Cognitive Behavioral Therapy Treatment Approach: Group Therapy vs. Individual Therapy

Kelly Huston
Pacific University

Follow this and additional works at: http://commons.pacificu.edu/otmh

Part of the Mental and Social Health Commons, and the Occupational Therapy Commons

Notice to Readers

This work is not a peer-reviewed publication. Though the author of this work has provided a summary of the best available evidence at the time of writing, readers are encouraged to use this CAT as a starting point for further reading and investigation, rather than as a definitive answer to the clinical question posed or as a substitute for clinical decision-making.

Select copyrighted material from published articles may be included in this CAT for the purpose of providing a context for an informed critical appraisal. Readers are strongly encouraged to seek out the published articles included here for additional information and to further examine the findings in their original presentation. Copyrighted materials from articles included in this CAT should not be re-used without the copyright holder’s permission.

Recommended Citation

http://commons.pacificu.edu/otmh/7

This is brought to you for free and open access by the OT Critically Appraised Topics at CommonKnowledge. It has been accepted for inclusion in Mental Health CATs by an authorized administrator of CommonKnowledge. For more information, please contact CommonKnowledge@pacificu.edu.
Cognitive Behavioral Therapy Treatment Approach: Group Therapy vs. Individual Therapy

Disciplines
Mental and Social Health | Occupational Therapy

Rights
Terms of use for work posted in CommonKnowledge.
Cognitive Behavioral Therapy Treatment Approach: 
Group Therapy vs. Individual Therapy
Clinically Appraised Topic (CAT)

Prepared by: Kelly Huston  (hust7582@pacificu.edu)
Date: 11/14/08
Review date: 11/21/08

Focused Clinical Question

What treatment approach has been found (between 1990 – 2008) to be more effective with DSM-IV axes I and II diagnoses, group cognitive-behavioral therapy or individual cognitive-behavioral therapy?

Clinical Scenario

Since the beginning of mental health treatment, around the 15th century, physicians, nurses, and therapists have been treating patients in groups. In 2008, we are still treating in groups in mental health settings. This group treatment approach raises many questions when looking at other health care settings where the primary treatment approach is 1-on-1. Which method is more effective in symptom remediation in mental health: group or individual?

Various studies have examined this question using a reliable treatment model, cognitive-behavioral therapy (CBT), proven to be effective with various DSM-IV diagnoses. This issue will impact the occupational therapy profession as they are generally the leaders of these mental health groups. Occupational therapist work with individuals experiencing mental illness, to increase their participation in ADLs, IADLs, work, leisure, play, education, and social interactions. Groups have been a cost effective method to achieve the biggest bang for the buck; more clients are able to be seen in a shorter amount of time. However, are the clients receiving the best care for their dollar? A typical client being seen at an inpatient mental health unit experiencing major depression may be asked to join various groups throughout the day, focusing on different skill-building activities, learning coping mechanisms, and medication management. The groups may range in size from 3 to 10 with multiple diagnoses represented within the participants. The only time the client is seen individually is when they are interacting with their doctor or social worker. The questions remain, are their individual needs and concerns being addressed? How much are they truly benefiting from the groups? Stangier, Heidenreich, Peitz, Lauterback, & Clark (2003) completed a study looking at the difference in treatment among individuals with social phobia. He found both approaches provided greater benefit than no treatment, however individual therapy proved to be significantly
Summary of Key Findings

- Stangier, Heidenrieich, Peitz, Lauterback, & Clark, (2003) studied the possibility of turning a CBT individual treatment program into a group treatment program and compared the two effect sizes. Three groups were formed: group cognitive behavioral therapy (GCBT), individual cognitive behavioral therapy (ICBT), & a wait-list group (control – receiving no treatment) and all participated in this 15-week study receiving between 12 (GCBT) to 15 (ICBT) hours of therapy. The ICBT group resulted in a large effect size where the GCBT resulted in a medium effect size. After treatment, 50% of the ICBT no longer met DSM-IV criteria while only 13.6% from the GCBT no longer met the criteria. The ICBT group showed continued improvements at follow-up.

