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Two Forms of Group Therapy and Individual Treatment of Work Related Depression: A One Year Follow-Up Study, by C. Sandahl, Ph.D., U.E. Lundberg, Ph.D., A. Lindgren, M.A., G. Rylander, M.D., J. Herlofson, M.D., A. Nygren, M.D., and M. Asberg, M.D.

Estimated Time to Complete this Activity: 90 minutes

Learning Objectives:

The reader will be able to:

1. Describe research on group psychotherapy for work-related depression.
2. Distinguish between cognitive and psychodynamic group psychotherapy.
3. Describe the similarities in outcome between two forms of group psychotherapy.

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Åke Nygren, Nothing to Disclose

Marie Asberg, Nothing to Disclose

Two Forms of Group Therapy and Individual Treatment of Work-Related Depression: A One-Year Follow-Up Study

CHRISTER SANDAHL, PH.D.
ULRIKA LUNDBERG, PH.D.
ANNIKA LINDGREN, M.A.
GUNNAR RYLANDER, M.D.
JÖRGEN HERLOFSON, M.D.
ÅKE NYGREN, M.D.
MARIE ÅSBERG, M.D.

ABSTRACT

Patients on long-term sick-leave (> 90 days) from white collar work, with a diagnosis of work-related depression, dysthymia, or maladaptive stress reaction were randomized either to cognitive group therapy (CGT), focused psychodynamic group therapy (FGT), or to a comparison group. All patients were interviewed and responded to self-report questionnaires before the start of treatment and at 6 and 12 months. At the 12-month follow-up, 70% of the patients met the

Christer Sandahl is Professor of Social and Behavioral Sciences and head of the Leadership and Group Counselling Unit at the Medical Management Centre, Karolinska Institute in Stockholm, Sweden. *Annika Lindgren* is head of the Psychotherapy Unit at the Department of Clinical Neuroscience, Karolinska Institute, *Ulrika Lundberg* and *Gunnar Rylander* are former members of the staff at Department of Clinical Sciences, Danderyds Hospital, Karolinska Institute, and are now in clinical practice, *Jörgen Herlofson* is in private practice. Professors emeritus *Åke Nygren* and *Marie Åsberg* are jointly heading the Unit for Stress Research at the Department of Clinical Sciences, Danderyds Hospital, Karolinska Institute.

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criteria for reliable change of the target symptom (depression), and the sample as a whole improved significantly on all measures used. However, there were no differences in outcome between the three treatment groups.

Work-related depression (mainly professional burnout) has increased rapidly as the main reason for sick-listing in Sweden (National Board of Social Health and Welfare, 2003). Similar developments have been reported from many European countries such as The Netherlands, Germany, Denmark, and Norway (Schaufeli & Enzmann, 1998; Tennant, 2001). This trend calls for effective treatment and rehabilitation interventions. However, scientifically evaluated treatments, interventions, and rehabilitation strategies intended for this patient group are seldom found in the literature.

Burnout is most commonly defined as a reaction to long-term work-related stress, mainly characterized by emotional exhaustion and disengagement from work (Demerouti et al., 2001). Maslach, Jackson, and Leiter (1996) have stressed that burnout is neither a medical term nor a diagnosis, but should rather be conceptualized as a psychological crisis emerging from chronic work stress. However, it has been established that burnout often occurs parallel to significant health deterioration (Shirom et al., 2005). Burnout has also been related to sick leave (Borritz et al., 2006). As sick leave based on psychiatric conditions increased in Sweden, the need for a proper medical diagnosis for use in sick-listing became apparent. Therefore, in 2003 the Swedish National Board of Health and Welfare published diagnostic criteria for *exhaustion disorder*, a term which in Sweden has now replaced the term *burnout* in clinical contexts. However, this was after the present study was initiated.

