
Group Therapy



VA/DoD CLINICAL PRACTICE GUIDELINES FOR PTSD (2010)

Presented by
National Center for PTSD
U.S. Department of Veterans Affairs

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Group Treatment for PTSD



We'll be talking today about group treatment for PTSD and the 2010 VA/DoD Clinical Practice guidelines for PTSD.

Meet the Presenters: Tracie Shea, Ph.D. and Denise M. Sloan, Ph.D



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PRESENTATION OBJECTIVES

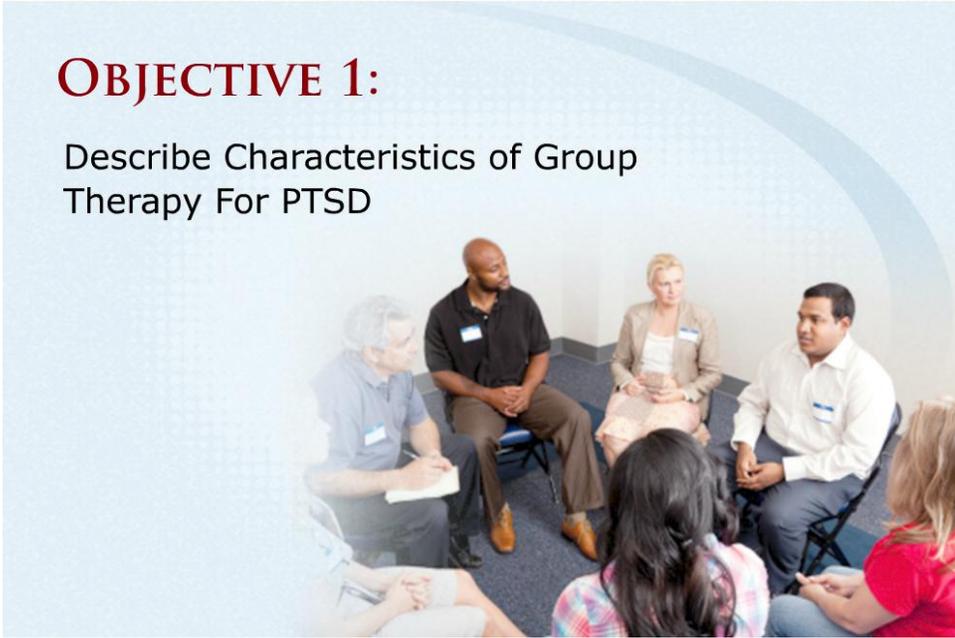
1. Describe characteristics of groups
2. Describe critical methodological factors to consider when evaluating group treatment research and review the existing research for group treatment for PTSD
3. Review the 2010 VA/DoD Clinical Practice Guideline recommendations for group treatment for PTSD

We have three objectives that we'll cover today. First, we'll describe group therapy for PTSD, second we'll describe critical methodological factors to consider when evaluating group treatment research and review the existing research for group treatment for PTSD, and then, finally, review the 2010 VA/DoD Clinical Practice Guideline recommendations for group treatment for PTSD

Objective 1: Describe Effective Characteristics of Group Therapy for PTSD

OBJECTIVE 1:

Describe Characteristics of Group Therapy For PTSD



So, let's start with objective one, describe group therapy for PTSD.

OVERVIEW

- ▶ Advantages and disadvantages of groups
- ▶ Different types of groups
- ▶ Considerations for selecting group members
- ▶ Group Dynamics
 - Developing group cohesion
 - PTSD symptoms and group process



Ok, so what I'm going to focus on here includes the advantages and disadvantages of groups, different types of groups for PTSD, and some considerations for selecting group members. And then, finally, a little bit about group dynamics, including developing group cohesion, and how PTSD symptoms can affect group process.

ADVANTAGES OF GROUP THERAPY

▮ Practical reasons

- More efficient?
- Less costly?
- Assumes group therapy is as effective as individual therapy —(no evidence to support this assumption)

▮ Therapeutic reasons

- Reduce isolation
- Normalize symptoms
- Opportunity for support, validation, and positive interactions with others



So, what are the advantages of group therapy? Well, often it's believed that group therapy is more efficient, might be less costly and that's clearly because you can provide treatment to more than one individual at a time. Whether, in the long run, that's the case we simply don't know, because that assumes that group therapy is as effective as individual therapy, and, as you will hear later, we really don't have evidence to support that.

So, more important, in terms of advantages, I think, are therapeutic reasons. Groups can be very powerful, in my experience, treating Veterans for PTSD in terms of reducing isolation, making symptoms understandable – normalizing symptoms – seeing that others have experienced some of the same kinds of symptoms and life experiences and just that opportunity for them to interact, provide each other with support, provide each other with validation and just having positive interactions with others.

I typically ask, at the end of each group that I do, what each member thinks is some of the more important aspects of the group that helped them. And, I always hear these reasons in response: that just being able to talk to other people who understand, and feel comfortable with other people was what they see as being particularly helpful.

POSSIBLE DISADVANTAGES

- ▶ Scheduling is more difficult and less flexible
- ▶ Less time to focus on individual work
- ▶ Difficult for some patients to talk/feel comfortable in groups

A composite image with a light blue background. On the left is a white desk calendar with a red top and the word 'Calendar' in white. The calendar shows dates from 1 to 28. In the center, a man with grey hair, wearing a light blue shirt, has his hands pressed against his face in a gesture of distress or embarrassment. To the right, the back of a woman's head and shoulder, wearing a blue jacket, is visible, suggesting she is part of a group.

And, of course, there are some disadvantages, just even logistically. Scheduling is tougher. You have to meet a lot of people's schedules to make that work. There is less flexibility. Another disadvantage is there is less time to focus on individual work when you have 6 or 8 people in a group, clearly you can't go over individual experiences, or, if homework is assigned, you can't spend as much time per each individual.

And, then, finally, there are some patients who just simply do not want to be in groups. They don't feel comfortable talking in a group and are quite resistant. You don't want to give up too easily though, because, again, my experience has shown me that often some who have been quite resistant to being in a group, once in the group, has found it to be a very valuable and pleasant experience.

DIFFERENT FORMATS

- ▶ Open vs closed membership
- ▶ Time-limited vs open-ended
- ▶ Amount of structure (session agendas)



So, what about different types of groups? There's a lot of different formats that are frequently used in providing group therapy for PTSD. Sometimes groups are open, that are like drop-in groups so that the membership changes at any given session versus closed membership, where the group membership is set at the beginning and remains the same to the end. They really have different purposes with closed groups really providing an opportunity, again, to develop that kind of relationships or cohesion.

Some groups are time limited from the start, others are open-ended with no clear end date in mind. Groups differ a lot in terms of how much structure is present. By that I mean how focused and detailed is the agenda ranging from very structured, which would be very didactic in covering a lot of material to less structured, perhaps driven more by the group members' agendas more than the clinicians'.

