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Group psychotherapy with young alcoholics: specialization or integration?

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Introduction. Group therapy (GT) is widely used in the treatment of alcoholism. Nevertheless, few data are available on the inclusion criteria for specific individual, as well as on specific group, techniques for the management of some types or groups of patients with homogeneous characteristics.

Method. Compliance with group therapy has been analyzed in a sample of 459 alcoholics under 36 years of age, 303 of whom were placed in specific GT for young people (Y groups) and 156 were allocated in standard GT (NY) groups.

Results. Similar rates of discharge (16.8 % vs 18.6 %), withdrawals and drop-outs (63.4 % vs 61.5 %) of patients have been found in both groups. No differences were found in the survival function of time of compliance adjusted for gender and age (Y: 27.2 %, and NY: 33.3 % at one year, and Y: 18.4 %, and NY: 21 % at 2 years).

Conclusions. There is no scientific evidence to support the use of Y groups in the treatment of young alcoholics. On the other hand, the possibility still exists that the use of groups with composition, techniques and specific objectives may provide improvement in compliance and in the therapeutic results as long as they adequately identify the characteristics of the patients who may benefit from a homogeneous treatment.

Key words:
Alcoholism. Group psychotherapy. Compliance.

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Grupos de terapia para alcohólicos jóvenes: ¿especialización o integración?

Introducción. A pesar de la amplia utilización de la terapia grupal (TG) para tratar el alcoholismo no existen criterios para su indicación individualizada a los distintos pacientes ni para el diseño de tipos o técnicas específicas de TG para algunas clases o grupos de enfermos con características homogéneas.

Método. Se ha comparado la adherencia a la TG de 459 pacientes alcohólicos menores de 36 años, de los cuales 303 fueron asignados a grupos de TG específicos para jóvenes (grupos J) y 156 a grupos de TG convencionales (grupos NJ).

Resultados. Los resultados del estudio han revelado similares porcentajes de altas (16,8 frente a 18,6 %), bajas y abandonos (63,4 frente a 61,5 %), así como similar supervivencia una vez ajustada la edad y el sexo, en ambos tipos de grupos de TG (J: 27,2 %, y NJ: 33,3% al año, y J: 18,4 %, y NJ: 21 % a los 2 años).

Conclusiones. Se concluye que no hay evidencias científicas que apoyen el uso de grupos de TG especializados para pacientes jóvenes. En cambio sigue abierta la posibilidad de que el empleo de grupos con composición, técnicas y objetivos específicos puede proporcionar una mejora en la adherencia y en los resultados terapéuticos siempre que se identifiquen convenientemente las características de los enfermos que pueden beneficiarse de un tratamiento homogéneo.

Palabras clave:
Alcoholismo. Terapia grupal. Adherencia.

INTRODUCTION

Group therapy (GT) for alcoholics is a technique that has been widely used for years. Its efficacy has only recently begun to be verified experimentally[1]. This depends of the correction of the techniques used, the therapists training in them and the patient selection criteria, since they are not always effective[2].

However, as with other psychotherapeutic treatments, there is the problem of treating each type of patient with the most adequate specific treatment[3]. In the case of group therapies, little is known on the type of patients who may

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best benefit from them and their different variants[4,5]. Furthermore, it has not always been found that this patient-treatment pairing improves the outcome[6].

There is a series of inclusion and exclusion criteria to indicate group therapy in alcoholic patients. There are slight differences among the different authors. The presence of psychiatric condition, cognitive deterioration or serious physical or sensorial limitations is commonly a reason to exclude these types of group therapies[7,8,9]. Reindication of group therapy after drop-outs or previous non-attendance has also been shown to be ineffective[10].

However, once the therapist considers that the patient may be a candidate for group therapy, the group must also have some characteristics that favor his/her adequate integration in it. These characteristics include homogeneity within the group, which may facilitate identification and projection mechanisms between the different members.

Initially, gender and age were two characteristics whose homogeneity was commonly thought to influence group compliance, however, this supposition has not always been demonstrated.

On the one hand, years ago, an attempt was made to separate men and women in group therapies for alcoholics in the belief that the women were somewhat «expelled» and criticized by the men or that the women were more ashamed in the presence of men. Over the years, the good functioning of women within the mixed groups has been verified, even much better than that of the men[1,11,12]. Changes in the mentality of society may also have had an influence, however, we must adapt to the passage of time.