With respect to burnout, most studies aim to establish predictors (Maslach, Schaufeli, & Leiter, 2001). The intervention studies that have been carried out are typically preventive and conducted among individuals in working populations (e.g., Van Rhenen et al., 2005). Randomized controlled studies of treating burnout in clinical samples are practically non-existent (Blonk, et al., 2006). Most common among outcome studies are cognitively or cognitive behaviorally (CBT) oriented approaches (Schaufeli

& Enzmann, 1998). However, although such approaches generally show beneficial results, they are rarely compared to other treatments in the same study. One exception is a randomized controlled study in which there was no difference in outcome for patients with stress-related illness who were given either CBT treatment or participated in a physical activity program (Heiden et al., 2007). Van Rhenen and colleagues (2005) call for more studies comparing different interventions with one another. It would be of special interest to include psychodynamic approaches which are common in clinical practice but less scientifically investigated. Moreover, most studies have evaluated the effect of *individual* treatment interventions on burnout/exhaustion disorder. Group therapy is to a large extent based on social interaction with others in the same situation which might be of special importance for patients who have similar experiences of painful work situations (see Brattberg, 2005). If proven effective and appreciated by the patients, group therapy is also a cost-effective alternative to individual treatment (Burlingame, Mackenzie, & Strauss, 2004).

The aim of this study was to develop two forms of short-term group therapy based on cognitive and psychodynamic principles respectively. We also wanted to evaluate the treatment effects (in terms of depression, anxiety, psychiatric symptom load, burnout, and return to work) of the therapies in a clinical sample of sick-listed individuals with work-related depression.

METHOD

The study was approved by the Board of Research Ethics at Karolinska Institutet. Subjects were recruited from the database of Alecta, a large Swedish occupational pension company. Alecta provides disability pensions that cover loss of income after >90 days of sick-listing for white collar workers employed within the private sector. In the present study, all clients in the database listed due to a psychiatric condition constituted the basis for recruitment. No maximum days of sick-listing were stated in the database, and some clients had been on sick leave for up to two years (average sick-listing was six months).

The Alecta database includes no information on (medical or other) treatments offered to the clients. Thus, in the present study, any treatment received before inclusion that might have affected recovery is unaccounted for. However, at the time of the study, standard treatment recommendations for clinical burnout symptoms in Sweden included medication and rest from work only.

Development of the Treatments

For about a year and a half, clinical trials were carried out with patients recruited from the Alecta database. Ten groups (five of each model) with 6-8 patients in each were videotaped and discussed by two teams of clinicians, specialized in cognitive and psychodynamic therapy respectively. Two of the authors were responsible for one team each (Herlofson for the cognitive and Sandahl for the psychodynamic). They shared the impression that the patients were highly motivated for treatment and very appreciative of the group format and the opportunity it offered to share painful experiences from work. However, it gradually became clear that certain aspects of standard treatment had to be modified to meet the needs of this patient group.

The cognitive treatment was based on cognitive principles. Every session had the same structure, and the themes for each session were pre-planned and adjusted to the kinds of problems presented by this patient group. According to the therapists, this *cognitive* treatment was more interactive and process-oriented compared to how *cognitive behavior therapy* is usually described in the literature. However, compared to the *psychodynamic* approach, it was more structured and included handouts, a similar agenda for each session, and individualized homework assignments. In the group, patients were expected to learn new ways of thinking about their problems through the didactic parts which were integrated into the reflection and exchange of experiences between group members. Homework assignments were supposed to support behavior change in everyday life.