DIFFERENT FORMATS

- ▶ Clinician vs peer-led
- ▶ Telehealth
- ▶ Group plus individual
 - Both part of same treatment
 - Simultaneous but independent

An illustration of a person in a dark suit sitting at a desk, talking on a telephone. The desk has a computer monitor and some papers. The background is a light blue gradient with a faint grid pattern and a large, curved, light blue shape that frames the text and the person.

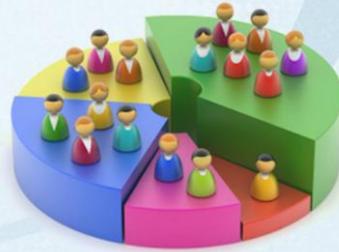
And, we typically think about groups as being clinician-led, but there is an increasing interest, and occurrence, of groups that are led by peers. So, the individual with PTSD gets training to facilitate the groups, and that can be also very useful and powerful example of a group.

Telehealth is another recent development. There's strong interest due to difficulty of distance that characterize many of the Veterans who are coming back from these recent wars. So, there's been strong interest in delivering groups actually, and other treatments, using video conferencing, and there is some evidence to date that that is just as effective as delivering a group in in-person setting.

And then, finally, it is not either/or. Certainly groups can, and often are, delivered at the same time that the individual is in individual therapy. Whether they are both focusing on the same treatment, or whether they are independent but just occurring simultaneously – that's again very common – so, in such cases one can have the advantages of both individual therapy and group therapy.

SIZE

- ▶ Two therapists are ideal, particularly for trauma focus and process groups
- ▶ Psychoeducational and skills training groups – manageable with one therapist
- ▶ Six to eight group members is ideal
- ▶ Psychoeducational and skills training groups can be larger



What about size? First of all, how many therapists? Two therapists are ideal, and this is particularly true for trauma focused groups and process groups. They just, in my experience, you can do them with one but it's just much preferable, if you can, to have another person in the room so that you can increase the amount of observations and think of different points. It's just often a richer intervention if there are two therapists.

Some of the more structured groups like the psycho-educational and skills training groups may be easier, or more manageable, than the other types of groups delivered by one therapist; but still it's nicer to have two.

What's the ideal size? Typically, 6-8 group members is recommended as ideal. So, why is that? If you get much smaller than 6, if you have a dropout or someone is not able to attend a session, the numbers get small and you lose the sense of a group. So, starting with 6 at the minimum is advisable.

And, why not more than 8? Again, if you are doing a group such as a trauma focused group, you need to have, if you have too many group members you can lose that sense of cohesion and you can also just not have enough time to deal with each individual. So, on the other hand though, again, more didactic groups, like psycho-educational and skills training, can be larger because, again, the focus of those groups are quite different.

FOCUS AND GOALS

- ▶ Psychoeducation
- ▶ Skills training
- ▶ Trauma focused
- ▶ Present centered
- ▶ Co-occurring diagnoses/
symptoms
- ▶ Recovery oriented

A photograph of a woman with short blonde hair, wearing a light blue button-down shirt and a name tag, sitting at a table. She is smiling and looking towards the camera. The background is a light blue wall with a large, faint, curved graphic element.

So, what about different types of groups in terms of what the focus of the group, or the goals, are? From the simplest, being psychoeducation, where the goal is really just to provide information and increase the individuals with a sense of mastery just by understanding what they are experiencing.

Skills training is a frequently used type of group, certainly in our clinic. Trauma focused is another important kind of group therapy for PTSD. Groups are often what's referred to as present centered, which I will talk about a bit more. And, often groups are focused on co-occurring diagnoses and symptoms allowing the group to focus more specifically on some of those other symptoms or issues besides just the PTSD. And, then, finally there is an increasing movement towards what's referred to as recovery oriented groups, where the goal is really to maintain progress and continue focusing on life goals.

FOCUS AND GOALS

- Skills Training
 - Purpose: improve ability to manage symptoms
 - Use of cognitive behavioral strategies
- Examples
 - Stress management/coping skills
 - Anger management
 - Affect regulation



So, one very common type of group that are used for people with PTSD is skills training, the purpose really being to improve the individual's ability to manage their symptoms. Typically these use cognitive behavioral strategies, and, just some examples, stress management, typically using relaxation approaches, ways of just understanding and predicting and dealing with stress.

Anger management, I find, in the work that I do with Veterans here at the Providence VA, that that is one of the most frequently sought-after group because the issues of anger, of course, are very big with a lot of Veterans.

And, then another example would be groups focused on just the ability to regulate affect.

FOCUS AND GOALS

- ▮ Present centered
 - Purpose: decrease isolation and increase mastery of current life problems
 - Support: support and validation from group members
 - Process: also use of interactions among group members to facilitate learning

A photograph showing a group of about eight people sitting in a circle on a wooden floor, engaged in a discussion or therapy session. They are dressed in casual to business-casual attire. The background is a light blue wall with a large, faint, curved graphic element.

So, moving on to a different type of group, present-centered groups. Essentially, with present-centered groups, the idea is to help the Veterans increase mastery of their current life problems and also to decrease isolation, which, as we mentioned before, is very common in people with PTSD.

So, an essential part of a present-centered group is the support aspect where group members are providing each other support and also validation. And, this, in fact, can be a very powerful aspect of group therapy for people, again, who have sort of thought they have been alone in their experiences, maybe isolated.

There are also groups that focus on process, in other words, really using the interactions among group members to help them learn more about their interpersonal functioning or their interpersonal style and the ways that they deal with problems.

FOCUS AND GOALS

- Co-occurring diagnoses/symptoms
 - Substance use disorders
 - Depression
 - Sleep
- Recovery oriented
 - Maintain progress
 - Focus on life goals

A man in a white shirt is drawing a black arrow on a whiteboard. The arrow starts at the bottom left and curves upwards to the right, pointing towards the top right. The background is a light blue grid pattern with a large, faint white arrow shape pointing from the bottom left towards the top right.

And, then there are several groups, that are often delivered for PTSD, that focus on the co-occurring diagnosis and symptoms, of which there are many, as is well known. For example, substance use disorders that's co-rmorbid with PTSD; there are groups that focus explicitly on both of those disorders being present at the same time. You can have groups that are focused on depression or groups that focus specifically on improving sleep.

And, then there are another type of group that focuses more on recovery. So, this would be after, most likely, the individual has done other work, other kinds of therapy, whether group or individual, and at this point, wants to maintain their progress and continue to focus on their life goals.

