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A Systematic Review of the Efficacy and Clinical Effectiveness of Group Analysis and Analytic/Dynamic Group Psychotherapy

Executive summary

Aims of the review

The main aim of the review was to assess the evidence and the studies available as to efficacy and effectiveness of Group Analysis (GA) and Analytic/Dynamic (A/D) Group Psychotherapy. Factors that influence the outcome of group therapy were also assessed. The review also presents information on the numbers and types of clients using GA and A/D groups, including the size of groups, and the duration of therapy.

Methods

Initial scoping searches were undertaken on the PsycINFO database using key terms approved by a specialist advisory group ('Expert Panel') appointed by the Institute of Group Analysis, London (IGA) and the Group Analytic Society (GAS). The key terms included 'group analysis, 'group dynamic psychotherapy' and 'psychoanalytic groups. The review team conducted a sensitive search of seven electronic databases including Medline, EMBASE, CINAHL, the Cochrane Database of Systematic Reviews (CDSR), the Central Register of Controlled Trials, Health Technology Assessments (HTA) Database and the Database of Abstracts of Reviews of Effects (DARE). Studies were selected if published in English between 2001 and 2008 or if they were systematic reviews; and if an evaluation of GA or A/D group psychotherapy was described that included an additional control or comparison group. Randomised controlled trials (RCTs), cohort studies, 'before and after' studies, qualitative studies and systematic reviews were included; studies with other designs were not. Findings from studies before 2001 were captured by synthesizing evidence from systematic reviews of primary research which included them. Reference lists from included studies were followed up and contact was made with key authors in the field. As the studies identified were heterogenous, findings from both primary and secondary studies were considered together in the narrative syntheses.

Findings

Number of studies

We found 37 primary studies and 23 reviews which met the inclusion criteria.

Of the 37 primary studies, data were not extracted from three papers because they reported on the moderating, secondary variables of group climate and self-efficacy but not outcomes. Of the 34 remaining primary studies, 5 (15%) were randomised controlled trials (RCT), a further 2 (6%) were randomised controlled trials where group therapy was only one element in a complex treatment (RCT-partial), 5 (15%) employed case controls mainly using a 'matched' or 'wait-list' comparison group (CaCo), 21 (62%) were observational studies (Obs), and 1 (3%) was qualitative (Qual).

Of the 23 reviews, two were excluded because they only covered papers already included in our systematic review, one was excluded because it included just one group-based intervention, and one was excluded because it was not a review *per se* but was, instead, a specialist re-analysis of a previous meta-analysis. Nineteen relevant reviews which included studies published before 2001 were identified and summarised in a 'review of reviews'.

Efficacy and Clinical effectiveness

Randomised controlled trials

Five randomised controlled trials gave the following results:

- Piper *et al.,* 2001 found patients with complicated grief improved in both psychodynamic and supportive group treatment; there was no significant difference between therapy types
- Blay *et al.,* 2002 found brief psychodynamic group treatment gave clinically and statistically significantly greater benefit than usual clinical care for a mixed diagnosis group at the end of 8 weeks treatment, but at follow up (9-30 weeks post randomisation) there was no significant difference
- Lanza *et al.,* 2002 compared psychodynamic group therapy with group cognitive behaviour therapy for reducing aggression and violence in male veterans with a history of assault. With a small sample size (n=10) the degree of improvement was not statistically significant for either therapy and there was no significant difference in outcome between the psychodynamic group and the CBT control, although the rate of improvement was better in the psychodynamic group
- Tasca *et al.,* 2006 found binge-eating patients gained similar benefit from psychodynamic interpersonal therapy and group cognitive behaviour therapy, both being superior to no-treatment controls at the end of therapy: follow up data on the no-treatment control group were not available
- Lau *et al.,* 2007 compared modified group analysis with systemic group therapy and found the latter somewhat more effective, although both groups showed a treatment response

These results provide evidence for the efficacy and clinical effectiveness of group therapy approaches in a range of clinical problems, but not for specific benefits of any particular theoretical approach.

Other controlled studies

The other controlled studies gave support for the use of group psychotherapy in a variety of conditions.