The psychodynamic approach was based on an integration of principles from group analysis, object relations theory, self-psychology, systems-centered, and interpersonal therapy. It was

argued that the use of common factors (support, learning, and action) in group therapy, rather than a special technique, improves the clinical work. The core of the treatment was to find and formulate an individual focus expressed in behavioral terms. This was done during the individual pre-therapy preparation. The focus was then worked on in the here-and-now of the group therapy. The instruction to the therapist was to formulate a focus, in collaboration with the patient, which was related to feelings of self-esteem in emotionally challenging situations in relation to other people. It was argued that the focus should express both a strength and weakness, in order for the patient to realize how one could build on some already existing competencies, thereby contributing to hope and providing some degree of safety. The reasoning was that change will occur when a patient has the experience of mastering a new way of being (e.g., to be assertive) in a real relationship in a cohesive and trustful group. The thought was that the satisfaction which accompanies the expression of feelings will reinforce a balanced self-expressive behavior in itself, which would be expected to contribute to an increased competence to cope with emotional situations. It was argued that being able to master challenging emotional situations will also contribute to increased self-esteem. This in turn will improve both cognitive functioning and problem-solving capacity and will result in more constructive behaviors. After these new behaviors are tested in the safe environment of the group, they can then be tried out in everyday situations.

While the focus in the cognitive approach was on the learning that took place between the sessions, learning and behavior change in the psychodynamic treatment were mainly expected to take place in what was metaphorically described as the social laboratory of the group. Homework assignments were also given now and then in the psychodynamic approach, but in that case as a result of a spontaneous group process. At the end of the development phase, a manual was written for both group therapy approaches (Herlofson, 2003; Sandahl & Lindgren, 2003). The two manuals were studied carefully by the therapists, individually and in the respective groups of therapists, and were actively used during the whole period of the research project.

The psychotherapists (5 CGT and 5 FGT) who participated in the present study were part of the two teams that developed the group therapies. They were previously trained in cognitive and psychodynamic psychotherapy, respectively, and all of them had long (10-30 years) of clinical experience as psychotherapists.

Cognitive Group Therapy (CGT). The cognitive therapy was based on the notion that ill health ensues from a dysfunctional interplay between the individual and his or her surroundings. The aim of the group therapy was to a) re-establish the participants' sense of authority and feelings of being active agents, b) reflect on their life stories and review dysfunctional assumptions about themselves, and c) develop adaptive strategies of importance for interacting in everyday work life. Each session followed the same agenda: 1) an introductory orientation (including, for example, a breathing exercise), 2) a short review of the previous session, 3) information from group members, 4) approximately an hour of free discussion of experiences regarding homework since last session, to some degree supported by the group leader, 5) introduction of the theme of the session, 6) short common reflection of the group, 7) personal choice and decision of new assignments, 8) reading of the assignments the patients have given themselves, and ending with, for example, 9) a breathing exercise. The CGT included two individual pre-therapy interviews for assessment and preparation, when individual goals and focus were also formulated. The therapy consisted of fourteen 90- to 120-minute group sessions and two shorter individual sessions.

Focused Psychodynamic Group Therapy (FGT). The focused group therapy was based on the notion that a patient's ability to regulate self-esteem is central to regaining balance after long-term sick leave due to work-related depression. The group focus was on understanding and exploring experiences of work-induced depression. Together with the therapist, each group member formulated an individual focus during the preparatory interviews to describe his or her problematic interpersonal functioning, which was to be worked on during therapy. These individual foci were introduced to the groups between sessions five and eight.

Since the treatment procedure has been reported in detail elsewhere (Sandahl & Lindgren, 2006), only a brief description is given here. The treatment included three pre-therapy interviews

and eighteen 90-minute sessions, the first eight to ten of which were conducted twice weekly and the remaining eight once a week. The therapists were trained to conduct group therapy according to the treatment manual, and they received supervision by the authors of the manual.

Comparison Condition (CC). Initially, the comparison group was meant to serve as a control group and was offered treatment as usual (medication and rest) while on the waiting list for group therapy treatment. However, the majority (85%) of those assigned to the comparison group initiated some kind of therapy for themselves (typically individual therapy of different orientations). About the same number of patients participated in the group treatments after initial drop-out. At the follow-up it was discovered that nine patients had been in individual CBT treatment (average number of hours = 11), fourteen in eclectic/supportive (average number of hours = 11), five in psychodynamic (average number of hours = 17), two in group therapy (one 10 hours, the other 35 hours), and four in regular treatment contact with a GP or similar. Hence, the intended control group was used in the present study only as a comparison to the group treatments. The two patients from the comparison group who were in group treatment were excluded from the analyses in order to reduce the confounding factors.

