EFFECTIVE TREATMENTS FOR PTSD

Practice Guidelines from the International Society for Traumatic Stress Studies

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Group Therapy

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The purpose of this chapter is to present a critical review of group therapy approaches currently used in the treatment of chronic posttraumatic stress disorder (PTSD). A brief overview of the historical development of group treatment for PTSD is first presented, followed by a discussion of three commonly utilized group treatment approaches. Data on the empirical support for group treatment for PTSD are next detailed; indications and contraindications for the use of group interventions with specific survivors are described; and areas of necessary further investigation are then identified.

Given the contemporaneous recognition of PTSD as a psychiatric diagnosis and the growth of the self-help movement and group treatment modalities in the 1970s, it is perhaps not a coincidence that group therapy attracted great interest as a front-line treatment for PTSD during this epoch (see, e.g., Horowitz & Solomon, 1975). The appeal of group interventions for PTSD rests, to a large extent, on the clear relevance of joining with others in therapeutic work when coping with a disorder marked by isolation, alienation, and diminished feelings (Allen & Bloom, 1994). A group intervention seems even more suitable for populations such as Vietnam veterans or sexual assault survivors, who often feel ostracized from the larger society or even judged and blamed for their predicament. Furthermore, it is not at all surprising that among these individuals who felt alienated from the greater community, group interventions originally tended to adopt a "survivor helping survivor" or "band of sisters/brothers" model, in which the group facilitator(s) in fact shared the same traumatic exposure history as those seeking counseling

(Lifton, 1973; Shatan, 1973). These interventions emphasized communality and mutual commitment. The genesis of veterans' "rap groups" and the creation of the VA Readjustment Counseling Service, in which Vietnam veterans were hired to assist other veterans outside of the traditional hospital setting, epitomizes this type of approach.

While informal rap groups have a place historically in the evolution of group treatment methods for PTSD, there have been no controlled trials to establish an empirical basis for their efficacy in promoting recovery from traumatic events. However, mental health professionals from several theoretical orientations have refined and tested a number of more systematic group interventions for PTSD over the past 20 years. In contrast to rap groups, these interventions hold to clearly delineated lines between therapist and clients and are intended for group members who share a specific, well-diagnosed, acknowledged psychiatric disorder. Some have argued that they are especially appropriate in more chronic forms of PTSD (Walker & Nash, 1981).

From a broad theoretical perspective, these group approaches might be classified as "supportive," "psychodynamic," or "cognitive-behavioral." While they may differ in their underlying formulations of symptom etiology and maintenance, these approaches share some similar features: (1) homogeneous membership in the group by survivors of the same type of trauma (e.g., combat veterans or sexual assault survivors); (2) acknowledgment and validation of the traumatic exposure; (3) normalization of traumatic responses; (4) utilization of the presence of other individuals with a similar traumatic history to dispel the notion that the therapist cannot be helpful to the survivors because he or she has not shared the experience; and (5) adoption of a nonjudgmental stance toward behavior required for survival at the time of the trauma. Incorporating these principles facilitates the development of a psychologically safe, respectful therapeutic environment.

The theoretical contributions of Yalom's (1975) principles of group process to the conduct of each of the three types of group treatment have often been acknowledged (e.g., the importance of instilling hope). Nevertheless, it is imperative to note that none of these approaches is, strictly defined, "process-oriented"; that is, the critical therapeutic ingredient is not thought to be the corrective recapitulation of the primary family group, nor is it expression of intense affect between members about their relationship. In terms of how group treatments are designed specifically to address the traumatic experiences of their members, distinctions have been made between "covering" and "uncovering" methods. Supportive groups represent a "covering" approach in which the emphasis is placed on addressing current life issues, while psychodynamic and cognitive-behavioral approaches are designed to address members' specific traumatic experiences and memories directly (i.e., "uncover" the trauma). In fact, current group treatments from either psychodynamic or cognitive-behavioral perspectives are often described

as "trauma focus" groups, wherein members' recounting of their traumatic experiences is a primary feature. Trauma focus groups of either type are more likely to be conducted as "closed" or cohort groups, while supportive groups are amenable to an "open" format in which members can be added after the group begins. Some clinicians have posited that a combination of approaches, tailored to the individual's specific phase of the disorder and clinical status, may be most appropriate (see, e.g., Herman, 1992).

DESCRIPTION OF TECHNIQUES

Brief descriptions are provided for each of these three different kinds of group treatment types: supportive group therapy, psychodynamic group therapy, and cognitive-behavioral group therapy.