On the other hand, an attempt has also been made to separate the youngest patients in the belief that they may better explain their problems related with alcohol consumption, going deeper into them, and feel better understood with persons of a similar age. We know that patients under 35 years generally comply worse in the therapy groups[1,12] than older ones. However, we ignore if the fact of attending specific groups for young alcoholics, different from the general groups, improves therapy compliance and abstinence rates.

The following are found among the differential characteristics of young alcoholics: *a)* their different family situation, with a much lower percentage of married subjects or those having children; *b)* lower rates of occupation incapacity, linked to less psychic and physical deterioration; *c)* greater use of other drugs, especially cannabis and cocaine and finally, and *d)* a socialization process often underdeveloped, with patients called «non-chronological adolescents», who have only related with their peer group. These groups are often formed only by other alcohol and drug consumers, who are not independent of their parents in regards to residence, even though most have jobs, although sometimes quite unstable.

This present study aims to compare group therapy (GT) compliance of young alcoholic patients (less than 36 years) based on whether they are included in specific groups for them (youth) or in conventional groups, together with the remaining alcoholic patients.

METHODS

This was a follow-up at two years of a cohort formed by 459 first consecutive indications of group therapy conducted from January 1, 1987 to December 31, 2000 in alcoholic patients of 35 years of age or less treated in the alcohology unit of the Hospital Clínico of Barcelona (AU-HCB).

Inclusion criteria: patients who fulfilled DSM-III, DSM-III-R or DSM-IV criteria of alcohol dependence, whose individual therapists indicated group therapy (GT) for them and who were under 36 years of age at the time of this indication.

Exclusion criteria: patients in whom GT had been indicated in the AU-HCB in some previous occasion are excluded.

If a patient, according to his/her therapists, changes therapy group, this would be considered as only one indication, adding up the total attendance time that is consecutive in the different groups attended by the patient. To analyze belonging to a certain therapy group, only the last is considered chronologically.

Criteria to indicate a GT has already been detailed in other studies[9,13]. GT is not indicated in patients with social margination, cognitive, memory or sensorial deficits or with psychiatric disorders that may interfere in the functioning of the group dynamics or who have active alcohol consumption or that of any other drug, except tobacco, or have dependence on opiates that is not in complete remission. Including patients with a history of unfinished or failed alcoholic treatments, who are considered chronic alcoholics and would be tributary to other types of treatment, is also avoided.

The criteria to measure compliance were: *a)* time in days to the last GT session attended, with a limit of 2 years and drop-out of GT as event to be measured; *b)* type of ending GT (discharge, drop-out, justified withdrawal or non-attendance), and *c)* attendance or not to the GT one year after its indication.

Procedure

After GT is indicated by the individual therapist, the patient is always interviewed by a psychologist who reviews the compliance of the indication criteria, investigates the existence of other psychological, socio-familiar or organic obstacles that may hinder GT compliance, evaluates motivation or doubts of the patient regarding GT and informs the patient on GT functioning and utility.

If the patient agrees to have GT, one of the therapy groups available in the AU-HCB are agreed on and specified based on time availability and adequacy to the characteristics of the remaining members. The patient is also given a therapeutic contract with the group guidelines. If the patient is young, an attempt is made to assign him/her to one of the specific therapy groups for his/her age (Y). The patient will only be assigned to one of the usual therapy groups for adults and without differential characteristics (NY) in the case of time difficulty.

The AU-HCB had a total of 18 out-patient therapy groups during the years the study lasted, four of which were for youth (Y). While the study lasted, several groups were open (initiated), closed (finished) and underwent time changes. However, there were always at least twelve that existed simultaneously, two of which were for youth and the rest conventional therapy groups for alcoholics (NY).

During the period studied, mean age of all the patients (both those under 36 years included in the study and those who are not) assigned to Y groups for youth was 30.1 ± 5 years, while it was 45.4 ± 8.9 years in the (NY) groups.