Subjects

Included in the project were patients aged 18-65, living in the greater Stockholm area, on sick leave for at least 90 days on a minimum of 50 % of full-time work, with a diagnosis of depression (current or in partial remission), dysthymia, or maladaptive stress reaction according to DSM-IV, judged by the project physicians to be clearly work-related. Exclusion criteria were acute psychotic state, bipolar affective disorder, ongoing drug abuse, acute suicidal risk, antisocial or schizotypal personality disorder, other ongoing psychotherapy, or insufficient command of Swedish.

The sample of 120 eligible participants were asked to state their informed consent and were then consecutively randomized (this process took about a year and a half) to 1) five FGT groups with 8 patients in each, 2) five CGT groups with 8 patients in each, and

3) a comparison group ($n = 40$). However, during the pre-therapy interviews it was discovered that two patients who had been already randomized to the FGT treatment met the exclusion criteria (acute suicidal risk and other ongoing psychotherapy) and one did not meet the inclusion criteria (depression not work-related). The remaining patients were invited to participate in the project and the final sample therefore consisted of 117 patients. The patients were contacted at 6 and 12 months after beginning the treatment. They were interviewed on the telephone regarding work situation and satisfaction with the treatment, and they also responded to questionnaires that were mailed to them.

A majority of the patients were female (70%) and mean age was 43 years ($SD = 1.8$). Sixty-four percent were married or cohabiting and 46% had children younger than 15 years. The educational level was comparatively high (25% had an academic degree), 25% had a leading position, and 31% worked in a position requiring theoretical specialist competence. Most patients had their main treatment contact at occupational health care (53%), 33% in primary care, and only 14% in psychiatric outpatient care. Background characteristics were similar across the treatment groups and an analysis of non-responders also showed a similar pattern. At inclusion, 63% of patients in FGT were on SSRI medication, 79% in CGT, and 56% in the comparison group. The drop-out rate in FGT was higher (19%) as compared to CGT (10%), but all statistical analyses were based on intention to treat.

Assessment instruments

Self-report questionnaires assessing depression, anxiety, and general psychiatric symptom load and burnout were distributed at inclusion, after six months coinciding with the end of therapy, and at one-year follow-up.

Depression and anxiety were assessed using items from the Comprehensive Psychopathological Rating Scale-Self-Affective (CPRS-S-A; Svanborg & Åsberg, 1994). CPRS-S-A is a 28-item self-report questionnaire covering symptoms of anxiety, depressive and obsessive-compulsive syndromes, and borderline personality disorder. The subscales for depression and anxiety have shown adequate psychometric properties in terms of reliability and va-

lidity, with reported correlations between self-assessment and expert ratings in the range $r = 0.80-0.94$ (Svanborg & Åsberg, 1994). The items are rated on a four-point Likert scale, with three intermediate levels, ranging from “no symptoms” to “extreme symptoms.” The subscales for depression and anxiety, covering nine items each, were used in the current study.

General psychiatric symptom load as experienced during the last seven days was assessed with the Symptom Checklist-90 (SCL-90; Derogatis, 1983; Derogatis, Rickels, & Rock, 1976; Fridell et al., 2002). The 90 self-report items are rated on a five-point Likert-type scale ranging from zero (“not at all”) to four (“very much”). The mean score of SCL-90 is calculated to constitute a Global Severity Index (GSI). The internal consistency of the GSI was satisfactory at all time-points in the present sample (alpha at intake = 0.97; at 6-month follow-up 0.96, and at 1-year follow-up 0.98).