Supportive Group Therapy

While diverse in purpose and theoretical orientation, groups within the supportive modality bear a "family resemblance," tending to share certain characteristic and distinguishing features. Unlike uncovering therapies, supportive groups include little focus on the actual details of traumatic experiences, although they acknowledge and validate the impact of trauma. Interventions aim at exploring middle-range affects (e.g., frustration, sadness, happiness, hurt), diffusing more extreme affects related to hyperarousal (e.g., rage, terror). While supportive groups may incorporate structured material, the purpose of such information is generally to enhance the comfort level of the group in contrast to the use of content in cognitive-behavioral skills training and formal psychoeducational groups. Demand on clients is typically low to moderate, with little or no homework or testing for mastery of material. Supportive groups are designed to maintain a sense of interpersonal comfort and to keep transference at a low to moderate level.

As an alternative to exposure-based, uncovering, and skills-building treatments, supportive group therapy provides a context that orients members toward current coping. For individuals with PTSD, struggles with intrusions, avoidance and numbing, and hyperarousal may disrupt present-day living. Over time, this disruption from the traumatic past can interfere with attention and response to current circumstances, leading to deterioration in functioning. Relying on many of the intrinsic therapeutic factors of group psychotherapy (Yalom, 1975), supportive PTSD groups mobilize the strengths and competence of group members to reduce or control interference from symptoms and trauma-based attitudes as they affect social, emotional, occupational, recreational, and health-related functioning.

"Supportive" is an umbrella term covering a variety of modified-process group approaches that focus on current life issues and problems. Sup-

portive groups can be conducted in a range of clinical and paraclinical settings as a means of engendering in members a sense of community for otherwise isolating chronic conditions and circumstances. In PTSD programs, supportive groups may serve as the primary therapy modality, as introduction and preparation for further therapy, or as support for compliance with other concurrent treatment (e.g., individual or group trauma work, or formal skills building). In intensive outpatient, partial hospitalization, or inpatient programs for PTSD, this modality is often the "glue" that holds the overall treatment package together, providing the cohesion that increases patients' comfort with more demanding therapies.

Psychodynamic Group Therapy

The goal of psychodynamic group treatment for PTSD is to give each survivor new understanding about what it means to have been exposed to trauma and to have reacted the way he or she did, and to help the survivor confront the continuing issues presented by the experience. From a psychodynamic perspective, a clarification of the working model of self and other(s) involved in reactions to the traumatic event is a key therapeutic ingredient. These clarifications may be in the form of cognitive appraisal of internal dialogue about the meaning of the event, "lessons learned," or personal meaning attributed to an event, or an aspect of an event. This process involves the exploration of conscious and unconscious self-concepts related to weak and strong self-representations evoked by the trauma, as these self-concepts are related to current conflicted views of the self and connected to the self-representations from early development. As well, clarification of frequently implicit assumptions (e.g., someone has to be blameworthy) about the meaning of the trauma for the individual can be as important as the actual process of being in a group treatment where discussion of what happened occurs in a safe context.

Effective treatment involves integration of an accurate recounting of traumatic events, to the degree possible, including pre- and posttrauma issues that are an important components of the story. The latter may include responses by family or significant others, or other issues, in the social milieu in which the event occurred. Appropriate affective involvement, monitored to control patients' feelings of being overwhelmed and offset the risk for precipitating dissociative reactions, is a fundamental requirement of the approach. This affective involvement usually proceeds from initial anxiety prior to recounting the incident, anxiety and/or tears of pain during the telling, to a kind of "calm after the storm," during which some consolidation occurs. In the psychodynamic approach, the painful affects are traced back to views, frequently irrational, of self and other. These irrational views include the need for omnipotent control, the assumption that betrayal is inevitable, the belief that trauma happens only for a good or understandable

reason, and that avoidance of strong feelings is a necessary or positive protective strategy.

Cognitive-Behavioral Group Therapy

The primary objective of cognitive-behavioral group therapy is to reduce PTSD symptoms directly or to enhance members' control of their chronic symptoms. Improving self-control and quality of life in those whose lives have been controlled by their symptoms is seen as equally important to immediate symptom reduction. Emphasizing these objectives takes into account the frequent intractable nature of chronic PTSD insofar as lifelong risk for symptom exacerbation is concerned. However, the approach challenges members to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation.

Cognitive-behavioral focus group therapy emphasizes application of systematic, prolonged exposure and cognitive restructuring to each individual's traumatic experience, and relapse prevention training to enhance members' coping skills and resources for maintaining control over specific PTSD and related symptoms (Foy, Ruzek, Glynn, Riney, & Gusman, 1997). The cognitive-behavioral model of trauma focus group therapy may be set in a developmental perspective, taking into account important relationships and experiences occurring across the entire life span (over pretrauma, trauma, and posttrauma time frames) for group members who may now be in middle adulthood (Gusman et al., 1996). Thus, cognitive-behavioral models may feature an autobiographical emphasis that combines both individual narrative construction and the group concept of others bearing witness nonjudgmentally as members publicly recount their significant life experiences. In addition, by encouraging group members repeatedly to experience their personal tragic events, as well as being exposed vicariously to the experiences of other group members, the model incorporates trauma processing. Relapse prevention planning is a final core component of cognitive-behavioral trauma focus groups. Emphasis on mobilizing coping resources to be used in predictable, high-risk situations is intended to help maintain treatment gains between sessions and after group therapy is completed.