The type of therapy group used is slow semiopen, with between 8 and 12 patients, focused on the discussion of problems related with and/or derived from alcoholic beverage consumption. Leadership style is not very authoritarian, defined as self-convincing approach type[14,8]. The groups are lead by two fixed cotherapists among a total of eigth (2 psychologists, 4 psychiatrists, one social worker and one nurse) who are combined in different pairs between the different therapy groups. Periodicity is weekly, with a one hour long duration. The group follows a method type that can be called «Discussion Group», «self-knowledge and interpersonal and situational introspection»[8], «self-knowledge and support»[15] and «oriented towards personal problems»[16].

The approximate length of group therapy (GT) is about 2 years. However, this is always according to the main criterion of the patient's individual therapist and according to the group therapists and therapy group members the patient belongs to. In every case, the patients follow an individual psychotherapy that is simultaneous, parallel and coordinated to the GT. This treatment has psychological support, introducing awareness of the disease and relapse prevention by the individual therapist, psychiatrist and/or psychologists in the AU-HCB. These treatments may include different drugs, the time, duration and dose according to that considered adequate by the attending psychiatrist. Antidipsotropic agent, especially disulfiram, SSRI antidepressives and, in recent years, also naltrexone and acamprosate, but with much less frequency, are those most commonly used. Use of any benzodiazepine should be avoided once detoxification is finished. In any event, a secondary objective of the treatment is to achieve alcoholic abstinence maintenance without the help of any drug as soon as possible.

These patients' evolution is followed until discharge from GT or drop-out, although the 2-year limit is established in the treatment survival analysis.

The greatest problem of therapy groups, similar to treatment of alcoholism in general, is the high percentage of drop-outs. In the case of the therapy groups, this becomes worse due to patients who do not even come to the first session after this has been agreed upon and arranged. These drop-outs are the terminal events that are measured with the survival analysis.

However, there may be changes in therapy groups or therapeutic withdrawals that are justified and agreed upon with the individual therapists before the discharge, and these are not considered drop-outs.

Statistical analysis

Frequency, means and standard deviations for description of the subjects. Student's t test for comparison of means, analysis of variance in case of more than two means and chi squared (χ^2) for comparisons between qualitative variables.

Survival analysis in the group therapy treatment according to the Kaplan-Meier method. Drop-out (even if the subject never attended the first session) is considered as the event analyzed and its corresponding time, up to two years (720 days) in which the subject is discharged from the group therapy. Patients discharged before finishing the therapy due to several justified causes have been considered censured.

Cox proportional hazard models were used for evaluation of differences in treatment maintenance of group therapy according to group type (specific for young alcoholic patients «Y» or conventional for all the NY alcoholic patients), adjusting for age and gender.

RESULTS

Age of the sample studied is 29.9 ± 3 years, with a range of 18 to 35. A total of 69.8 % are males. There are no age differences between genders.

Distribution of ages was asymmetric (asymmetry coefficient: –0.824), shifted towards upper ages (there are more patients as the age increases).

Forty percent are single, 44 % married or living with a partner, 15 % separated and the rest widow(er)s.

Men are more frequently single or living with a partner than women (41.5 % and 44.9 % versus 37.1 % and 41.9 %, respectively). Women tend to be separated or widow more

often than men (18.5 % and 2.4 % versus 13.6 % and 0 %; χ^2: 8.9; p = 0.03).

Age is also greater among widow(er)s and separated subjects (31.3 ± 2 years and 31.2 ± 3 years) than in single, married subjects (28.6 ± 4 years and 30.7 ± 2 years respectively; F: 15.6; p < 0.0001).

A total of 66 % of the patients were assigned to a specific group for youth (Y) and the rest to the NY groups.

In the Y groups, the percentage of women included is less than in the NY groups (27.4 % versus 36.5 %; χ^2: 4; p = 0.04). On the contrary, patients who are included in the Y groups are younger than those included in the NY groups (28.8 ± 3 years versus 32 ± 2 years, respectively; t: 11.1; p = 0.000).

There were no statistically significant differences in patients' age based on group therapy end type (discharge, drop-out, justified withdrawal or not attending the first session). There was also no significant difference when the patients included in specific groups or in non-specific NY were analyzed separately. However, there is a slight positive correlation between age and time duration of GT participation (r: 0.114; p < 0.05).

