a period of abstinence) and a "relapse" (return to regular use). The EVA, which involves frustration, diminished perceived self-efficacy, and guilt, can prevent the individual from resuming abstinence, turning a lapse into a full relapse.

B. Structure of the Sessions

The learning of skills facilitated in group sessions is organized into three categories:

1. **Coping Skills Training:** Specific interventions aimed at improving self-efficacy, impulse control, emotional regulation, and self-awareness. These interventions also include functional analysis of substance cravings and high-risk situations.
2. **Cognitive Restructuring:** Applied to self-perception as well as distorted beliefs about substance use/addiction and mental schemas.
3. **Lifestyle Changes:** The goal is to help individuals develop new social relationships, leisure activities, and healthy habits that distance them from addiction.

Group sessions are conducted by psychologists and follow this structure:

1. **First part (approximately 90 minutes):** Focused on the content described above, i.e., skills learning (self-efficacy, triggers and functional analysis, emotional regulation skills, distorted beliefs, the Abstinence Violation Effect, etc.), while promoting interaction

among group members as a key therapeutic element.

2. **Second part (approximately 30 minutes):** Review of homework assignments, assignment of new tasks, and participants share experiences from the past week.

If participants have chosen to include **substance use monitoring** as a protective measure, this is conducted through urine tests before the start of the group session.

C. Application of the Model in an Addictive Behaviors Unit

The **Relapse Prevention (RP) model** in group format, implemented by the Therapeutic Team of the UCA Grao-Padre Porta, specifically by the psychologists, is an essential component of the overall addiction treatment.

All psychological interventions for individuals with addiction in the UCA are based on a treatment philosophy derived from the principles of **Motivational Interviewing** (Miller & Rollnick, 1991). Accordingly, the relapse prevention model emphasizes collaboration (vs. imposition), acceptance (vs. confrontation), evocation-empowerment (vs. education), and compassion (vs. indifference). A motivational perspective must always be present in any psychological intervention with people with addictions, both individually and in groups, along with work on emotional regulation, given the significant role of emotional states in recovery processes.

The RP model has been implemented in our UCA using an **open group format** (participants can join any group session), aiming to optimize intervention and reduce waiting lists. Additionally, the inclusion of new participants enhances **vicarious learning** and serves as a **social reinforcer** (Südmeier & Muschalla, 2024).

Patients beginning the group are previously evaluated by the therapeutic team and informed about its format and content. Participation is always voluntary and may or may not be combined with individual psychological treatment, depending on the severity of the case and the needs of the person in treatment.

Patients entering the group have been informed in advance about the functioning and therapeutic objectives. Abstinence is **not a requirement** for inclusion, but the patient must at least be in the **advanced contemplation or preparation phase** of motivation. The number of sessions a patient attends is **not predetermined** and depends on their progress. There is no maximum number of sessions as long as the intervention remains beneficial.

As previously mentioned, effective psychological treatments for addiction require **intensity and sustained duration**, which is why our services adopt group interventions in this **open format** (no limit on the number of sessions attended). This model also strengthens **intra-group bonds** and connections with the therapeutic team, enhancing treatment adherence.

Two RP groups are held each week, with different patients, so each patient attends **once per week**, with sessions lasting **two hours**.

Although the Marlatt and Gordon model does not explicitly include family intervention, our UCA consider family participation **essential** in the recovery process. Specifically, at UCA Padre Porta, psychologists

conduct weekly **family groups** for psychoeducation and mutual support. Once a month, these sessions become **multi-family groups**, attended by both patients and family members. These groups have proven highly effective in improving family dynamics and repairing attachment bonds (Sempere & Fuenzalida, 2017). Furthermore, **joint family therapy** involving patients and family contributes to better retention in treatment (Lorenzo & González, 1985).

CONCLUSIONS

In light of these two experiences of group treatment developed in two different Addictive Behaviors Units, and based on professional experience accumulated over the past twenty years, we can affirm that patients who incorporate group therapies into their treatment and recovery process are more likely to achieve better control over their addiction.

The Marlatt and Gordon Relapse Prevention Model and the Matrix Model have demonstrated considerable therapeutic potential over the years (Magill & Ray, 2009; Obert, London, & Rawson, 2002) and are also highly cost-effective. These are intensive, long-duration interventions, but many people benefit from treatment simultaneously in the same time frame. They are also highly engaging, which reduces dropout rates. Patients in more advanced stages serve as role models for those beginning the process, while simultaneously benefiting from the positive social reinforcement present within the group. The cost savings of this treatment modality could free resources that could be reinvested to facilitate access to substance use disorder treatment for a larger number of people (Markus & King, 2003).

The motivational approach and psychoeducation about addiction, provided throughout the treatment process, facilitate the involvement of both patients and their families in learning about addiction and the recovery process. As is often said, *"Addiction is not curable, but recovery is possible."*

Families should be included in group therapy alongside the patient. This allows them to benefit from acquiring new knowledge about addiction and learning new communication and coping skills, promoting progress in the recovery processes of both the patient and their family.

Although the therapeutic group is led by a psychology professional, all team members must work together in a coordinated manner to ensure that group psychological therapies are conducted efficiently.

We have frequently observed that, despite the proven effectiveness of group psychological treatments, especially in addictions, many therapists are reluctant to implement them, prioritizing individual interventions. Several factors may contribute to this situation, one of the most relevant being the therapists' insecurity regarding group treatment, due to the very limited (or even non-existent) training in group therapies within the standard psychology curriculum. Other barriers may include structural constraints (lack of space and/or personnel) or insufficient team support for conceptual reasons (if the theoretical foundation of the therapeutic work is not based on a biopsychosocial model).

We recommend the **systematic implementation of group therapies in all Addictive Behaviors Units** as a fundamental therapeutic tool for people with addiction

problems and their families. To achieve this, institutions must promote and facilitate the necessary training for professionals, as well as provide the required spaces and materials to carry out these therapies.

Conflict of Interest

The authors declare no conflict of interest.

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