Differences between Psychodynamic and Cognitive-Behavioral Approaches

While the two uncovering approaches share a common emphasis on direct trauma processing, there are notable differences between them regarding treatment goals, methods, and assumed mechanisms. Psychodynamic group treatments are oriented toward increasing understanding (insight) of survivors' traumatic experiences and reactions, and giving meaning to current life. In contrast, cognitive-behavioral treatments are primarily intended to

decrease or improve control over trauma-related symptoms. Carefully recounting the traumatic event with controlled affective arousal is typical of the psychodynamic treatment method, while cognitive-behavioral methods utilize prolonged, repeated exposure to the traumatic experience. Restructuring self–other representations is likely to be described as the assumed treatment mechanism in psychodynamic treatment, in contrast with the principles of habituation and extinction that are invoked by cognitive-behavioral theorists.

METHOD OF COLLECTING DATA

The primary method used to identify empirical studies of group treatment for PTSD was a literature search using the PILOTS database at the National Center for PTSD in White River Junction, Vermont. Additionally, members of the group treatment subcommittee and others were asked to submit other studies that, to their knowledge, were not initially identified. Standards to evaluate study methodologies were derived from Kazdin and Bass (1989) and Foa and Meadows (1997).

SUMMARY OF LITERATURE

In this section, clinical trials of group psychotherapy for adult trauma survivors are briefly reviewed. The review excludes case studies and reports on the efficacy of multicomponent inpatient programs in which combinations of various types of group therapy are delivered. Table 8.1 lists the reviewed studies, along with information about selected methodological features and major findings. Treatment typically was delivered in 10–15 weekly sessions (range = 6 weeks to 1 year), and session length was usually set at 1½ or 2 hours. Tables 8.2 and 8.3 display effect sizes for those studies whose data permitted these calculations. Almost all of the studies were conducted with female survivors of childhood or adulthood sexual abuse; very few studies were found to be conducted with male participants.

Supportive Group Therapy

Table 8.1 shows three studies (Cryer & Beutler, 1980; Richter, Snider, & Gorey, 1997; Tutty, Bidgood, & Rothery, 1993) designed to evaluate supportive group therapy, sampling adult female survivors of childhood sexual abuse (2 studies) or survivors of domestic violence (1 study). With treatment duration ranging from 10 to 15 sessions, these studies examined treatment outcome through measures of self-esteem, depression, and anxiety. None of these studies measured PTSD symptoms directly. Favorable results were reported in each study, and Tables 8.2 and 8.3 show that the effect sizes

TABLE 8.1. Studies of Group Psychotherapy for Trauma Survivors: Cognitive-Behavioral, Psychodynamic, and Supportive Types

Study (type)	Treatment group (% of enrolled)	Comparison group (% of enrolled)	No. of sessions/ group sizes	Population	Major findings
Randomized designs					
Alexander, Neimeyer, Follette, Moore, & Harter (1989) (psychodynamic)	16 interpersonal transaction 20 process group (84% across treatment groups)	21 wait-list control (% NA)	10 weekly/ NA	Female CSA survivors	Not controlling for pretest scores, both treatment groups improved more than controls in depression and distress; only the process group improved in social adjustment; gains were generally maintained at 6-month follow-up.
Zlotnik et al. (1997) (cognitive-behavioral)	17 affect management (71%)	16 wait-list control (67%)	15 weekly/ 6–8	Female CSA survivors w/PTSD who had received individual psycho- and/or pharmacotherapy	Controlling for pretest scores, affect management improved more than controls in PTSD and dissociation.
Nonrandomized designs					
Hall, Mullee, & Thompson (1995) (psychodynamic)	53 analytic (open enrollment) (56%)	18 no-treatment control (53%)	6 months weekly (varied)/ ≤ 12	Female CSA survivors	Not controlling for pretest scores, posttest service utilization decreased in the treatment group but not in the comparison group. Within the treatment group, depression decreased over time.