The final situation of the 459 patients with group therapy (GT) indication was: 81 (17.6 %) did not come at any time, 11 (2.4 %) were discontinued in agreement with their therapists due to justified causes, 287 (62.5 %) abandoned GT prematurely and against therapeutic criterion and 80 (17.4 %) achieved therapeutic discharge from GT.

Attendance to the first session

A similar percentage of patients in groups Y and NY (18.5 % versus 16 %, respectively; χ^2: 0.427; p = ns) did not come to the first agreed on session of group therapy. The same occurs when we analyze the older patients separately (14 % versus 16.2 %, respectively; χ^2: 0.2; p = ns) and those under 30 years (20.9 % versus 15.4 %, respectively; χ^2: 0.6; p = ns).

In addition, age is similar among patients who do not come to the first session and those who do (29.4 ± 3 versus 29.9 ± 3 years; t: 1.1; p = ns)

However, the percentage of women who do not come to this first session is much lower than that of men (12.1% versus 20.1 %; χ^2: 4.1; p = 0.04).

Justified withdrawal of the group therapy

Percentage of justified withdrawal is less in the Y groups than in the NY ones (1.6 % versus 5.3 % of the total, respectively; χ^2: 4.2; p = 0.04.), although its number is limited (11, 2.4 % of the total).

Age is similar among patients with justified withdrawals than in the rest (29.9 ± 3.6 versus 29.8± 3.9 years; t: 0.2; p = ns).

Drop-outs from the group therapy

Once the 81 patients who never came to the GT and the 11 who left with justification and in agreement with the therapist were excluded, we obtained 367 patients who had really come to the group therapy and had no objective reasons to leave it.

At that point, the patients who achieved discharge from GT and those who dropped out were compared, showing that the percentages of drop-outs are similar among those assigned to groups Y and to groups NY (79 % versus 76.6 %, respectively; χ^2: 0.27; p = ns). There was also no different age in the discharges and drop-outs (30.6 ± 3 versus 29.8 ± 3 years; t: 1.7; p = ns).

The result of the analysis is similar if patients stratified by different ages are studied: 81 % of those assigned to groups Y dropped out and 86.7 % of those assigned to groups NY in subjects under 31 years (χ^2: 0.5; p = ns). The respective percentages are 75.6 % and 73.4 %, respectively (χ^2: 0.1; p = ns), in those over 35 years.

The men/women percentage was also not significantly different among those who dropped out and those who achieved discharge, regardless of the age group of if they were included in a young therapy (Y) or adult (NY) group.

A special case is patients under 26 years who were assigned to a NY group: all of them dropped out of the GT. However, the few existing cases (only 3) made it impossible for there to be statistical significance.

Attendance at the end of one year

At the end of one year of GT, 26.75 of those assigned to type Y therapy groups and 30.1 % of those assigned to NY type groups came (χ^2: 0.5; p = ns).

Survival analysis at two years

At one year of the onset of group therapy, the accumulated proportion of those who remain in it is 27 % of the patients, a percentage that decreases to 18.5 % at 2 years. However, the greatest risk of drop-out is in the first month. During this first month, 34 % of the patients dropped out, 17.4 % of whom did not attend the first session and 16 % the rest of the first month. Women have greater survival at

two years of GT than men, both when using actuarial statistical tests (mean time of survival in days: 199.7 in women and 97 in men; Wilcoxon: 5.8; p = 0.01) as well as the Kaplan-Meier method (Breslow: 5.6; 0.01).

Although there are no significant differences in survival time if we divide the patients into three age groups (18 to 25 years, 26 to 30 years and 31 to 35 years), it has been found that it is longer in the 31 to 35 year old group than in the 26 to 30 year old one (119 days versus 108 days of mean survival time; Wilcoxon: 3.6; p = 0.05). This is related with the positive correlation between age and group follow-up duration.

Comparing the patients assigned to groups Y and NY with the survival analysis until group drop-out, a lower mean survival is observed in the patients assigned to groups Y (88.8 days of mean survival time versus 199.9 days; Wilcoxon: 5.4; p = 0.01), as seen in figure 1. Similar results are obtained using the Kaplan Meier method (Breslow: 5.3; p = 0.02). At one year, survival percentage in GT is 27.2% in groups Y and 33.3 % in groups NY. These percentages decrease to 18.4 % and 21 % respectively at 2 years.