Analysis of the 'outcome predictors, mediators and moderators' identified in studies suggests that there may be important effects of age, sex, self-efficacy, duration of therapy and psychological

mindedness on outcomes and that attachment style and interpersonal distress influence group attendance. These effects have been reported for specific client groups and may not generalise to others; they may also be mediated by group climate and individual factors. The quality of object relations- the lifelong pattern of interpersonal relationships - seems to be an important moderator of the impact of treatment type on outcome. Those with high quality of object relations had better outcomes from interpretive group therapy than from supportive group therapy whereas those with poorer quality of object relations were helped more by supportive group therapy. Predictors of outcome for long term analytic group therapy are likely to be different from those for short-term groups.

Observational studies

The observational studies also showed consistently promising results across a variety of settings, conditions and measures.

Benefits identified by these studies tend to derive from treatments of longer duration than is typically the case in RCTs, which tend to use shorter, manualised treatments. Furthermore, observational studies may employ different measures of change or assess qualitative changes and these may not be identified in more formal designs. However the finding of of observational studies are based on pre-post outcomes and may overstate improvements as there are no controls or randomisation. There is no way of securely attributing the changes found to the effects of the group intervention rather than to confounding factors such as 'spontaneous' improvement, selection bias, reporting bias etc.

Review of reviews

A review of reviews was undertaken which confirmed that group therapies in general are more effective than wait list or standard care controls. Where a specific comparison was made between group therapy and individual therapy, there was typically no advantage to group therapy, although there are exceptions to this finding. Most of these comparisons were made through meta-analysis rather than through 'head-to-head' trials with adequate statistical power and cost-effectiveness analysis. In general, the type of group therapy does not predict outcome.

Conclusions

The studies examined, including earlier reviews, consistently support the use of Group Psychotherapy as an effective approach, across diverse conditions, participant groups and settings. In addition, there may be important effects of age, sex, self-efficacy, psychological mindedness and the quality of object relations on outcomes; attachment style and interpersonal distress have an important bearing on group attendance. However, the number of empirical studies, in particular of high quality RCTs, into the effectiveness of Group Analysis and Analytic/Dynamic Group Psychotherapy is small.

The methodological quality of the studies identified was variable. The five randomized controlled trials were assessed using a research quality rating scale (see Appendix) and this suggested that one trial was of noticeably poorer quality than the other four of moderate to good quality. Unpublished outcome measures with unknown psychometric properties were too often used, and the variety of outcome measures made it impossible to conduct meta-analysis. In respect of reporting, the terminology used to describe the therapeutic interventions was often ill-defined. Key words were

omitted from titles and abstracts thus making it difficult to capture these studies via electronic searches. These problems presented significant methodological challenges to the review.

The relatively low numbers of currently available studies on Group Analysis and Analytic/Dynamic Group Psychotherapy presents both a challenge and an opportunity to the therapeutic community to undertake research into these group approaches in order to consolidate these findings.

Recommendations for further research

To increase the amount and the quality of the evidence base for GA and A/D group psychotherapy there is an urgent need for more high-quality studies, employing both qualitative and quantitative methods.

Areas where evidence is currently lacking include:

- the types of patients for whom GA and A/D group therapies are most effective;
- the different indications for group versus individual psychotherapy and the comparative cost-effectiveness of the two treatment modes;
- the aspects of heterogeneity versus homogeneity of group membership that impact on outcome;
- equivalence or non-inferiority trials of GA and A/D group therapies compared with CBT group therapies;
- a study of group members experience or a review of service users' personal testimony.

If possible, further research should be undertaken to address these areas. To increase the awareness and use of research, and to facilitate systematic reviews, the reporting of research in GA and A/D group psychotherapy requires improvement. Specifically, we recommend the use of structured abstracts, clear definitions of different types of group intervention and agreed keywords for use in titles and abstracts and consistent use of a set of outcome measures. The research committees of the IGA and GAS, after consultation with other relevant bodies, could develop these recommendations further by producing good practice guidelines for the conduct and publication of research examining GA and A/D group psychotherapy.