(continued)

TABLE 8.1. *(continued)*

Study (type)	Treatment group (% of enrolled)	Comparison group (% of enrolled)	No. of sessions/ group sizes	Population	Major findings
Nonrandomized designs *(cont.)*					
Resick & Schnicke (1992) (cognitive-behavioral)	19 cognitive processing therapy (90%)	20 wait-list control	12 weekly/ 5–8	Female sexual assault survivors	Not controlling for pretest scores, cognitive processing treatment improved more than controls in PTSD and depression scores. Within the treatment group only: relative to pretest scores, posttest scores improved in PTSD, depression, distress, and social adjustment; changes were maintained at 3- and 6-month follow-up, and depression continued to improve from posttreatment to 3 months.
Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak (1988) (cognitive-behavioral)	12 stress inoculation 13 assertiveness training 12 supportive psychotherapy (86% across treatment groups)	13 wait-list control, all of whom were included in treatment groups	6 weekly/ 4–8	Female sexual assault survivors	No improvement from pretest to posttest in wait-list group; not controlling for pretest scores, all groups improved similarly from pre- to posttest on anxiety, depression, self-esteem, fear, and PTSD; improvements were generally maintained at 3- and 6-month follow-up.
Richter, Snider, & Gorey (1997) (supportive)	78 problem-solving group, some of whom are counted in comparison group; total $n = 115$ (87%)	80 wait-list control, some of whom are counted in treatment group	15 weekly/ 4–10	Female CSA survivors	Not controlling for pretest scores (but which were equivalent), active treatment improved more than controls in depression and self-esteem scores.

Roth, Dye, & Lebowitz (1988) (psychodynamic)	7 active treatment (78%)	6 no-treatment control (46%)	1 year weekly/ 7	Female sexual assault survivors	Not controlling for pretest scores, active treatment improved less than controls in intrusion scores by Session 8; no differences in five other measures. Within the treatment group only: relative to pretest scores, Session 20 scores improved in rape-related fears, psychosocial functioning, and intrusion; gains generally maintained at end of treatment.
Single-group designs					
Carver, Stalker, Stewart, & Abraham (1989) (psychodynamic)	29 process group (51%)		10 and 15 weekly/ NA	Female CSA survivors	Relative to initial assessment, pretest scores showed no change ($n = 20$; all 20 did not necessarily complete pre–post assessment). Relative to pretest scores, posttest scores showed improvement in all SCL-90 scores except paranoid ideation but not in (a non-SCL measure of) depression and social behavior.
Cryer & Beutler (1980) (supportive)	9 unspecified treatment (NA)		10 weekly/ 9	Female sexual assault survivors	Relative to pretest scores, posttest scores improved in distress, obsessiveness, anxiety, and expression of control.
Frueh, Turner, Beidel, Mirabella, & Jones (1996) (cognitive-behavioral)	11 social and emotional rehabilitation (group component of trauma management therapy) (73%)		10 weekly and biweekly/ 2–5	Male Vietnam combat veterans	Relative to midtreatment scores (when treatment switched from individual to group), posttest scores improved in clinical global impressions, anxiety, and social activities.

(*continued*)

TABLE 8.1. *(continued)*

Study (type)	Treatment group (% of enrolled)	Comparison group (% of enrolled)	No. of sessions/ group sizes	Population	Major findings
Single-group designs *(cont.)*					
Hazzard, Rogers, & Angert (1993) (psychodynamic)	78 process group (53%)		1 year weekly/ 4–10	Female CSA survivors	Relative to pretest scores, posttest scores improved in locus of control, sexual problems, self-esteem, PTSD symptoms, and distress.
Lubin, Loris, Burt, & Johnson (1998) (cognitive-behavioral)	29 cognitive-behavioral (76%)		16 weekly/ 6–7	Female multiple trauma survivors	Relative to pretest scores, posttest scores improved in intrusion, avoidance, hyperarousal, and depression.
Stauffer & Deblinger (1996) (cognitive-behavioral)	19 cognitive-behavioral (56%)		11 weekly/ NA	Nonoffending females and their sexually abused, 2- to 6-year-old children	Relative to pretest scores, Week 10 scores improved in adult distress, PTSD symptoms, parenting behavior, and child sexual behavior; gains maintained at 3-month follow-up.
Tutty, Bidgood, & Rothery (1993) (supportive)	60 support group (67%) 32 (53%) 6-month follow-up		10–12 weekly/ NA	Female survivors of domestic violence	Relative to pretest scores, posttest scores improved in locus of control, self-esteem, stress and coping, marital relations, and physical and nonphysical violence; improvements maintained at follow-up, although sample was biased toward highest functioning women.

Note. NA, not available; CSA, childhood sexual abuse.