FOCUS AND GOALS

Trauma Focused

- ▶ Purpose: process individual traumas
- ▶ Cognitive behavioral
 - Imaginal exposure
 - Cognitive restructuring
- ▶ Psychodynamic
 - Focus on understanding how individual's specific trauma(s) are influencing current life problems and conflicts

So, then moving on to trauma focused groups where the purpose is to do just that, process individual traumas. The most common type of trauma focused group is, again, cognitive behavioral incorporating, essentially, two components. One is imaginal exposure, which is reliving the experience in the context of the group setting, and the other is cognitive restructuring, in other words, trying to identify and change cognitive distortions that are associated with the trauma.

Trauma focused groups are sometimes also delivered using a psychodynamic format, which also focuses on the trauma, but is less direct and tries to understand essentially how the individual's specific trauma history is influencing their current life problems and conflicts.

REVIEW EXERCISE

Match the type of therapy group to its purpose.

Recovery oriented

Present centered

Co-occurring diagnoses

Trauma focused

Skills training

Increase mastery of current life problems and decrease isolation

Process individual traumas

Improve ability to manage symptoms

Maintain progress and focus on life goals

Focus on comorbid conditions with PTSD

TRAUMA FOCUSED GROUP

- Possible advantages of cognitive restructuring
 - Feedback and support from group members—powerful influence on changing distorted cognitions
- Possible disadvantages of exposure
 - Triggered by others' traumas?
 - Reluctant to discuss trauma in group setting
 - Number of in session exposures lower
- Does appear that conducting exposure in group can be tolerated and effective for some

So, sometimes people ask, “Should you do exposure in groups? Is it recommended?”

And, we don't have a definitive answer for that, but there are possible advantages. For example, the feedback and support from other group members can have a powerful influence on changing distorted cognitions. That's because the other group members have a lot of credibility in terms of understanding what the individual is talking about.

The disadvantages that's some are concerned about is, well, would the person be triggered by other people's traumas? Aren't people reluctant to discuss trauma in a group setting? And, another possible disadvantage is that given that it's in a group context, then the amount of time that can be spent in session on individual work is lower.

Nonetheless, despite all these considerations, it does appear that conducting exposure in group formats can be tolerated and effective for some Veterans, at least, and others in PTSD groups

CONSIDERATIONS FOR INCLUSION

- ▶ Similarity of trauma type
 - Groups not focused on trauma (e.g. skills training) can accommodate different types of trauma histories
 - Trauma focused groups—important to consider nature and severity of trauma
- ▶ Avoid having single member of a group who differs from other group members in important way
- ▶ Trauma focused groups—ability to tolerate distress without negative consequences (e.g., behaviors that disrupt or pose harm to others in the group)



So, another question that comes up is, “How do you select group members?” Are there some people who are simply not a good fit for groups?

And, again, there’s no hard and fast rules about this but just some considerations. Immediately you think about well, should we include people with different types of trauma histories in the same group. And, I think that for some kinds of groups, such, again, as the skills training or psychoeducation, where the focus is not on trauma, that it’s okay, that these kinds of groups can accommodate people with a variety of kinds of trauma histories.

On the other hand, if you are doing a trauma focused group, its much more important to think about that; to think about the nature of the trauma and the severity of the trauma so that each individual member of the group feels that they belong there essentially.

A second general rule for selecting members is you just don’t want to have a single member of a group who differs from the other group members in an important way. Again, like for example, gender, type of trauma or other things that are really going to result in that individual feeling that they don’t connect or can’t be part of the group.

And then, also, for trauma focused groups, consideration is you want to make sure that the individual, to the best that you can, that the individual has the ability to tolerate distress without negative consequences.

CONSIDERATIONS FOR EXCLUSION

- Features that may negatively impact the individual's benefit from the group and/or the group process
 - Acutely psychotic
 - Cognitively impaired
 - Severely depressed
 - Current crisis or chaotic life situation



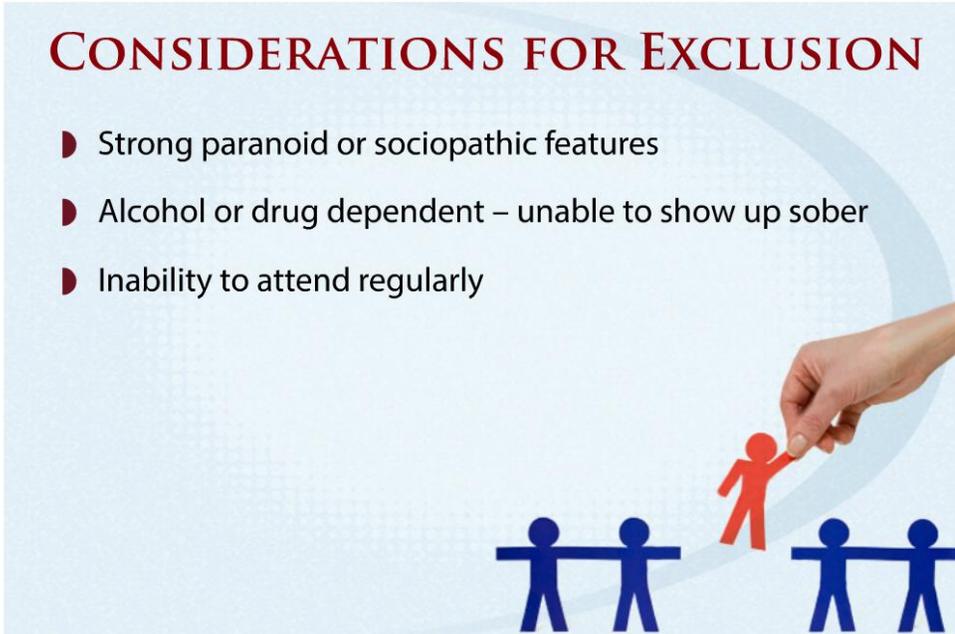
So, and then, are there any features that would automatically exclude someone from a group? And, again, this varies depending on the type of group, but the general consideration is that you want to think about features that might negatively impact the individual's ability to benefit from the group, or have a negative impact on the group process.

So, examples of such features might include being acutely psychotic, cognitively impaired to the extent that one simply can't take in the information that's being provided or interact in a successful way with other group members. Perhaps someone who is severely depressed, again, would not be able to take advantage of the group in the sense of interaction and taking in information.

Another consideration is someone who has a current life crisis that is quite salient, or severe, because that will draw the attention away from the work of the group in terms of the crisis.

CONSIDERATIONS FOR EXCLUSION

- ▶ Strong paranoid or sociopathic features
- ▶ Alcohol or drug dependent – unable to show up sober
- ▶ Inability to attend regularly



Other considerations for exclusion, these having to do with actually the ability of the group to function successfully, is that individuals with strong paranoid or sociopathic features can be difficult to manage in a group and can often be disruptive to the group process.