Burnout was measured with the Oldenburg Burnout Inventory (OLBI; Demerouti et al., 2001). The OLBI assesses emotional exhaustion and disengagement from work. Both positively and negatively phrased statements concerning exhaustion and disengagement were made, and participants were asked to agree or disagree on a four-point Likert scale. The reliabilities were adequate at all time-points for exhaustion (intake alpha 0.72, 6-month follow-up alpha 0.83, and 1-year follow-up alpha 0.84) as well as for disengagement (intake alpha 0.73, 6-month follow-up alpha 0.84, and 1-year follow-up alpha 0.88).

Data analyses

To investigate the mean differences across time between the treatment conditions (FGT, CGT) and the comparison condition, a mixed model ANOVA was used over all treatment conditions. The same analysis was applied in order to investigate differences between the two treatment conditions and also in order to compare the treatment conditions on the one side with the comparison condition on the other; all together three mixed-model analyses were performed. Within-group effect sizes were calculated based on Cohen's *D*. Further, a Reliable Change Index (RCI) was calculated (Jacobson & Truax, 1991). RCI is a measure that estab-

lishes whether a patient has changed sufficiently that the change is unlikely to be due to simple measurement unreliability. The RCI is calculated as the difference between the two scores before and after treatment divided by the standard error of the difference between the scores. In a pre-post treatment analysis, a RCI >1.96 is unlikely to occur if the patients have not changed at all. Number of patients who have an RCI >1.96 is reported here.

RESULTS

An analysis was carried out to investigate the expected interaction effect between time and treatment, that is, if symptoms had decreased more in the treatment groups than in the comparison condition. A main effect of time was found on symptoms (depression, anxiety, GSI, and burnout) between intake, after treatment, and at follow-up. However, no significant interaction between time and treatment could be established (See Table 1).

The same pattern was found when the group treatments were compared to each other and when the two treatment conditions together were compared with the comparison condition. This implies that while symptom mean scores changed significantly across time *within* all treatment conditions, no differences *between* treatment conditions could be detected. Hence, the participants improved significantly on all symptom scales, but the effect could not be statistically ascribed to either of the group treatments (compared to those patients receiving individual treatment).

To further investigate the potential role of therapy in relation to symptom reduction, the course of symptom development was investigated in the overall sample. Mean scores, as well as effect sizes, of different symptoms indicate that depression decreased between intake and end of treatment and continued to decrease also until follow-up ($D = 0.72$ at 6 months and 1.59 at 12 months). A similar pattern was detected for anxiety symptoms ($D = 0.36$ at 6 months and 1.22 at 12 months). However, the GSI scores ($D = 0.73$ at 6 months and 0.77 at 12 months), as well as scores on burnout (exhaustion; $D = 0.62$ at 6 months and 0.68 at 12 months and disengagement; $D = 0.44$ at 6 months and 0.68 at 12 months) showed the greatest decrease during the treatment period, and

TABLE 1. Mixed Model Anova, Type III Tests of Fixed Effects Modelled on Heterogeneous Compound Covariance Structure

Dependent Variable		df	F	Sig.
Depression	Treatment	145	.05	.949
	Time	173	307.51	.000
	Treatment * Time	173	.02	.980
Anxiety	Treatment	158	1.40	.250
	Time	171	133.77	.000
	Treatment * Time	171	.88	.419
GSI	Treatment	146	.47	.625
	Time	178	75.81	.000
	Treatment * Time	178	.11	.896
Exhaustion	Treatment	148	.62	.538
	Time	143	29.00	.000
	Treatment * Time	143	.25	.779
Disengagement	Treatment	144	.36	.696
	Time	142	23.36	.000
	Treatment * Time	142	.18	.836

only a marginal further decrease could be detected between end of treatment and follow-up (See Table 2).