TABLE 8.2. Hedges's Unbiased Effect Size Estimator (*g*) for Comparisons with Control Groups

Authors (year)	Target population	No. and length of treatment sessions	Dependent measure	Control and treatment groups	Sample and effect sizes for completers	
					n	*g*
Alexander, Neimeyer, Follette, Moore, & Harter (1989)	Female CSA survivors	10 wk 1½-hr sessions	Modified Fear Survey (MFS)	Wait-list control	21	—
				Interpersonal transaction	16	0.04
				Process format	20	−0.23
Zlotnick et al. (1997)	Female CSA survivors receiving individual therapy concurrently	15 wk 2-hr sessions	Davidson Trauma Scale	Wait-list control	17	—
				Affect management	16	0.83
Resick & Schnicke (1992)	Female sexual assault survivors	12 wk 1½-hr sessions	PTSD subscale of the SCL-90-R	Wait-list control	20	—
				Cognitive processing	19	0.62
Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak (1988)	Female sexual assault survivors	6 sessions 2 hr ea.	IES (intrusions)	Wait-list control	13	—
				Assertiveness	13	0.33
				Supportive	12	0.19
				Stress inoculation	12	0.07
			IES (avoidance)	Wait-list control	13	—
				Stress inoculation	12	0.60
				Assertiveness	13	0.57
				Supportive	12	0.50
Richter, Snider, & Gorey (1997)	Female CSA survivors receiving individual therapy concurrently	15 wk 1½–2-hr sessions	BDI	Wait-list control	80	—
				Supportive	78	0.60
Roth, Dye, & Lebowitz (1988)	Female sexual assault survivors receiving individual therapy concurrently	1 yr 2½-hr sessions	IES (intrusions)	Wait-list control	6	—
				Psychodynamic	7	−1.56
Hall, Mullee, & Thompson (1995)[a]	Female CSA survivors	1–45 sessions		Control	34	—
				Psychoanalytic	94	—

Note. SCL-90-R, Symptom Checklist 90–Revised; IES, Impact of Event Scale; BDI, Beck Depression Inventory.
[a]Effect size cannot be calculated with data provided.

TABLE 8.3. Hedges's Unbiased Effect Size Estimator (*g*) for Pretreatment versus Posttreatment Comparisons

Authors (year)	Target population	No. and length of treatment sessions	Dependent measure	Treatment groups	Sample and effect sizes for completers	
					n	*g*
Carver, Stalker, Stewart, & Abraham (1989)[a]	Female CSA survivors	10–15 wk	Zung Depression Scale	Psychodynamic	20	—
Cryer & Beutler (1980)	Female sexual assault survivors	10 wk 1 ½-hr sessions	GSI of the SCL-90	Supportive	9	0.66
Frueh, Turner, Beidel, Mirabella, & Jones (1996)	Male Vietnam combat veterans	12 wk 14 1 ½-hr sessions	CAPS -1	Trauma management (social and emotional rehabilitation)	11	1.09
Hazzard, Rogers, & Angert (1993)	Female CSA survivors	1 yr 1 ½-hr weekly sessions	Trauma Symptom Checklist (TSC-33)	Process format	34	0.44
Lubin, Loris, Burt, & Johnson (1998)	Female multiple trauma survivors	16 wk 1 ½-hr sessions	CAPS	Cognitive-behavioral	29	0.81
Stauffer & Deblinger (1996)	Nonoffending mothers and their sexually abused children ages 2–6 yr	11 wk 2-hr sessions	IES (intrusions) IES (avoidance)	Cognitive-behavioral	19 19	0.24 0.56
Tutty, Bidgood, & Rothery (1993)	Female survivors of domestic violence	10–12 wk 2- to 3-hr sessions	Perceived Stress Scale	Supportive	60	0.54

Note. CAPS, Clinician-Administered PTSD Scale; CAPS-1, Clinician-Administered PTSD Scale; GSI, Global Severity Index of Symptom Checklist.
[a]Effect size cannot be calculated with data provided.

obtained on primary measures in these three studies were highly similar (0.54, 0.60, and 0.66) even though the actual outcome variables were different in each study. An advantage of the studies on supportive therapy is that two of them included relatively large sample sizes (n = 60–115).

Psychodynamic Group Therapy

Table 8.1 includes five studies examining psychodynamic group therapy (Alexander, Neimeyer, Follette, Moore, & Harter, 1989; Carver, Stalker, Stewart, & Abraham, 1989; Hall, Mullee, & Thompson, 1995; Hazzard, Rogers, & Angert, 1993; Roth, Dye, & Lebowitz, 1988), four of which included larger group sizes (n = 29–78). For all five studies, female adult survivors of childhood sexual abuse were sampled. In this set were three studies using control group designs. As was the case with supportive group therapy, each of the studies of psychodynamic group therapy reported positive treatment outcome associated with that treatment condition. Treatment duration was bimodal in distribution, with two studies in the 10- to 15-session range, while two other studies extended treatment for 1 year. PTSD symptoms were directly assessed in two studies; depression and anxiety were measured in the other three studies.

Tables 8.2 and 8.3 show that effect size calculations were possible for three of the studies (–0.23, –1.56, and 0.44). The negative effect size values for the Alexander and colleagues (1989) and Roth and colleagues (1988) studies do not indicate that the psychodynamic treatment groups worsened with treatment. In both of these studies, there was notable discrepancy between the initial status of treatment and wait-list groups, with the wait-list group being less symptomatic in both cases. In the Alexander and colleagues (1989) study, scores on the fear survey for both wait-list and treatment groups decreased in equivalent amounts. In the Roth and associates (1988) study, both the wait-list and treatment groups remained the same over the interval of 8 weeks, the last time point at which the wait-list group was assessed.