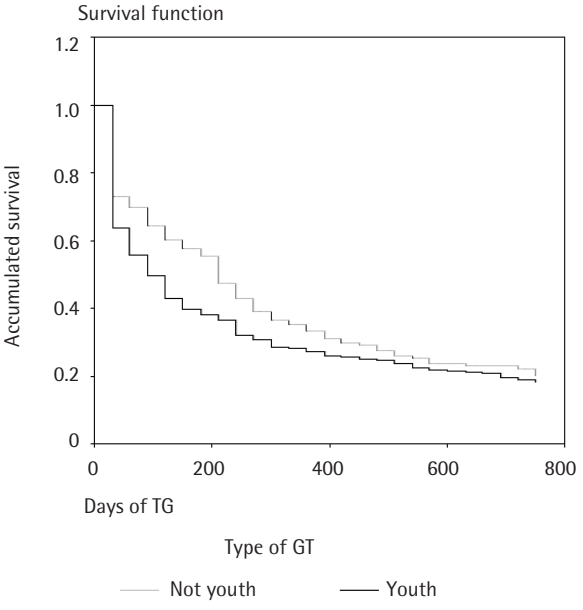

Figure 1 *Survival function until time of group therapy (GT) drop-out based on assignment to a therapy group for youth (Y) or a conventional on (NY).*

Survival analysis stratified by ages

When the survival analysis was repeated among patients assigned to groups Y or NY, but separating patients over 30 years from those younger or equal to this age, we found no differences in survival in either of them in both types of groups (84 days of mean survival time versus 202.1 days; Wilcoxon: 2.6; p = 0.1 and 94 days versus 197.6; Wilcoxon: 1; p = 0.3, respectively). There were also no differences when the Log-Rank and Breslow statistics were calculated.

However, in the case of those under 30 years, their drop-outs are concentrated in the 10 first months of their attendance to groups Y (Mean survival time of 84 days) and then they tend to stabilize and become chronic, remaining a long time (fig. 2). On the contrary, when they are assigned to NY groups, they remain more at the beginning, but then begin to drop-out and continue to do so constantly, even after the initial 10 months (mean survival time of 202 days).

Survival analysis at two years, adjusted by age and gender

Given that both age and gender influence GT compliance (greater compliance in women and older subjects) and that these factors are not distributed in a balanced way between groups Y and NY (assignment was not random but by time availability of the patients and places in the therapy group), survival analysis was done, comparing the two group types (Y and NY) and adjusting age and gender following the Cox method.

The equation obtained shows that we have no evidence of the existence of differences in drop-outs among group Y and group NY patients. This was adjusted for age and gen-

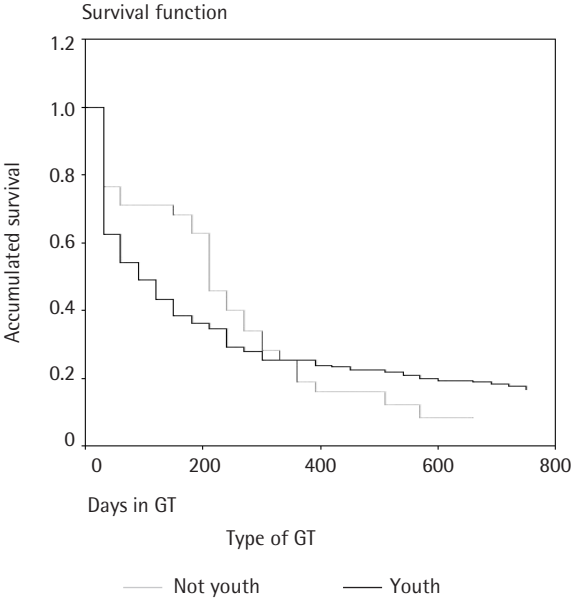

Figure 2 *Survival function until time of group therapy (GT) drop-out based on assignment to a therapy group for youth (Y) or a conventional one (NY), only including patients under 30 years.*

Table 1 Percentage of each type of end of group therapy based on type of therapy group assigned. Stratification by ages, comparison of percentages by χ^2