Another consideration is alcohol or drug dependence, which is not necessarily an exclusion for all groups, but certainly the individual has to be able to show up sober. If they can't then that obviously isn't going to work in a group setting.

And then, finally, just the inability to attend regularly; having all members attend regularly is certainly very important to the group process.

GROUP COHESION

■ Goals

- Develop a sense of safety
- Help the group members begin to feel comfortable with each other and with the group format

■ Strategies for early sessions

- Provide information: be very clear about group process and provide a rationale – how the procedures that will be used in the group will help their PTSD symptoms or problems
- Establish ground rules and expectations

So, let me say a little bit about group cohesion, which is generally considered just a key element of the success of group therapy. Essentially what you want to do is help the group develop a sense of safety and you want to help the group members begin to feel comfortable with each other and with the group format.

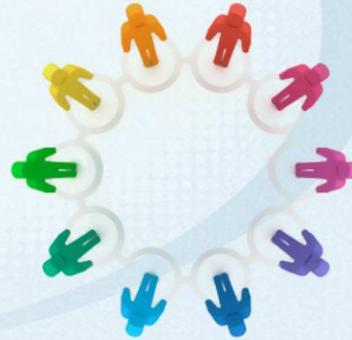
So, in the early sessions it is important to address a few things. For one, you want to provide information. You want to be very clear about how the group process will work and also provide a rationale – how the procedures that will be used in the group will help their PTSD symptoms or problems.

Another very important piece is to establish ground rules and expectations of group members.

GROUP COHESION

▮ Ground rules

- Regular attendance
- Confidentiality
- No violence or threats of violence
- Topics to avoid (e.g., politics)
- Be clear about whether individual traumas will or will not be discussed



So, examples of ground rules include regular attendance, confidentiality, no violence or threats of violence, any topics to avoid, and politics is usually a good one to include in this category. And, be clear about whether individual traumas will or will not be discussed.

Setting up these kinds of boundaries or limits is intended to get everybody on the same track and allow people to feel safe. As you can see, for example, confidentiality is a guarantee that nobody is going to take anything that is discussed outside the room; increase the sense of safety.

PTSD SYMPTOMS AND GROUP PROCESS

Hyperarousal symptoms can

- ▮ interfere with ability to take in verbal information
- ▮ increase misunderstanding and poor communication among group members
- ▮ lead to aggressive behavior in the group
 - Establish an aggressive norm in the group
 - Intimidate some group members, decrease sense of safety

The illustration at the bottom of the slide features four icons on a light blue background. From left to right: a person with their hands on their head, a head profile with sound waves, a group of three people with arrows indicating communication, and two people in a physical confrontation.

So, moving on to how do PTSD symptoms, how can they affect the group process? What is unique about PTSD in this regard? Well, if you think about the hyperarousal symptoms, if someone is very hyperaroused, it is hard for them to take in verbal information, which might mean to be careful to include repetition in groups that are providing information.

It also can make it more difficult to understand and result in more misunderstandings or poor communications among group members. Again, because the attentional focus is not as direct as it needs to be.

Hyperarousal also can lead to aggressive behavior in the group, and this can go a couple ways. Aggression can be contagious, and it can set up an aggressive norm in the group. Alternatively, it might end up intimidating some group members and decrease their sense of safety. So, that's something that needs to be addressed or confronted very early on.

PTSD SYMPTOMS AND GROUP PROCESS

- ▶ Severe numbing can
 - reduce empathy
 - make it hard to feel connected to the group

- ▶ Re-experiencing
 - Intrusive thoughts and images may be triggered simply by being in the group
 - Can pull attention away from the present
 - Can lead to avoidance of the group



Numbing symptoms, essentially feeling very numb, makes it hard to feel connected and that would operate in the group as well. So, makes it hard to feel empathy for group members, and it can make it hard just to feel connected to the group.

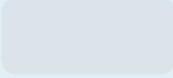
Re-experiencing symptoms. Even just coming to a group, whether or not it's focused on trauma histories, per se, we found that just coming to the group can result in a lot of re-experiencing, intrusive thoughts coming up and images, simply by being there.

So, that, of course, can pull attention away from the present, away from what's going on in the group and can also lead to avoidance of the group. So, I mentioned these as just a few recommendations to be attuned to and to try and pay attention to if needed.

REVIEW EXERCISE

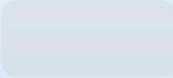
Match the type of PTSD symptom with how it could interfere with the group treatment process.

Numbing



Poor communication, aggressive behaviors

Hyperarousal



Triggered by group, pulled out of present moment, avoid group

Re-experiencing



Reduce empathy, difficult to feel connected to group

CONCLUSIONS

- ▶ Group therapy for PTSD can be used to provide education, increase coping skills, provide support for current life issues, or to process trauma
- ▶ Advantages of group therapy for PTSD include the opportunity for support, validation, and positive interactions among group members
- ▶ Group therapy can be combined with individual therapy



So, moving on to just some conclusions. Number one, group therapy for PTSD can be used to provide education, it can be used to increase coping skills, it can be used to provide support for current life issues, or to process trauma. There are strong advantages to group therapy for PTSD including the opportunity for feedback, and validation, and support, which, again, is very powerful, often, for people who have had these kind of traumatic experiences and feel very alone. And then, finally, these are not mutually exclusive. Group therapy can be combined with individual therapy, whereby one can experience the benefits of both.

Objective 2: Describe Critical Methodological Factors to Consider When Evaluating Group Treatment Research, and to Review the Existing Research that's been conducted on Group Treatment for PTSD

OBJECTIVE 2:

Describe critical methodological factors to consider when evaluating group treatment research and review the existing research for group treatment for PTSD



So, Dr. Shea has just reviewed objective one, and now I'm going to review objective two and three. The second objective is to describe the critical methodological factors to consider when evaluating group treatment research, and to review the existing research that's been conducted on group treatment for PTSD.

SPECIAL CONSIDERATIONS IN PSYCHOTHERAPY TRIALS

- ▶ Choosing a comparison condition
- ▶ Special statistical issues for group-based treatments
- ▶ Assigning therapists to conditions
- ▶ Manualization
- ▶ Training, supervision, and monitoring
- ▶ Additional treatment
- ▶ Equating a comparison condition

There are a number of important factors to consider when conducting psychotherapy research, and this next slide lists a number of those factors that should be considered. I want to highlight a couple of these factors to help us interpret the research literature on group treatment for PTSD.

The first issue is the comparison condition that one uses, and the second issue is special statistical considerations that need to be taken into account when conducting group based treatment research.