Cognitive-Behavioral Group Therapy

There are six studies examining cognitive-behavioral treatment listed in Table 8.1 (Frueh, Turner, Beidel, Mirabella, & Jones, 1996; Lubin, Loris, Burt, & Johnson, 1998; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Resick & Schnicke, 1992; Stauffer & Deblinger, 1996; Zlotnik et al., 1997). There is some variability in the trauma populations sampled in these studies. Three studies sampled adult female survivors of childhood sexual abuse. Combat veterans, female survivors of multiple trauma, and mothers with their sexually abused children were sampled in the other three studies. While the group sample sizes in these studies are relatively small (n = 11–37), the results pattern is the same as for the other two types of treatment; that is,

every study showed positive treatment outcome for the cognitive behavioral group(s) relative to wait-list controls (three studies) or comparing pre- to post-treatment scores. In this set of studies, treatment duration was relatively short in every case, ranging from 6 to 16 sessions. In every study, direct measures of PTSD were employed, and four studies used equivalent instruments, making direct comparison of results possible. Tables 8.2 and 8.3 show effect sizes ranging from 0.33 to 1.09, with a mean of 0.68 obtained for the set of six studies. Two studies (Resick et al., 1988; Stauffer & Deblinger, 1996) that reported separate measures for intrusion and avoidance symptoms produced similar findings, showing relatively larger treatment effects for avoidance symptoms.

Comparisons across Treatment Types

To date, only one study (Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988) has made a direct comparison between types of group treatment. Resick and her colleagues compared stress inoculation, assertion training, and supportive group therapy to each other as well as to a wait-list condition (all of whose members subsequently were included in one of the three treatment groups). Similar improvements were obtained across therapy conditions, although there was some variability in treatment effect sizes shown on intrusion measures.

Even though effect sizes were calculated on 12 of the 14 studies on group treatment, differences in study design and, most notably, nonequivalence of primary outcome measures constrain direct comparisons of results and conclusions of relative efficacy. In terms of design and methodology, supportive and cognitive-behavioral group treatments were found to be shorter in duration (6–15 weeks in every study) compared to psychodynamic treatments (up to 1 year in three studies). For supportive and psychodynamic treatments, outcome was more likely to be measured as broader aspects of distress or adjustment, while all six cognitive-behavioral treatment studies used direct measures of PTSD severity. Sample sizes for studies of supportive and psychodynamic therapies were typically larger than those in studies of cognitive behavioral therapy. In general, the data show that group psychotherapy, regardless of the nature of the therapy, is associated with favorable outcomes in a range of symptom domains. PTSD and depression are the most commonly included outcomes, but efficacy has been demonstrated for a range of other symptoms as well, including anxiety, self-esteem, and fear.

Methodological Limitations

Despite this generally favorable body of findings, however, significant methodological issues constrain inferences that can be drawn about the efficacy of group treatment generally, or about superiority of one type of group treat-

ment over the others. The strongest inferences may be drawn from the randomized studies that have been conducted. Both Alexander and colleagues (1989) and Zlotnik and colleagues (1997) found that treatment, relative to a wait-list condition, was associated with favorable changes in female survivors of sexual abuse. Using a study design that includes a wait-list comparison group is highly appropriate for evaluating the efficacy of treatment that has not been studied, because inclusion of this group controls for history, maturation, testing, instrumentation, regression to the mean, selection, attrition, and interactions of participant characteristics with these threats to internal validity. However, it is notable that only some of the threats are controlled if random assignment is not used. Because a wait-list comparison group differs in so many ways from a treated group, such designs limit our ability to know whether, or to what extent, observed effects are due to the particular treatments delivered, as opposed to the fact that any treatment was delivered—a problem of construct validity. Although Alexander and associates (1989) found some evidence of treatment specificity (process group treatment, but not interpersonal transaction group treatment, was associated with gain in social adjustment), the problem of interpreting treatment effects generally remains.

Most studies that have not used random assignment also have found that treatment is associated with improvements in symptoms and functioning (Hall, Mullee, & Thompson, 1995; Resick & Schnicke, 1992; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Richter, Snider, & Gorey, 1997; Roth, Dye, & Lebowitz, 1988). Non-randomized designs yield data that are somewhat ambiguous because of the threats to internal validity inherent in the comparison of nonequivalent groups (e.g., maturation, selection). An important method of addressing (but not eliminating) these threats—statistical control for pretreatment differences—was not used in any of the studies in this category. Adding to the interpretation difficulties is the fact that most of these studies had only wait-list/no-treatment comparison groups.