	Type of group	Discharges	Drop-outs	Justified withdrawls or changes	Do not come
All patients under 36 years included (p = ns)	Y (n = 303)	16.8 %	63.4 %	1.3 %	18.5 %
	NY (n = 156)	18.6 %	61.5 %	3.8 %	16 %
	Total (n = 459)	17.4 %	62.7 %	2.2 %	17.6 %
Only patients under 31 years included (p = 0.04)	Y (n = 196)	14.8 %	63.3 %	1 %	20.9 %
	NY (n = 39)	10.3 %	66.7 %	7.7 %	15.4 %
	Total (n = 235)	14 %	63.8 %	2.1 %	20 %
Only patients between 31 and 35 years included (p = ns)	Y (n = 107)	20.6 %	63.6 %	1.9 %	14 %
	NY (n = 117)	21.4 %	59 %	3.4 %	16.2 %
	Total (n = 224)	21 %	61.2 %	2.7 %	15.2 %
Only patients under 26 years included (p = ns)	Y (n = 51)	13.7 %	66.7 %	3.9 %	15.7 %
	NY (n = 3)	0	100 %	0	0
	Total (n = 54)	13 %	68.5 %	3.7 %	14.8 %
Only patients between 26 and 30 years included (p = 0.005)	Y (n = 145)	15.2 %	62.1 %	0	22.8 %
	NY (n = 36)	11.1 %	63.9 %	8.3 %	16.7 %
	Total (n = 181)	14.4 %	62.4 %	1.7 %	21.5 %

der (Hazard Ratio: 1.11; 95 % CI: 0.83, 1.46), the instantaneous relative risk of dropping out of the GT being almost identical for the patients of both types of group (fig. 3).

Comparison of discharges and drop-outs stratified by ages.

The discharge percentage regarding those of drop-outs and non-attendance to the first session considered together (not considering the changes or justified group withdrawals) have been compared according to whether they attended groups Y or NY, separating the 30 year old or less patients from those over 30.

In the case of the youngest, the respective percentages are 14.9 % versus 85.1 % when they attend the Y groups while they are 11.1 % versus 88.9 % when they attend the NY groups. There are no statistically significant differences.

For those over 30 years, attendance to groups Y provides discharge percentages versus drop-outs or non-attendance (21 % versus 79 %) which are also very similar to when they attend NY groups (22.1 % versus 77.9 %).

Late drop-outs

There are 51 patients who presently continue in the GT at 2 years of its onset, 64.75 of which are in groups Y.

Of these patients, 42.4 % of those in groups Y are older than 30 years while 100 % of those in the NY groups are (χ^2: 16.5; p = 0,000). However, the percentages of patients over 30 years assigned to groups Y and NY had initially been 35.3 % and 75 %, respectively. Stated otherwise, all the patients under 30 years who continue coming to GT at two years do so in Y groups for youth, while only 43.8 % of those over this age only do so and the rest go to the NY groups.

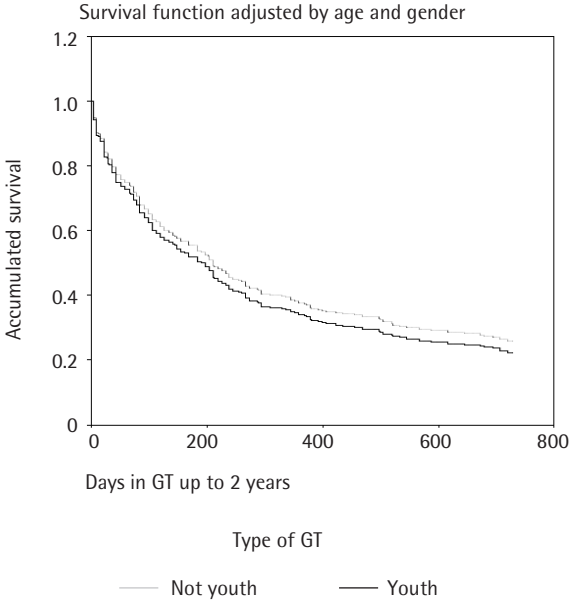

Figure 3 *Survival function until time of group therapy (GT) drop-out based on assignment to a therapy group for youth (Y) or a conventional one (NY), adjusting for age and gender.*

Of these 51 years, 42 achieved discharged, two were justified withdrawals and seven drop-outs after 2 years. One of the three patients over 30 years who dropped out after 2 years went to the Y groups versus all the 4 patients under this age (χ^2: 3.7; p = 0.05).