Appendix- Research quality rating scale for randomised controlled trials

1.	Clear objectives & outcomes specified *a priori*	0 = objectives unclear 1 = objectives clear but main outcomes not a priori 2 = objectives clear & pre-specified outcome method
2.	Sample size adequate	0 = inadequate (n<50) 1 = moderate (n= or >50) 2 = large (n=>100) or pre-specified by power calculation
3.	Trial duration	0 = too short (<3 mth) 1 = reasonable (3-6 mth) 2 = long enough for assessment of long term outcomes
4.	Power calculation stated *a priori*	0 = not reported 1 = mentioned without details 2 = details of calculations provided
5.	Integrity of randomised allocation	0 = unrandomised & likely to be biased 1 = partially or quasi-randomised some bias possible 2 = randomised allocation
6.	Concealment of allocation from those involved in patient recruitment?	0 = not done or not reported 2 = concealment of allocation code detailed
7.	Treatments clearly described	0 = main treatments not clearly described 1 = inadequate details of main or adjunctive treatments 2 = full details of main or adjunctive treatments
8.	Manualised treatment*	0 = no treatment manual 2 = treatment manual
9.	Representative subjects and source	0 = source of subjects not described 1 = source of subjects given but no info on sampling 2 = source of subjects given & representative sample (e.g. consecutive admissions or referrals or random sample)
10.	Inclusion criteria with formal diagnoses to confirm	0 = none 1 = diagnostic criteria or clear exclusion criteria 2 = diagnostic criteria and clear exclusion criteria
11.	Exclusion criteria & no of exclusions/refusals recorded	0 = criteria & number of exclusions/refusals not recorded 1 = criteria or number of exclusions/refusals recorded

		2 = criteria and number of exclusions/refusals recorded
12.	Sample demographics & clinical characteristics well described	0 = little/no information (only age/sex) 1 = basic details (e.g. marital status, ethnicity) 2 = full description (e.g. socioeconomic, clinical history)
13.	Blinding of assessor & integrity of blinding tested	0 = not done 1 = done but no test of blinding 2 = done and test of blinding
14.	Compliance with experimental procedures, e.g. attendance, adherence	0 = not assessed 1 = assessed for some experimental treatments 2 = assessed for all experimental treatments
15.	Details on side effects/unwanted effects recorded	0 = inadequate details 1 = recorded by group but details inadequate 2 = full unwanted effects profiles by group
16.	Information on withdrawals; number and reasons.	0 = no info on withdrawals by group 1 = withdrawals by group reported without reasons 2 = withdrawals and reasons by group
17.	Psychometrically sound outcome measures, described clearly	0 = main outcomes not valid or described clearly 1 = some of main outcomes not clearly described 2 = main outcomes valid or described clearly
18.	Comparability on prognostic variables, and stats used to adjust for differences	0 = no info on comparability 1 = some info on comparability & appropriate adjustment 2 = full info on comparability & appropriate adjustment
19.	Inclusion of withdrawals (intention to treat analysis)	0 = less than 95% subjects included 2 = 95% or more subjects included
20.	Presentation of results	0 = little information presented 1 = adequate information 2 = comprehensive information
21.	Appropriate statistical analysis including correction for multiple tests	0 = inadequate 1 = adequate 2 = comprehensive & appropriate
22.	Conclusions justified (i.e. accurate representation of results, critique of the limitations of the methods used, possible sources of bias considered, other relevant literature discussed).	0 = no 1 = partially 2 = yes
23.	Declaration of interests	0 = no 2 = yes
24.	Allegiance to therapy stated, declaration of interests e.g.	0 = no

	funding.*	2 = yes
25.	Duration of follow up after therapy*	0 = end of therapy measures only 1 = < 6 month follow up 2 = 6 month or more follow up
26.	Co-interventions avoided or equal*	0 = no 2 = yes
27.	Record concurrent drug use*	0 = not recorded 2 = recorded & reported
28.	Credibility of treatments equal & expectancy for improvement assessed?*	0 = credibility clearly unequal & expectancy not assessed 1 = credibility equal but expectancy not assessed 2 = expectancy assessed
29.	Consecutive subjects recruited*	0 = non-consecutive or not reported 2 = consecutive subjects
30.	Presented results include data for re-analysis of main outcomes (e.g. point estimates & measures of variability for each primary outcome such as SD, 95% CI)*	0 = data inadequate for re-analysis 2 = data complete for reanalysis