Among studies that did not employ a comparison group (Carver, Stalker, Stewart, & Abraham, 1989; Cryer & Beutler, 1980; Frueh, Turner, Beidel, Mirabella, & Jones, 1996; Hazzard, Rogers, & Angert, 1993; Stauffer & Deblinger, 1996; Tutty, Bidgood, & Rothery, 1993), all found pre- to posttreatment improvements in outcomes. By themselves, these studies have limited interpretability because almost all threats to internal validity cannot be controlled. The study by Carver and colleagues (1989) provides some stronger evidence that the improvements are specific to therapy and not to other factors, especially maturation or regression to the mean. Carver and colleagues made *two* pretest assessments, 7 weeks apart, and found no change in symptoms, while symptom changes were observed posttreatment. The extended baseline observation does not completely rule out threats to validity, but it does substantially strengthen the conclusion that the changes were due to treatment; this is similar to Resick and colleagues' (1988) wait-list condition.

In a conservative interpretation of these findings, the data suggest that

group therapy is associated with positive outcomes. A remaining concern is with construct validity—why, or how, group therapy works. Are the observed outcomes merely due to placebo effects? Further studies are needed to determine the mechanisms by which positive outcomes are achieved.

Conducting research on the effectiveness of group psychotherapy is challenging, and our comments about the existing research are not meant to be harsh criticisms of the authors, who, in fact, have done an excellent job in advancing research to its present state. Only because of their work can we recommend that additional research be done, because their demonstrations of efficacy provide a basis for going forward. Although a detailed methodological critique is beyond the scope of this chapter, we later call attention to key issues that are particularly important for future research in this area.

SUMMARY

In the past 20 years since the inception of PTSD as a diagnostic entity, relatively little research attention has been given to evaluating group therapy techniques designed for treating the disorder. Despite an exhaustive search, less than 20 studies of group psychotherapy outcome were identified. Only two of these studies employed randomization in their design methodology. Additionally, other methodological limitations were identified that limit the scientific conclusions that can be drawn from the results of these studies. Most studies sampled populations displaying chronic PTSD symptoms. Nevertheless, positive treatment outcomes were reported in most studies, lending general support to the use of group therapy with trauma survivors. While three distinct types or combinations of group therapies are represented in the literature, treatment outcome findings do not presently favor a particular type. Since research on group therapy for PTSD is in its infancy stage, much more research activity is warranted before techniques producing superior outcomes are clearly identified.

RECOMMENDATIONS

Individuals recovering from PTSD can experience great emotional volatility. Thus, the development of a comprehensive, effective treatment plan, well-suited to the individual, is of paramount importance. Generally, group treatment for PTSD is recommended as potentially effective, based upon consistent evidence from the studies reviewed in this chapter. The levels of evidence for this recommendation range from two studies using randomized control designs (AHCPR Level A), and five studies using nonrandomized control designs (AHCPR Level B), to seven studies using single-group designs in which pre–post differences were examined (AHCPR Level C).

In evaluating an individual's characteristics for appropriateness for participation in a group intervention, two pivotal issues must be addressed: (1) Is a group approach suitable for this individual? and (2) If a group approach is suitable in this case, which type of group would be most appropriate?

Tables 8.4 and 8.5 present factors identified in the literature as important considerations in matching trauma survivors to group treatment. Since these selection factors are primarily rationally derived, they do not constitute hard-and-fast criteria so much as they represent useful guidelines for informing the matching process. Relative to individual forms of therapy for PTSD, group therapies tend to be more structured and place more rigid requirements upon the individual for participation. There is less flexibility for accommodating individual needs that may arise over the course of therapy in the group format. For some individuals, extreme social interaction anxiety may block beneficial participation in group therapy activities.

Comparing selection factors for trauma focus groups to supportive groups, it is evident that there are more stringent requirements for assignment to the "uncovering" modality. Generally, individuals need to be psychologically stable and willing to undergo reexperiencing their traumas. Supportive group therapy may be a better match for less stable individuals or for those who do not accept the rationale for personal trauma processing. Assignment considerations for the two types of trauma focus group therapy appear to be very similar. Clear factors for differentiating between assignment to psychodynamic or cognitive-behavioral group therapies have not been identified.

