The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders

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CRD summary
This review concluded that group cognitive behaviour therapy was effective for the treatment of unipolar depression and can be used with confidence. In view of the numerous potential sources of bias, lack of validity assessment and lack of consideration of heterogeneity when producing an average effect size across studies, the authors’ conclusions may not be reliable.

Authors' objectives
To assess the effectiveness of group cognitive behaviour therapy (GCBT) for unipolar depressive disorders.

Searching
PUBMED and PsychINFO were searched from inception; search terms were reported. Reference lists of identified studies were searched for additional relevant studies. Only studies published in English during the previous 30 years were eligible for inclusion.

Study selection
Studies of GCBT or group cognitive therapy (GCT) for the treatment of adults with depression reporting sufficient data to calculate relevant effect sizes were eligible for inclusion in the review. Studies of GCBT or CT for prevention, rather than treatment, and studies where depression was not the target of treatment were not eligible.

The included studies assessed GCBT or GCT in a range of populations with major or minor depression and other mood disorders including: depressed students; depressed patients with other health problems such as cancer or multiple sclerosis; depressed prison inmates; and depressed nursing home residents. In one study patients had symptomatic HIV, but were not clinically depressed. The duration of GCBT or GCT ranged from 7.5 hours over five weeks to 69 hours over nine months (where stated). For controlled studies, the control groups received waiting list control, treatment as usual/minimal contact control or placebo control. A range of outcomes were measured; most studies used the Beck Depression Inventory as one of their outcome assessment tools.

The authors stated neither how the papers were selected for the review nor how many reviewers performed the selection.

Assessment of study quality
The authors did not state that they assessed validity.

Data extraction
All outcome measures used in a study were included in the effect-size analysis, by calculating the effect size for each variable and averaging the effect sizes to form a composite estimate. For controlled studies, effect sizes were calculated using the difference between the means of the intervention and control groups divided by the pooled standard deviation (Hedges g). This was then converted to a weighted effect size d (which takes into account differences in sample sizes between treatment groups in a study). For uncontrolled studies effect sizes were calculated using pre- to post-treatment changes using the same method.

The authors stated neither how the data were extracted for the review nor how many reviewers performed the data extraction.

Methods of synthesis
The mean average effect size was calculated for controlled studies and for uncontrolled studies.

Results of the review
Thirty four studies were included in the review (n=2,134, sample sizes ranged from 10 to 531): 13 controlled studies; and 21 uncontrolled studies.

Effect sizes of controlled studies all favoured GCBT/GCT over the control condition. Effect sizes ranged from 0.1 to 2.87 with an average effect size of 1.11 across studies. Effect sizes were highest (over 1.5) in populations of low socioeconomic status immigrant women, women adjusting to divorce, patients with multiple sclerosis or myotonic muscular dystrophy, and people with low self esteem and mood disturbance. Effect sizes were lower (less than 0.3) in populations of older adults, HIV positive homosexual men and patients with primary dysthymia.

Effect sizes of uncontrolled studies ranged from 0.3 to 3.72 with an average effect size of 1.30 across studies. Effect sizes were highest (over 1.5) in populations with major depressive disorder and in older adults, and were lower (0.3) in a population of nursing home residents.

Compared with other treatments, GCBT/GCT produced larger effect sizes than group behaviour therapy, group supportive insight, assertive skills training, group rational emotive therapy, individual CBT, group interpersonal therapy, group psychodynamic therapy, individual supportive counselling and an educational discussion group. However, GCBT/GCT produced smaller effect sizes than individual cognitive therapy, visual imagery, a mutual support group and comprehensive distancing.

Additional results were reported.

**Authors’ conclusions**
This review demonstrated that GCBT was effective for the treatment of unipolar depression and can be used with confidence.

**CRD commentary**
This review addressed a clear question supported by appropriate inclusion criteria. Limited attempts were made to identify non-English language studies and no sources of unpublished data were searched, thus increasing the potential for publication bias and language bias. The authors stated neither how studies were selected for the review nor the methods used for data extraction, making the potential for reviewer bias and error impossible to assess. The methodological quality of the included studies was not assessed. Heterogeneity between studies was not formally assessed. The mean average and range of effect sizes for GCBT/GCT compared with control conditions and with pre-treatment assessments in uncontrolled studies were presented. In view of the potential for publication bias, language bias, reviewer bias or error, the lack of validity assessment and lack of consideration of heterogeneity when producing an average effect size across studies, the authors' conclusions may not be reliable.

**Implications of the review for practice and research**
Practice: The authors stated that GCBT can be used with confidence in the treatment of depressive disorders in the western industrial world.

Research: The authors stated that further research was required to investigate the factors that might make a depressed person more suited to GCBT versus individual cognitive behaviour therapy. They also stated that further research was required to investigate the applicability of GCBT in minority groups and different cultures, the lack of widespread use of GCBT by mental health workers in community clinics, the cost benefit of group over individual psychotherapy and to produce better guidelines for training of the next generation of GCBT at institutional levels, and to develop a coherent GCBT theory.

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**Bibliographic details**
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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.