Potential explanations for greater effectiveness of ICBT:

- Individual format fosters great opportunity to attune to the individual and their idiosyncratic behaviors, strategies, and beliefs.
- Exposure to a group situation may have been too threatening for some participants in the GCBT.
- GCBT is a great way to immerse individuals in their fears and help desensitize them. It has the potential to backfire as an individual is placed in anxiety-provoking social situations resulting in them inverting or shutting down; gaining nothing from the group.

Limitations found within this study were the unaddressed interchanging use of the terms CBT and cognitive therapy (CT) in addition to the modest training the therapist received in CBT/CT.

- With 3-10% of school-aged children experiencing anxiety disorders, it was hypothesized by Manassis, K, et al (2002) that certain subgroups of these children would respond preferentially to one modality (ICBT or GCBT). This study consisted of two groups: GCBT & ICBT along with a group for parents of these children to participate in. The treatment lasted 12 sessions ranging from 45 minutes (ICBT) to 1.5 hours (GCBT). Various assessments were administered (Multidimensional Anxiety Scale for Children, Social Anxiety Scale for Children, Children’s Depression Inventory, Global Improvement Scale, Children’s Global Assessment Scale) along with collection of verbal and observational data from the parents and therapist. The results found that both treatment forms provided improvement however, the ICBT had the greatest improvement with 82% showing further gains post treatment. High social anxiety children responded preferentially to individual treatment.

Limitations identified within this study were that the researchers could not control the continuation and variation of treatment children received from their parents outside treatment sessions and limited ethnically and economically diverse sample population.
Using Oxford University’s CBT individual manual information, Chen, Touyz, Beumont, Fairburn, & Griffiths (2002) reformatted it to be used in a group setting and clinically compared the two formats (ICBT & GCBT) and their effectiveness of reducing Bulimia Nervosa symptoms. Sixty participants initially began the study and were tracked through pretreatment, post-treatment (4.5 mo), 3 mo & 6 mo follow-ups. The ICBT group met for 19 sessions lasting 50 minute with unlimited access to self-help books throughout their treatment and the option of an information session with family/friends. The GCBT had the same handout, session schedule and content as the ICBT however, their sessions lasted for 90 minutes and were conducted in small closed groups (6 participants). Both groups experienced significant improvement in primary and secondary conditions: depressed moods, self-esteem, state & trait anxiety, social adjustment, and general psychopathology. Various trends were noted but none had a largest enough effect size to be found significant. At post-treatment, fewer participants from the ICBT continued to meet eating disorder diagnostic criteria but it was not sustained at follow-up. The GCBT was found superior to ICBT in impulse control, state anxiety, and social functioning all of which remained at follow-up. The authors of this study concluded that GCBT is a great way to provide support and motivation to its participants and is cost-effective; therefore it should be the first line of treatment in a stepped care approach. Noted limitations within this study were the small sample size, high drop-out rates, lack of validating clinical interviews for assessing participants, and the lack of a control group.