DISCUSSION

Greater survival in GT of women and older patients confirms previous findings[1,11,12].

There is a tendency to assign younger patients from among the youth and more frequently the male gender to the specific groups for youth (Y). The former is logical, since the older young patients, although they are between 30 to 35 years, have more points in common with mature patients than with those youth under 30 years from the therapeutic point of view. Regarding gender, women also generally have more mature and socializing conduct patterns than men. Thus, it is likely that their therapists do not consider it as necessary to include them in specific groups for their age.

Comparing both types of groups, the fact that those from the NY groups have greater compliance of the patients is surely motivated by the bias due to the greater relative proportion of women and older subjects.

However, no differences are observed based on the results analyzed regarding percentages of non-attendance to the first GT session, justified withdrawals or percentages of drop-outs among patients included in the Y or NY groups.

Finally, using the survival analysis technique and controlling the effect of gender and age, no differences were found between young patients assigned to Y or NY groups, confirming all the previous considerations.

The obvious conclusion is that we find no empirical support to the use of specific therapy groups for ages.

The clinical belief that a greater homogeneity among young patients makes it possible to facilitate identification mechanisms among peers, decrease resistances and makes it possible for them to feel better understood and supported when speaking of specific subjects of their age such as the use of other toxics or greater lack of consolidated support family structures is not confirmed with the data.

Other factors in group compliance probably intervene. Precisely, one aspect that is missed in therapy groups specific for youth is the existence of social models to learn from.

They are often persons with incomplete socialization processes, or even non-chronological adolescents. The beneficial effect of sharing experiences and points of views with older persons and experience that may supply learning, socialization guidelines and a visions of the future may be superior to the handicap of being with persons who may be considered «different» or who do not understand subjects such as cannabis or cocaine consumption. Therapists may have maximized the importance of these consumptions and minimized that of the socialization process with older subjects.

We should not forget the existence of a precedent of these results in the use of groups by separate genders more than twenty years ago in the belief that woman felt inhibited by men. The reality is that the therapy groups for present alcoholics are almost always mixed, that women comply to them and benefit from them much more than men and that the therapists often appreciate the presence of women in the groups because they have greater capacity to express feelings and their facilitation of the group dynamics. In any event, some specific behaviors of the younger patients, with characteristics such as drop-out of all those under 26 years assigned to the NY groups, greater initial retention of those under 30 in the NY groups, or simply worse compliance of the younger subjects, leads us to think about the existence of complementary explanations of some of the data.

Among these, there is the possibility that we are mixing patients who have different problems, since it is likely that erroneously diagnosed subjects are found masked and overrepresented among the younger patients (under 26 years), such as those dependent on alcohol who should have been listed as only abusers or, in any event, as that the dependence is incipient.

In this case, these types of patients do not feel identified with any of the groups used. Perhaps they should have received indications of specific groups, not for youth, but rather with objectives such as training in the controlled consumption of alcohol[17].

Although the use of the cut-off at 35 years to define who is young may seem arbitrary, the study conducted has been very extensive, considering age by strata with a sufficiently sensitive analysis type to neutralize the possible distorting effects of including very different ages. Thus, we consider that there is no problem to use this age criterion, with a standard deviation below the mean age of the common therapy groups. Furthermore, the sample studied perfectly reflects the perceptions and intentions of the clinicians when we establish the use of groups with specific age for certain groups of patients.

In conclusion, the supposed advantages of using homogeneous and specialized therapy groups for young alcoholics are counteracted by those derived from mixing heterogeneous persons with different years of evolution in their experiences but who speak about problems which, basically, are similar regarding alcohol dependency.

This goes against using specific groups simply based on age. Another thing would be having therapy groups of ho-

mogeneous patients based on other characteristics, such as personality structure, consumption of other toxics or, above all, the presence of a dependence or simply alcohol abuse.

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