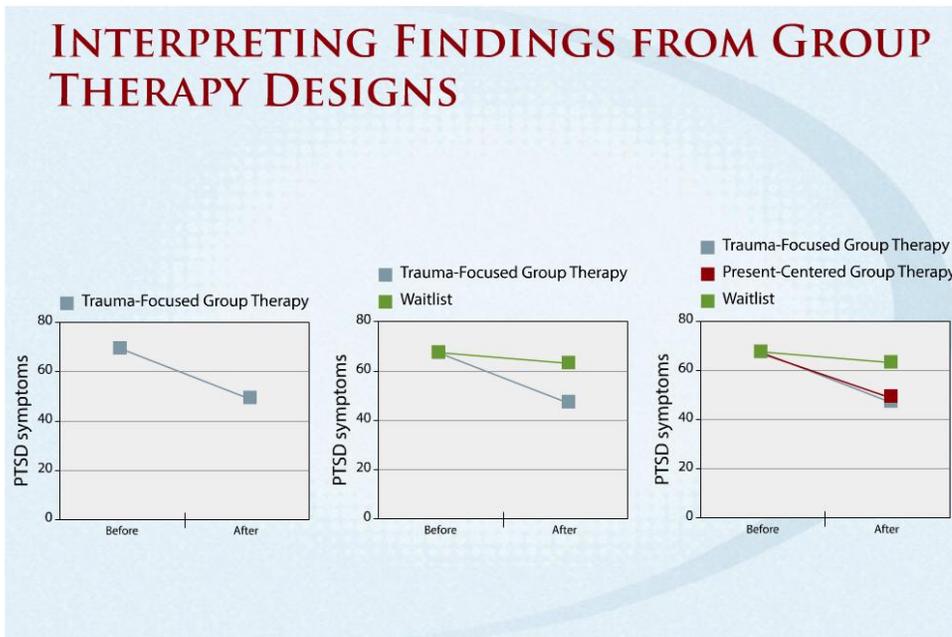
QUESTIONS ANSWERED BY GROUP PSYCHOTHERAPY RESEARCH DESIGNS

- ▶ Wait list: Does group treatment cause change?
- ▶ Nonspecific comparison/usual care: Is there a specific benefit of one type of treatment vs. another, e.g., cognitive behavioral therapy vs. present-centered group?
- ▶ Component control: What are the active ingredients, e.g., multi-component group vs. single elements?
- ▶ Other active treatment: Is group better or more efficient or cost-effective than, e.g., individual?

In terms of the type of comparison condition that's used, different comparison conditions address different questions. For example, a wait list comparison condition addresses the question of "Does group treatment cause change?" A non-specific comparison condition such as supportive counseling or treatment as usual addresses the question of "Is there a specific benefit of one type of treatment versus another? For example, cognitive behavioral treatment versus present-centered group treatment?"

A component control comparison condition addresses whether there are active ingredients or components to a treatment. For example, a multiple component group treatment that might include exposure based techniques and cognitive restructuring versus a cognitive restructuring group alone.

The last type of comparison condition is active treatment, and this type of comparison condition addresses the question of, "If group treatment is better, or more cost effective than, for example, individual treatment?"



So, on this next slide, there are three slides that illustrate the importance of a comparison condition to interpreting the effectiveness of group treatment. In the first graph, there's only one condition, a trauma-focused group treatment, and in this graph, we can see that people got better after treatment compared to before treatment. However, we don't know, without a comparison condition, why people got better, and they might've gotten better due to some other factors such as time.

In the second graph we have two conditions – one's a trauma-focused group therapy condition and the second is a waitlist – and we can see that people start the same in both conditions, but after treatment, the trauma-focused group participants are significantly reduced in their PTSD symptoms relative to waitlist comparison. So, in this condition, we know that people got better because of the group treatment. And, in the third graph we have three conditions: trauma-focused group treatment, present-centered group treatment, and waitlist comparison.

We can see again that participants all start off the same before treatment, but after treatment, the participants in the treatment conditions – trauma-focused and present-centered – have significant decreases in their symptoms relative to the waitlist. So, in this one we can see that people in group treatment got better, but the type of treatment didn't make a difference.

STATISTICAL CONSEQUENCES OF GROUP-BASED TREATMENT

- ▶ The influence of group members on each other can cause observations to be clustered, i.e., not statistically independent
- ▶ Group, not participant, is the unit of analysis
 - Participants should be nested within groups
- ▶ Failing to address group clustering can cause treatment effects to be overestimated

The second issue that I want to talk about that's important for reviewing group treatment for PTSD is the special statistical issues related to group based treatment. Analyses assume the independence of the data, however, in group treatment, group members influence each other. So, therefore, if one group member gets better, that influences the benefit of other group members as well. So, this data is not independent, and that needs to be taken into account when conducting the analyses.

Another issue with group treatment, for statistics, is that group, not the participant, is a unit of analysis. So, the degrees of freedom is much smaller than what would be if participants were the unit of analysis. When these two things are taken into account, the effect sizes are much smaller than would be otherwise. And, that means that if they're not taken into account, oftentimes the effect sizes will appear larger than what they really are, and so some studies might report significant effects that aren't actually significant.

WHAT DO WE KNOW ABOUT GROUP TREATMENT FOR PTSD?

- ▶ The majority of clinical group trials for PTSD have consisted of an uncontrolled design
- ▶ Most of these trials have found a significant reduction in PTSD symptom severity at post-treatment relative to pre-treatment
- ▶ However, given the single group design, these trials provide limited information about the efficacy of group treatment for PTSD

So, with these special consideration in mind, I want to, next, review what do we know about group treatment for PTSD. Most of the research in this area has examined single groups, that is participants who enter a group treatment, and examining them, or following them, before treatment and after.

And, most of these trials have found a significant reduction in PTSD symptom severity after treatment compared with before treatment. However, given the single group design, these trials have provided limited information about the efficacy of group treatment. We don't know why people got better, we don't know if it was the group treatment, or if they would have gotten better just as a matter of other factors, such as time.

WHAT WE KNOW

- ▶ To date, there have been 17 randomized controlled trials (RCTs) of group treatment for PTSD
- ▶ These studies are heterogeneous in terms of the target therapy, comparison condition, PTSD outcome measure, and trauma sample

The best type of design, in terms of providing information about efficacy of group treatment, are randomized controlled trials (RCTs). And, in these types of designs, two or more conditions are included, and participants are randomly assigned to the conditions. To date, there's been 17 randomized controlled trials for group treatment of PTSD. These studies are heterogeneous in terms of the type of therapy that's examined, the type of comparison condition that was included, the PTSD outcome measure that was used, and the trauma sample that was examined.