TABLE 8.4. Indications and Contraindications for Group Therapy

Indications for group therapy

1. Flexible in personal schedule in order to meet group at appointed times
2. Able to establish interpersonal trust with other group members and leaders
3. Prior group experience, including 12-step groups
4. Completion of a preparatory course of individual therapy
5. Not actively suicidal or homicidal
6. Shares similar traumatic experiences with other group members
7. Compatible for gender, ethnicity, and sexual orientation with other members
8. Willing to abide by rules of group confidentiality
9. Not severely paranoid or sociopathic
10. Has stable living arrangements

Contraindications for group therapy

1. Active psychosis
2. Severe organicity or limited cognitive capacity
3. Pending litigation or compensation seeking

TABLE 8.5. Indications for Trauma Focus versus Supportive Groups

1. Individual can tolerate high anxiety arousal or other strong affects
2. No active suicidality or homicidality
3. Substance abuse or other comorbidities are under control
4. Individual accepts rationale for trauma uncovering work
5. Willingness to self-disclose personal traumatic experiences
6. No current life crises

AREAS REQUIRING FURTHER EXPLORATION

In evaluating the utility of a psychotherapy format such as a group intervention, three questions are critical: (1) Does participation in the format yield symptom improvements? (2) Does participation in specific applications of the format (e.g., the psychodynamic group or the supportive group) yield differential improvements? and (3) How might validated applications be best generalized from the research laboratory to clinic practice? Additional systematic research on group treatment for PTSD would be useful on all three topics.

With regard to the first question—Does group therapy improve outcomes in PTSD?—the answer seems affirmative. As reflected in the studies reported in Table 8.1, group therapy utilizing diverse approaches appears to yield benefits, especially among female sexual abuse survivors. Unfortunately, randomized trials on any type of group therapy for PTSD with males are sorely lacking. Given the current prevalence of group approaches in many VA settings with combat veterans, this paucity of research is especially disturbing and merits attention.

With an acceptance of the hypothesis that group therapy yields improvements in PTSD outcomes, the issue of whether particular client characteristics are predictive of outcome becomes of interest. For example, individuals with multiple traumatic events and/or Axis II diagnoses might be expected to achieve more limited benefits from most therapeutic interventions, including group treatment. The identification of common predictive variables would greatly enhance treatment planning and inform our knowledge base.

The answer to the second question—Does participation in specific applications of group therapy yield differential improvement?—is less clear. Published empirical studies comparing different types of group therapy have been limited to that of Resick and colleagues (1988); this study found no special benefit in any of the group treatment approaches. Comparative outcomes studies are notoriously difficult to conduct (Kazdin, 1986), as they are complicated by significant methodological issues.

In terms of implications of the methodological critique of present work, we wish to call attention to five issues that are particularly important for fu-

ture comparative outcome research (see Foa & Meadows, 1997; Kazdin & Bass, 1989). The first issue is the use of random assignment, which is essential at this point to expand on existing knowledge. While it is most often applied to assignment of subjects to groups, randomization could also be expanded to include assignment of groups to treatment conditions. The advantage here is that smaller treatment facilities could participate in controlled trials when, otherwise, there would be an insufficient supply of study participants for randomizing individuals to competing treatment groups. Second is the use of comparison groups that permit inferences about why a given treatment works. Third is statistical power, which was inadequate for finding all but very large effect sizes in most published studies presented in Table 8.1. Adequate power is especially important for studies that compare one active treatment with another, where effect sizes are almost certain to be smaller than those for comparisons with a wait-list condition (Kazdin & Bass, 1989). A fourth issue concerns manualization and related therapist competence and adherence monitoring; these are important for standardizing treatment delivery and ensuring that therapist competence is equated across treatment conditions (only the following mentioned the use of manuals: Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Resick & Schnicke, 1992; Stauffer & Deblinger, 1996; Zlotnik et al., 1997). The fifth, and final, issue is statistical analysis, which needs to account for the clustering of participants within therapy groups (only Alexander, Neimeyer, Follette, Moore, & Harter, 1989, considered this issue).

The final question—How might validated applications be best generalized from the research laboratory to clinic practice?—incorporates two issues. First, most of the randomized trials presented in Table 8.1 are efficacy trials, with relatively strict control on participant inclusion–exclusion criteria and treatment implementation. Effectiveness trials, in which these interventions are evaluated in nonresearch settings, are clearly needed. Here again, research in settings that emphasize treatment in PTSD, such as the VA, would be especially critical. A second issue involves how specific group treatments might best be integrated in the range of clinical services often offered to individuals with severe (and usually chronic) PTSD. Many trauma survivors experience such severe behavioral dysfunction that they concurrently utilize multiple integrated treatment interventions, such as those described by Frueh, Turner, Beidel, Mirabella, and Jones (1996) and Johnson and colleagues (1996). A variety of group and individual therapies typically play a role in these comprehensive interventions. Data on whether comprehensive programs are beneficial are either preliminary (Frueh et al., 1996) or disappointing (Fontana & Rosenheck, 1997). Dismantling studies to identify effective treatment elements, including specific types of group therapy, will be required if positive reports are forthcoming. Here, the need to integrate individual and group treatment toward mutual treatment objectives (Brende, 1981) requires careful consideration. Similarly, the imperative to match inter-

ventions with the participant's ability to tolerate the distress inherent in trauma focus groups (Herman, 1992) is an important issue that requires empirical validation.

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