Comparing the effectiveness of individual therapy and group therapy in the treatment of depression: systematic review
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Authors' objectives
To present the best available information on the use of group therapy and individual therapy in the treatment of long term depression. The primary question to be addressed was: for the treatment of long term depression, is group therapy or individual therapy appropriate and, if so, in what form? If neither is indicated, what modality might be better?

Searching
CINAHL, MEDLINE, PsycLIT, Current Contents, Science Citation Index, the Cochrane Library, DARE and EMBASE were searched (search terms and dates not provided). Bibliographies of all identified studies and review papers were also searched. Dissertation Abstracts International and proceedings databases were searched for unpublished studies.

Study selection
Study designs of evaluations included in the review
Randomised or pseudo-randomised controlled trials (RCTs).

Specific interventions included in the review
Various forms of individual therapy (defined as any one to one interaction between the patient and the therapist) and group therapy (excluding family therapy). Studies involving only combined psychotherapy and pharmacotherapy and studies which involved pharmacotherapy alone were excluded, as were treatments combining both group and individual therapy.

Participants included in the review
Children or adults suffering from long term depression and a determined Beck Depression Inventory (BDI) value of 12 or above or a Hamilton Rating Score for Depression (HRSD) of 14 or above were examined. Studies having participants with accompanying psychiatric disorders (e.g. schizophrenia) were excluded.

Outcomes assessed in the review
Reduction in depression inventory scores such as BDI, HRSD.

How were decisions on the relevance of primary studies made?
Two reviewers assessed all identified abstracts for relevance. Studies identified from bibliography searches were assessed on study title.

Assessment of study quality
Methodological quality was assessed using a checklist that was designed and trialed by the Joanna Briggs Institute for Evidence Based Nursing and Midwifery (JIBEBNM) and criteria included: randomisation, blinding, intention-to-treat analysis, comparability of groups at baseline, identical treatment of groups other than for named interventions, outcome assessment, statistical analysis. At least two reviewers were involved in assessing validity as the authors state that disagreements between reviewers were resolved by discussion with another reviewer.

Data extraction
Data were extracted independently using a data extraction tool that was developed and tested prior to use by JIBEBNM. A separate reviewer dealt with disagreements.
Methods of synthesis
How were the studies combined?
If appropriate with available data, results from comparable groups of studies were pooled by meta-analysis. Odds ratios (OR) and 95% confidence intervals (CI) were calculated for categorical data, and weighted mean differences (WMD) and 95% CIs for continuous data. Where possible intention-to-treat and/or completer analysis was performed. Where statistical pooling was not appropriate or possible, the findings were summarised in narrative form.

How were differences between studies investigated?
Heterogeneity between combined studies was tested using a standard chi-squared test.

Results of the review
Nineteen RCTs and one systematic review. Numbers of participants were not clear.

Individual cognitive behavioural therapy versus pharmacotherapy (3 studies): both treatments were found to be effective in reducing BDI scores (n=155; WMD 1.3 favouring pharmacotherapy (95% CI: -1.3, 4.0)) and HRSD scores (n=138; WMD -0.6 favouring cognitive therapy (95% CI: -2.5, 1.2)). The authors note that the included studies predate selective serotonin reuptake inhibitors (SSRIs).

Individual cognitive therapy versus individual cognitive therapy combined with pharmacotherapy (2 studies): neither ICT nor combined therapy was found to be significantly more effective than the other in either trial. Due to the nature of the reporting of data, meta-analysis was not possible.

Individual cognitive therapy versus waiting list with medication support (1 study): ICT significantly reduced BDI scores over the period of treatment and at 6 month follow up compared to the control (p<0.05).

Cognitive individual and group therapy versus waiting list with support (treatment as usual) (2 studies): One study found significant reductions in BDI scores for group cognitive therapy compared to control at post treatment but the groups were not compared at follow-up. The other study found significant reductions in BDI scores for individual therapy compared to control at post treatment but not at 3 months follow-up. The two studies could not be combined in a meta-analysis.