Fals-Stewar, Marks, & Schafer were looking to enhance the amount of literature on Obsessive Compulsive Disorder (OCD) when they conducted their randomized control trial in 1993 using three different groups (Individual Behavioral Therapy (IBT), Group Behavioral Therapy (IBT), and a control group) in search for the best form of treatment for OCD. Their study consisted of 93 participants gathered from various outpatient settings who had been diagnosed with DSM-III OCD for at least one year. Three measures were utilized, Yale-Brown Obsessive-Compulsive Scale, Beck Depression Inventory, and Self-Rating Anxiety Scale throughout the pre-testing, interval testing, post-testing, and 6 mo follow-up. The IBT met 2 times a week for 1 hour for 12 weeks. The GBT met 2 times a week for 2 hours for 12 weeks. The control group also met for 12 weeks working on relaxation techniques. The results from this study found that those who participated in the IBT experienced quicker reductions in symptoms than the other two groups. Both the IBT and GBT had significant overall reduction in the three measures by the end of 12 weeks with sustained scores at 6 mo follow-up. This study noted the difference between IBT and GBT staff hours to be 720 to 48, concluding that GBT is more efficient and practical. A limitation found in this study was that participants had only mild to moderate OCD symptom severity, with individual’s diagnosed with major depression excluded. Also, some participants might have been taking serotonin reuptake inhibitors in conjunction with therapy treatment potentially having an affect on their outcomes.
DeRubeis & Crits-Christoph (1998) created a systematic review examining empirically supported individual and group psychological treatments for 11 different adult mental disorders: Depression, Generalized Anxiety Disorder, Social Phobia, OCD, Agoraphobia, Panic Disorder, PTSD, Schizophrenia, Alcohol Abuse – Dependence, and Substance Abuse – Dependence. Various treatment approaches were utilized throughout the treatment sessions with CBT and BT proving to be the most utilized and effective. The article did not end up specifying which form (group or individual) therapy of CBT or BT resulted in the greatest decrease of symptoms. However, this article did validate the use of CBT and BT with being one of the most effective forms of treatment for treating DSM-IV axis I and II diagnoses.

Clinical Bottom Line
Both GCBT and ICBT have proven benefits and illustrated improvements for individuals of all ages with social phobia, anxiety disorder, bulimia nervosa, and obsessive-compulsive disorder. Although GCBT is more cost effective, the five studies analyzed within this CAT have shown a greater clinically significant effect size in individuals receiving ICBT.

Limitation of CAT

- Limited levels of evidence available in literature
- Limited therapist training in CBT (Stangier et al, 2003)
- Confounding variables: outside influences & resources, medication, secondary conditions (Manassis et al, 2002; Chen et al, 2002)
- High drop-out rates (Chen et al, 2002)
- Interchanging use of CBT & CT (Stangier et al, 2003)
- Limited follow-up data (Fals-Stewart et al, 1993)
- Not an exhausted literature list
- Not an experienced researcher

SEARCH STRATEGY:
Terms used to guide Search Strategy:
Patient/Client: Individuals with mental disorders (axis I and II) classified in the DSM-IV
Intervention: CBT group therapy
Comparison: CBT individual therapy
Outcome(s): Decreased symptomatology

<table>
<thead>
<tr>
<th>Databases and Sites Searched</th>
<th>Search Terms</th>
<th>Limits Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane Systematic Review</td>
<td>Coercion; voluntary outcome; group based therapy; individual based</td>
<td>Full text, latest update, new reviews, recently updated, English only</td>
</tr>
</tbody>
</table>
### INCLUSION and EXCLUSION CRITERIA

**Inclusion:**
- Published between 1990 & 2008
- Patients meet DSM-IV criteria
- Written in English
- Used CBT or Cognitive Therapy or BT for intervention
- Looked at both individual and group treatment

**Exclusion:**
- Written before 1990
- Other form of treatment (refer to inclusion)
- Looked at only one form of treatment
## RESULTS OF SEARCH

**Table 1: Summary of Study Designs of Articles retrieved**

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Study Design/Methodology of Article Retrieved</th>
<th>Number Located</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Systematic review</td>
<td>1</td>
<td>Cochran systematic review</td>
</tr>
<tr>
<td>I</td>
<td>Meta-analysis</td>
<td>1</td>
<td>Cochran systematic review</td>
</tr>
<tr>
<td>I</td>
<td>Randomized control trials</td>
<td>3</td>
<td>Google Scholar – Wiley Periodicals; Medline - EBSCOhost; Cochran controlled trial</td>
</tr>
<tr>
<td>II</td>
<td>Two-group, nonrandomized</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>One-group, pre- &amp; post-test</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Descriptive study</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Case reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total = 5**
Reference:


