
GUIDELINE 9

Group Therapy

Description

Group therapy for posttraumatic stress disorder (PTSD) is widely practiced in clinical settings. Group approaches may vary across a number of dimensions, specifically, theoretical orientation (e.g., cognitive-behavioral, interpersonal), length (fixed-length vs. open-ended), trauma focus (whether trauma-related material is explicitly discussed), and group membership (e.g., sex, trauma type, open enrollment vs. cohort). There are several potential advantages of group therapy, including the opportunity to deliver effective treatment efficiently, the implicit inclusion of social support and social contact, and the availability of social learning through modeling. For persons with PTSD, in particular, group therapy may be especially useful for providing opportunities to develop trusting relationships and a sense of interpersonal safety, thus, ameliorating the isolation and alienation that often accompany PTSD.

General Strength of the Evidence

The research evidence for group therapy for PTSD shows positive change from pre- to posttreatment, with effect sizes ranging from small to large. There are relatively few well-designed randomized studies with sufficient sample size to provide definitive conclusions about the effects of specific forms of group therapy. Of the randomized studies, five are at an Agency for Health Care Policy and Research (AHCPR) Level A rating; three of these found significant effects for the group therapy being studied—two for cognitive-behavioral therapy (CBT) groups and one for interpersonal group therapy. Thus, most of the evidence comes from studies rated at AHCPR Level B or C. At present, there is no evidence for superiority of any specific type of group treatment

compared to others, nor is there evidence for the relative superiority of the group modality over individual therapy.

In summary, the empirical support for group therapy as a modality for treating PTSD is largely based on pre- to posttreatment change. There are promising findings from a few AHCPR Level A studies and several Level B studies for superiority of specific groups relative to wait-list controls. At present, there is not sufficient evidence to warrant recommendation of a specific type of group therapy, to recommend group therapy in favor of individual therapy, or to predict for whom group therapy might be more or less effective.

Course of Treatment

The group therapy protocols investigated in articles reviewed in Chapter 12 ranged from 6 to 52 sessions, with a modal treatment length of 12 sessions, and with most protocols including 10–25 sessions. Reviewed group therapies tended to be closed (with members of a group comprising a single cohort, rather than fluid group membership) and to meet weekly for approximately 1.5–2 hours. In each study, group therapy was sufficient to result in significant reductions in PTSD symptoms.

Summary and Recommendations

At present, the available data suggest that group therapy for PTSD is associated with improvement in symptoms, and specific forms of cognitive-behavioral and interpersonal group treatments are superior to no treatment. Group therapy may be an acceptable alternative to individual therapy for many patients, but research is needed to establish the relative efficacy of group versus individual treatments. The majority of studies of group treatment have included participants whose PTSD symptoms are due to childhood sexual abuse or combat trauma.

1. Group therapy is recommended as a useful component of treatment for PTSD related to different types of traumatic experiences.
2. There is no evidence supporting superiority of any type of group therapy relative to others, although cognitive-behavioral group therapy remains the most frequently studied and has the largest amount of empirical support.
3. The effect of individual characteristics on group therapy outcome has received little study. Preliminary evidence suggests that the inclusion of participants with borderline personality disorder may negatively impact the outcome of process–interpersonal group therapy.

Suggested Readings

- Baldwin, S. A., Murray, D. M., & Shadish, W. R. (2005). Empirically supported treatments or Type I errors?: Problems with the analysis of data from group-administered treatments. *Journal of Consulting and Clinical Psychology, 73*, 924–935.
- Foy, D. W., Ruzek, J. I., Glynn, S. M., Riney, S. A., & Gusman, F. D. (1997). Trauma focused group therapy for combat-related PTSD. *Journal of Clinical Psychology, 3*, 59–73.
- Krakow, B., Hollifield, M., Johnston, L., Koss, M., Schrader, R., Warner, T. D., et al. (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder. *Journal of the American Medical Association, 286*, 537–545.
- Schnurr, P. P., Friedman, M. J., Foy, D. W., Shea, M. T., Hsieh, F. Y., Lavori, P. W., et al. (2003). Randomized trial of trauma-focused group therapy for posttraumatic stress disorder. *Archives of General Psychiatry, 60*, 481–488.