Cognitive individual or group therapy versus waiting list (no other treatment) (2 studies): In one study group therapy generated significantly lower BDI and HRSD scores than control. In the other study, individual therapy was significantly more effective than control in reducing BDI and HRSD scores at post-treatment and at 2 month follow-up. Meta-analysis of these two studies could not be performed.

Cognitive group therapy versus individual cognitive therapy (4 studies): BDI scores post treatment (n=124) WMD 0.2 (95% CI: -2.1, 2.6) and HRSD scores (2 studies, n=42)) WMD -0.3 (95% CI: -3.6, 3.0). Follow up BDI scores were not significantly different between groups at 2 and 3 months, but at 6 months CGT was favoured (n=62; WMD -6.9, 95% CI -11.6, -2.2). One study using ITT analysis claimed a significant advantage of ICT over CGT in BDI scores at post treatment and follow-up (p<0.02) and two did not.

Individual psychotherapy versus individual cognitive therapy (1 study): no significant difference between treatments was shown.

Cognitive group therapy versus computer assisted therapy (therapeutic learning programme or TLP) (2 studies): both studies reported no significant difference in the effectiveness of treatments in reducing depression scores; meta-analysis could not be performed.

Coping with depression: a course, comparison of group or class therapy and individual therapy (2 studies): Meta-analysis showed individual treatment was significantly more effective at reducing BDI scores than was the class method (n=104; WMD 3.0, 95% CI 1.0, 5.0), however the effect did not persist at follow up at 1 and 6 months.

Individual cognitive therapy versus waiting list control (1 systematic review): Remission from depressive disorder was higher in the ICT group compared to control OR 2.2 (95% CI: 1.4, 3.5).
Cognitive group therapy versus waiting list control (2 studies): CGT was significantly better than control in reducing BDI scores post-treatment (n=56; WMD -11.2, 95% CI -16, -6.5). One study found this difference persisted at follow-up. CGT was also significantly better than control for producing participants with normal BDI scores post-treatment (n=46; Peto OR 11.8, 95% CI 3.3, 42.3).

Authors' conclusions
Individual and group cognitive behavioural therapies for moderately or severely depressed adults (BDI 14 or above) are comparable with each other in effectiveness and both are superior to providing no treatment at all. Individual cognitive therapy is equal to or better than tricyclic antidepressant drugs given at recommended therapeutic dosages for depressed people with a mean BDI of 30. This information is based on level II evidence (RCT).

CRD commentary
This is a good review. The inclusion criteria are clearly defined relative to the research question and the literature search is very comprehensive so it is unlikely that any studies would have been missed, although it is not stated whether studies were restricted by language. Details of the review process are given and validity was assessed but not used. Study details were not fully presented and could have been presented in an appendix. It may have been more appropriate to use relative risk rather than odds ratio as a summary estimate. Each comparison is based on quite a small number of participants in a few trials, and some reported only pre- versus post-treatment data rather than results of a randomised comparison. The authors’ conclusions do follow from the results but should be treated with some caution owing to flaws in methodological quality of the included trials reported in the text.

Implications of the review for practice and research
Practice: The authors state practice implications for adults and adolescents.

For adults, either group (CGT) or individual cognitive behavioural therapy (ICT) can be used to treat moderate to severely depressed patients with the choice of therapy dependent upon the clinicians perceived receptiveness of the individual patient to group versus individual treatment. The use of computer assisted therapy can be useful as an aid to CGT in moderate to severely depressed patients. ICT can be effective in place of pharmacotherapy in moderate to severely depressed patients if the patient is opposed to being treated with drug therapy. CGT has not been compared to pharmacotherapy so no direct recommendation can be given as to its effectiveness as a replacement therapy.

For adolescents, either group or individual cognitive behavioural therapy can be used to treat moderately depressed adolescents (BDI 14 or above).

Research: The authors state that more research is needed to determine the effectiveness of individual or group cognitive behavioural therapy in severely depressed adolescents (BDI 20 or above).

Bibliographic details

Indexing Status
Subject indexing assigned by CRD

MeSH
Cognitive Therapy; Depressive Disorder /therapy

AccessionNumber
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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.