Study Characteristics of Randomized Clinical Trials of Group Treatment for PTSD

STUDY CHARACTERISTICS OF RANDOMIZED CLINICAL TRIALS OF GROUP TREATMENT FOR PTSD			STUDY CHARACTERISTICS OF RANDOMIZED CLINICAL TRIALS OF GROUP TREATMENT FOR PTSD		
Study	Treatment Type	Comparison	Study	Treatment Type	Comparison
Beck et al. (2009)	Cognitive Behavioral Therapy (CBT)	MCC	Hollifield et al. (2007)	CBT	Waitlist and Acupuncture
Bradley & Follingstad (2003)	CBT	Waitlist	Krakov et al. (2000)	Imagery rehearsal therapy for nightmares	Waitlist
Classen et al. (2011)	CBT	Waitlist and Present focused group	Krupnick et al. (2008)	Interpersonal therapy	Waitlist
Dunn et al. (2007)	CBT (focus on depression)	Psychoed	Morland et al. (2010)	Anger management via teleconferencing	Anger management group via in person
Falsetti et al. (2008)	CBT (focus on PTSD and panic attacks)	Waitlist	Rogers et al. (1999)	CBT	EMDR
Harris et al. (2011)	Spiritually integrated trauma treatment	Waitlist	Schnurr et al. (2003)	CBT	Present centered group
Hien et al. (2009)	CBT (seeking safety)	Psychoed	Sikkema et al. (2007)	CBT	Waitlist and Support group
Hinton et al. (2011)	Culturally-adapted CBT	Applied muscle relaxation	Zlotnick et al. (1997)	CBT	Waitlist
			Zlotnick et al. (2009)	CBT (seeking safety)	TAU

CBT = Cognitive-Behavioral Therapy; MCC = Minimal Contact Condition; Psychoed = Psychoeducation; TAU = treatment as usual

So, the next two slides summarize the 17 randomized controlled trials that have been conducted for group treatment for PTSD. The first column indicates the lead author of the study and the year the study was conducted. The second column indicates the type of treatment that was examined, and the third column represents the comparison condition that was included.

There are a few things that I want to highlight in terms of these studies, and one is that most of the studies have been conducted in the past 5 years. The second thing that I want to highlight is that, more often, a waitlist comparison condition was the comparison condition that was included. And, the third is the type of treatment that was examined. Most of the treatments examine a cognitive behavioral treatment, but the type of treatment that was examined really varied from study to study.

The study by Morland and colleagues examined anger management delivered in video teleconferencing, and the comparison condition in that study was actually anger management that was delivered in person. So, this study is a little bit different from the other studies in that there were two active treatment comparisons, but one was delivered teleconferencing. And, this is actually a very exciting area for the field: how do you deliver treatment to people in remote areas, and how do you get treatment to people who might otherwise not be able to access it?

That study actually found that there was no differences in either of those treatments; that both participants in both conditions got better, and it didn't seem to matter that treatment was delivered via teleconferencing.

METHODOLOGICAL CHARACTERISTICS OF THE RCTs

- ▶ 7 of the 17 RCTs used a wait-list comparison condition
- ▶ 6 of the studies did not require a diagnosis of PTSD for study inclusion
- ▶ 2 studies examined a treatment that targeted symptoms other than PTSD (e.g., depression)
- ▶ 10 of the studies used a self-report PTSD outcome measure

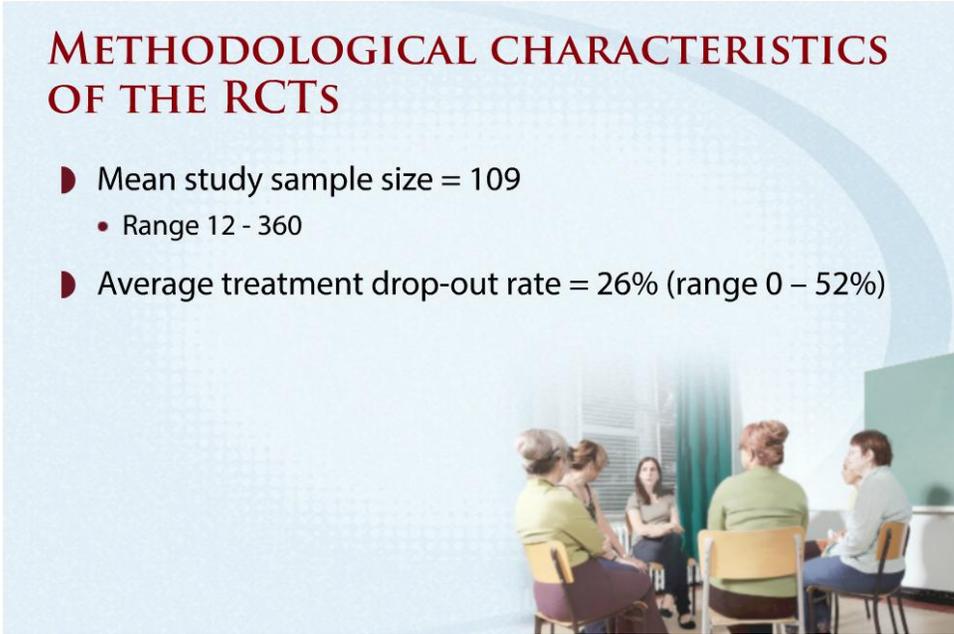


There are a number of characteristics of these studies that I want to review with you, and the first is that seven of the seventeen studies that have been conducted have used a waitlist comparison condition. So, that provides somewhat minimal information about the unique benefits of a type of group treatment.

All we can say is whether or not people got better compared to no treatment. Six of the studies didn't require a diagnosis of PTSD for study inclusion so, some of these studies might have included people who didn't actually have a diagnosis of PTSD. And, two studies examined a treatment that targeted symptoms other than PTSD, for example depression, which is commonly comorbid with PTSD, and ten of the studies use a self-report PTSD outcome measure, which isn't as ideal as using a semi-structured clinical measure.

METHODOLOGICAL CHARACTERISTICS OF THE RCTs

- ▶ Mean study sample size = 109
 - Range 12 - 360
- ▶ Average treatment drop-out rate = 26% (range 0 – 52%)



The mean study sample size was 109, although the range was considerable. One study had a sample size of 12, and another study had a sample size of 360 participants, which is quite large. The average treatment dropout of these studies was 26%, although, again, there was a considerable range, with a zero to 52% range.

The treatment dropout rate provides important information in terms of the tolerability of treatment. If a treatment is effective, but half of the people drop out of the treatment, it's probably not a treatment that clinicians would want to use. The treatment dropout rate of 26% is comparable to what has been observed for individual treatment for PTSD.

META-ANALYSIS OF RCT GROUP CLINICAL TRIALS FOR PTSD

- ▶ Sloan and colleagues (2011) conducted a meta-analysis of the 17 group RCTs for PTSD
- ▶ Data were reanalyzed to correct for the group effect in studies that had not done so (all but 3)

This meta-analysis was published after the Clinical Practice Guideline was released

So, my colleagues and I have done a meta-analysis of these seventeen studies, and a meta-analysis is basically a statistical analysis of the efficacy of these studies. We also reanalyzed the data to correct for the studies that didn't correct for the group clustering effect, which was the case in all but three of the studies.