Seventy percent of patients met the criteria for the RCI in symptoms of depression (FGT = 67%, CGT = 70%, and CC = 73%), 51 % of anxiety (FGT = 47%, CGT = 49%, and CC = 58%), and 56% on general symptom load (FGT = 64%, CGT = 55%, and CC = 50%). About one-third of patients recovered according to the results of the burnout scale (FGT exhaustion = 31%, disengagement = 34%; CGT exhaustion = 31%, disengagement = 27%; CC exhaustion = 41%, disengagement = 17%). However, it should be kept in mind that 31% did not work at all or worked less than half-time at one-year follow-up, and the burn-out questions are clearly directed to a work situation.

In the telephone interview at the 6-month follow-up, 74% of group therapy patients reported that they were either satisfied or very satisfied with the group therapy treatments, and 75% reported that they felt better or had recovered. There was no difference in this respect between the two group treatments. At the 12-month follow-up, 69% reported that they worked half-time

TABLE 2. Results on Symptom Scales at Inclusion, 6-Months, and 12-Months Follow-Up (*M*, *SD* and *D*)

	Inclusion			6-month follow-up			12-month follow-up		
	CGT ¹	FGT ²	CoGr ³	CGT	FGT	CoGr	CGT	FGT	COGr
Depression, <i>M</i>	9.33	9.05	9.67	6.14	6.218	6.37	2.45	2.32	2.77
<i>SD</i>	4.12	4.8	4.08	4.23	4.93	3.92	3.07	3.9	4.2
<i>D</i>				0.77	0.58	0.81	1.67	1.4	1.69
Anxiety <i>M</i>	8.24	7.51	9.14	6.81	6.74	6.95	3.34	3.44	3.38
<i>SD</i>	4.27	3.73	3.94	3.58	4.05	3.76	3.82	4.82	4.36
<i>D</i>				0.33	0.21	0.56	1.15	1.09	1.46
GSI <i>M</i>	1.12	1.1	1.26	0.67	0.71	0.75	0.66	0.65	0.74
<i>SD</i>	0.55	0.67	0.62	0.49	0.58	0.52	0.54	0.58	0.48
<i>D</i>				0.81	0.58	0.82	0.83	0.67	0.84
Exhaustion <i>M</i>	2.81	2.82	2.95	2.36	2.53	2.6	2.48	2.35	2.53
<i>SD</i>	0.62	0.59	0.59	0.71	0.68	0.56	0.7	0.62	0.59
<i>D</i>				0.72	0.49	0.62	0.52	0.79	0.73
Disengagement <i>M</i>	2.63	2.64	2.83	2.32	2.47	2.59	2.21	2.21	2.53
<i>SD</i>	0.54	0.56	0.55	0.59	0.81	0.64	0.66	0.75	0.69
<i>D</i>				0.57	0.3	0.44	0.77	0.76	0.55

¹ Cognitive group therapy ($n = 40-26$); ² Focused group therapy ($n = 37-29$); ³ Comparison group ($n = 38-25$).

or more (49% full-time, 7% worked 75%, and 13% worked half-time). At inclusion, only 25% worked half-time. The pattern of return to work differed somewhat between the groups, but that could be explained by differing patterns at inclusion. Therefore, the conclusion was that even with respect to return to work there was no difference between the three treatment conditions.

DISCUSSION

The results showed that the patients included in the study improved significantly on all study variables during a time span of one year. A majority had started to work again, and many also showed a clinical improvement in accordance with the conservative change indicator RCI. However, no significant differences could be detected between the treatment groups and the comparison condition.