EFFECT SIZES

- Within group effect size: $d = 0.71$ (moderate - large)
- Between group effect size: $d = .56$ (moderate)
 - Although this effect size is statistically significant, it is substantially smaller than within-group effect sizes from studies of individual treatment (which are typically greater than 1.0)
- Between group effect size for group treatment compared with active treatment: $d = 0.09$ (non significant)
 - This finding indicates that group treatment does not differ from group treatments intended to control for nonspecific benefits of group therapy

So, in terms of what we found for effect sizes, the within group effect size, which is how do people in the groups do before and after treatment, was moderate to large. It was a Cohen's Effect size of 0.71. The between group effect size, which examines how people in the group treatment did compared with the comparison condition, was significant and moderate at 0.56.

Although both of these effect sizes are statistically significant, they are substantially smaller than what's observed for individual treatment for PTSD, and usually in individual treatment it's at least 1.0. We also looked at the between group effect size for group treatment compared to some active comparison condition. So, this was studies that was something other than a waitlist comparison condition, and when we did that, we found a non-significant effect size of 0.09, which means it wasn't different than zero.

So, this finding indicates that group treatment does not seem to differ from group treatments that are intended to control for nonspecific benefits of group therapy such as therapeutic contact, empathy, warmth.

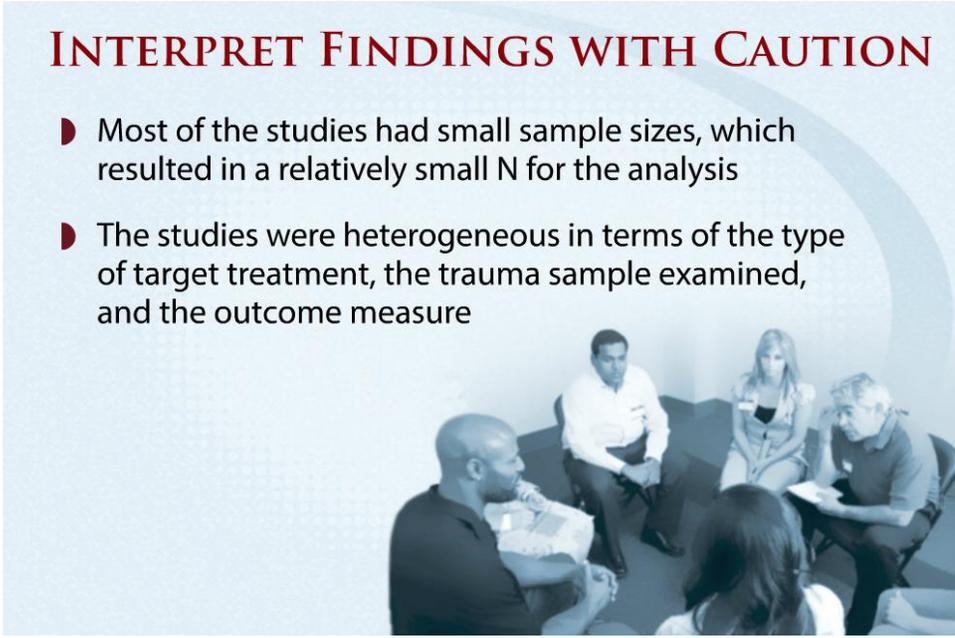
META-ANALYSIS SUMMARY

- ▶ Group treatment is effective relative to no treatment
- ▶ Group treatment is less effective than individual treatment, although no study has directly compared individual to group treatment
- ▶ None of the group treatments studied have unique benefits beyond the general benefits of group therapy

So, to summarize our findings, we found that group treatment is effective compared to no treatment. Group treatment is less effective than individual treatment, although I want to point out that no treatments directly compared individual to group treatment for PTSD, and that's an important future direction. Also, none of the group treatments studied seemed to have unique benefits beyond the general benefits of group treatment.

INTERPRET FINDINGS WITH CAUTION

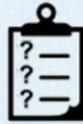
- ▶ Most of the studies had small sample sizes, which resulted in a relatively small N for the analysis
- ▶ The studies were heterogeneous in terms of the type of target treatment, the trauma sample examined, and the outcome measure



So, we should interpret these findings with caution for a number of reasons. First, most of the studies did have small sample size, smaller than what would be needed to detect significant between group effects. And, the studies were quite different in terms of the type of target treatment that was examined, the type of trauma sample that was examined, and the outcome measure that was used. So, in some ways, this is like mixing apples and oranges, and it might be difficult to really draw conclusions from this wide variety of studies.

WHAT WE DON'T KNOW

- ▶ The studies conducted to date have not generally addressed several important questions
 - Effectiveness of group treatment relative to individual treatment
 - Perceived advantage of social support or social contact
 - Cost-effectiveness of group treatment relative to individual treatment



So, now I just reviewed what we know about group treatment for PTSD based on the research literature, but I want to take a few minutes to review what we don't know, because there's quite a bit that we don't know, and would be important areas for us to address. First, we don't know much about the effectiveness of group treatment relative to individual treatment, and I just talked about that a few minutes ago. This is a really important question because it would help guide clinicians on whether or not they should be using group treatment in comparison to individual treatment.

We also don't know about this perceived advantage of social support or social contact. And, this is a primary reason that people do group treatment, is that they believe that there's some social benefit associated with the group treatment, but few studies have actually examined social support or social functioning as an outcome measure of group treatment, and the studies that have included this as an outcome measure have had mixed findings. Sometimes people find a benefit and people improve in group treatment in their social functioning, and other times there is no difference from no treatment. The studies that have found a benefit for social support, or social functioning, tend to be studies that focused specifically on interpersonal skills or social skills.

And, the last thing that we don't know much about is cost-effectiveness of group treatment. We typically assume that group treatment is more cost-effective than individual treatment, and that's a primary reason we often do group treatment for PTSD, but we actually don't know if that's the case, and it would be important for us to examine this question.

WHAT WE DON'T KNOW

- Does group treatment increase treatment retention (e.g., medication compliance)?
- Does group treatment result in increased treatment engagement?
- How do patients benefit from group treatment?

Some other things that we don't know is whether group treatment increases treatment retention. For example, patients might be more medication-compliant if they're in group treatment, but we don't know that. We also don't know if treatment engagement is increased as a function of group treatment. Sometimes patients tell me that they stay in treatment because they feel a sense of commitment to their other group members, and it might help them, then, stay in the treatment that they might have dropped out of otherwise, but this would be a question for us to address empirically.