It is a problem that we were not able to include a no treatment control, in spite of our intentions to do so. Strictly speak-

ing, one could argue that we were unable to demonstrate that the specific treatments had any effect on the patients' symptoms. The outcome could be the result of a spontaneous remission. The fact that after an average of six months of sick leave the patients still had a relatively high symptom level, although significantly reduced during treatment, might also not be convincing enough. However, it should be pointed out that in another study of the same patients participating in the FGT, it was found that the general level of alliance to the group-as-a-whole, averaged over time, was predictive of two out of three outcome measures (GSI, $p = .003$; Depression, $p = .061$; Anxiety, $p = .002$). In an exploratory examination of the correlations between each alliance measurement and the outcome variables it was shown that it was the alliance to the group as-a-whole at mid-phase of treatment that correlated substantially with outcome (Lindgren, Barber, & Sandahl, 2008). This suggests that the treatments in themselves contributed to the improvement and that it was not only the result of a normal recovery process. It should also be noted that more than two-thirds of the patients met the criteria for reliable change of the target symptom, depression, at the one-year follow-up. Most studies which have compared group therapy to individual treatment are based on cognitive behavior therapy. It is of importance to the field that similar findings (i.e., no difference in outcome) can be repeated with other approaches, such as cognitive and psychodynamic group therapy.

Yet, it is a complication that we know very little about natural recovery from exhaustion disorder. We aimed to use a randomized control design to deal with this complication. Our ambition was undermined by the fact that most individuals in the comparison condition sought out similar psychological treatment on their own initiative during the study period. Although disappointing for our evaluation, it might be a sign that the patient population is highly motivated to seek treatment and recovery, which was also the therapists' subjective impression. It might also have been related to the fact that the study included many highly educated individuals, with many in leading positions.

Regarding the comparison between the two group treatments, one process-oriented psychodynamic approach and one cognitive that was more didactic and structured, we failed to establish

superiority of one over the other. The two treatment approaches had some technical overlap (i.e., process work in the cognitive group and homework in the psychodynamic group). However, when one studies the videotapes taken from some of the groups, it becomes quite obvious that the two approaches differ in terms of didactic and content focus in the cognitive treatment condition and process and the “here and now” focus in the psychodynamic condition. Such anecdotal information is unfortunately of little scientific value, and it would have been helpful to systematically measure the processes in the two groups (Getter et al., 1992; Hilsenroth et al., 2005).

Considering the fact that few studies exist that compare different treatments with each in one and the same study, the present study must, in spite of its shortcomings, be considered an important contribution to psychotherapy research. The results are in fact in line with many previous comparative studies where no differences in outcome were reported (Cuipers et al., 2008; Lambert & Ogles, 2004). There seems to be accumulating evidence, including the results of this study, for the hypothesis that measures of effectiveness will show similar outcomes, when different treatment approaches and modalities are studied within the same design. If this pattern is repeated in future studies, there are reasons to question the strict division among schools of thought. Instead, we might need to continue the search for similarities and common factors across methodologies in order to develop new integrative approaches. Most probably, in future psychotherapy research we will observe a dramatic increase in studies focusing on how process factors contribute to treatment outcome. Two recent studies from one pooled study database are examples of this. In one of them, for example, it was found that improvements in self-understanding, compensatory skills, and views of self were associated with symptom change in such diverse therapies as alliance fostering, schema-focused cognitive, relationship-focused cognitive, compensatory skills, family, supportive expressive, and supportive therapy. One conclusion was that self-understanding and such compensatory skills as psychotherapeutic processes in themselves may produce changes in outcome, rather than simply co-vary with outcome (Connolly Gibbons et al., 2009). The other study found no difference in alliance measures in Motivational

Enhancement Therapy (MET) and counselling as usual, which was unexpected when one takes into consideration the heavy emphasis on such factors as empathy, acceptance, and positive regard in MET. However, therapists did vary significantly in their mean alliances, and in addition, variability in alliance at the therapist level had a curvilinear relation to outcome (Crits-Christoph et al., 2009). Based on such findings, it seems reasonable to continue to define and identify basic curative factors in therapy in general and to train therapists, belonging to different orientations, in the skills needed to reinforce such processes in therapy. There are strong reasons to assume that this kind of developmental work also will apply to group psychotherapy.

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Christer Sandahl
LIME
Karolinska Institutet
171 77 Stockholm, Sweden
E-mail: christer.sandahl@ki.se

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