And, the other thing that we need to really focus on is whenever studies have examined if people are satisfied with the group treatment they've received, uniformly we find that patients say they like the group treatment, they feel they've benefitted from it, but we're not quite sure how, exactly, they perceive they've benefitted from the group treatment. So, it'd be important to look more closely at how do people, that are patients, benefit from treatment, or perceive that they benefit from treatment, and then focus on those areas as an outcome measure in the clinical trials.

Objective 3: Review the 2010 VA/DoD Clinical Practice Guidelines for Group Treatment for PTSD

OBJECTIVE 3:

Review the 2010 VA/DoD Clinical Practice Guidelines for group treatment for PTSD

www.healthquality.va.gov

So, now onto the third objective of this talk, which is to review the 2010 VA/DoD Clinical Practice Guidelines for group treatment for PTSD, and you can find the clinical practice guidelines at the website www.healthquality.va.gov

VA/DoD PRACTICE GUIDELINE: SUMMARY OF THE EVIDENCE

- "Overall, group-based treatment for individuals with PTSD is associated with improvements in PTSD symptoms" (p. 139)
 - Limitations of the literature are noted
- "Reported pre-to post-treatment effect sizes range from small to large, but likely overestimate the true effect of the treatment" (p.139)
- "The amount of change exceeded that of wait-list controls for most studies" (p.139)

So, the VA/DoD Practice Guidelines for group treatment of PTSD first summarizes the evidence for the group treatment literature. And, they summarize the evidence by stating that group based treatment for individuals with PTSD is associated with improvements in PTSD symptoms, but they also note the limitations of the literature, which I had just described for you; primarily that most of these trials have only included one condition.

They also state that the pre- to post-treatment effect sizes range from small to large, but they likely overestimate the true effect because they don't take into account, or correct for, the group clustering effect in their statistical analyses. The practice guideline also summarizes the literature by stating that the amount of change exceeds that of a waitlist control for most studies.

VA/DoD PRACTICE GUIDELINE: SUMMARY OF THE EVIDENCE

- ▶ Psychodynamic treatment evidenced the weakest within-group effects
- ▶ Interpersonal therapy evidenced small to large effects
- ▶ Significant support exists for cognitive-behavioral approaches, for both Veterans and adults with abuse histories, with effect sizes for PTSD symptoms ranging from small to very large

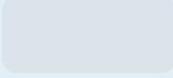
In terms of the specific content of treatment, the practice guideline indicates that psychodynamic treatments indicate, or show, the weakest within-group effect sizes; so that's the weakest difference from pre- to post-treatment.

Interpersonal therapy evidence is small to large effects. And, they state that significant support does exist for cognitive behavioral approaches for both Veterans and adults with abuse history, with the effect sizes ranging from small to very large

REVIEW EXERCISE

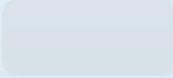
Match the type of treatment with the strength of effect.

Psychodynamic



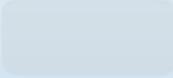
Small to very large effects

Interpersonal
therapy



Weakest within-group effects

Cognitive-
behavioral
therapy



Small to large effects

VA/DoD PRACTICE GUIDELINE: SUMMARY OF THE EVIDENCE

- Noted the lack of studies examining group treatment versus individual treatment for PTSD
- Also highlighted that equal benefit has been found for trauma-focused and present-centered supportive therapies

So, the VA/DoD Practice Guideline summarizes the evidence by noting the lack of studies examining group treatment versus individual treatment for PTSD, and how important that would be to address that area. They also highlight that equal benefits have been found for trauma-focused and present-centered supportive therapy. And, this is much like the result that I found in my meta analysis when we looked at active treatments versus the target treatment – that there are no differences.

VA/DoD PRACTICE GUIDELINE RECOMMENDATION FOR GROUP TREATMENT

- ▶ “Consider group treatment for PTSD” (p. 139)
 - Consider means that based on the available research there is no recommendation either for or against group treatment as a first line treatment
 - There is at least fair evidence that group treatment can improve outcome

So, in terms of the recommendation that the VA/DoD Practice Guideline gives for group treatment, they state that “Clinicians should consider group treatment for PTSD.” And, “consider” has a very specific meaning the practice guidelines. It means that based on the available research, there’s no recommendation either for or against group treatment. There’s at least fair evidence that group treatment can improve outcome, but the balance of the benefit and harms is too close to justify a general recommendation.

VA/DoD PRACTICE GUIDELINE RECOMMENDATION FOR GROUP TREATMENT

How should I decide whether my client would do better in group or individual?

- ▮ There is no trial comparing individual vs. group treatment, but overall, considering research outcomes and methodology of studies, best option is individual
- ▮ But practically, have to consider resources, goals, severity of symptoms, patient characteristics

So, given all this information that Dr. Shea and I have provided, I might still get asked a question from a clinician, “How should I decide whether or not a client would do better in a group or in an individual format?” Well, the research would tell us that the person would be more likely to do better in evidence-based trauma-focused individual treatment, such as Cognitive Processing Therapy or Prolonged Exposure treatment.

With that being said, it’s not always feasible or preferred. So you might have to make a decision based on the amount of resources that you have available, the kinds of treatment goals that you have for a patient – and the patient has for themselves – the severity of the symptoms for the patient, and the kind of patient characteristics that an individual patient has that might be important to consider for group treatment versus individual.

IMPLICATIONS OF FINDINGS FOR CLINICAL PRACTICE

- ▶ Clinicians should consider group treatment for their patients, taking into account what the CPG states about individual treatment, practical factors and patient preferences
- ▶ The average effect size for group treatment for PTSD is smaller than the average effect size observed in trials of individual treatment for PTSD
- ▶ The evidence indicates that group treatment is better than no treatment *for PTSD symptoms*
- ▶ Evidence also indicates that trauma-focused treatment and supportive group treatment produce similar levels of improvement in PTSD symptoms

So, now that we've reviewed all three of these objectives, I want to take a few minutes just to summarize what we know about group treatment, and where we've come, and where we need to go. So, group treatment is frequently used in practices in general including the VA settings. And, surprisingly, we don't know much about what types of group treatments work, what are effective, and who are the best types of clients for group treatment for PTSD.

But given that, it is definitely the case that group treatment has lagged behind the research literature for individual treatment for PTSD. But, there have been a large number of studies of randomized clinical trials of group treatment for PTSD that's been conducted just in the last five years. So, we're gaining a lot of information in this area, and there's still a lot to do, but we have acquired a lot of information in the past several years.

So, I think we have a lot to look forward to in terms of knowledge that we gain, and there are studies underway that are examining individual treatment compared directly to group treatment for PTSD, as well as cost-effectiveness of group treatment. So, we have much to look forward to in the upcoming years of helping us guide clinicians of when to give group treatment and how it compares to individual treatment.

I want to thank you for listening to this presentation, and I hope that it's been useful and valuable to you.