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Acceptability and Efficacy of Group Behavioral Activation for Depression Among Adults: A Meta-Analysis

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The evidence base for behavioral activation (BA) as a front-line treatment for depression is grounded in individual delivery. No valid previous meta-analytic reviews of BA delivered in groups have been conducted. This study therefore examined the efficacy and acceptability of group BA drawn from clinical trial evidence. Randomized controlled trials of group BA were identified using a comprehensive literature search. Depression outcomes at posttreatment/follow-up, recovery and dropout rates were extracted and analyzed using a random-effects meta-analysis. Treatment moderators were analyzed using meta-regression and subgroup analyses. Nineteen trials were quantitatively synthesized. Depression outcomes postgroup BA treatment were superior to controls (SMD 0.72, CI 0.34 to 1.10, k=13, N=461) and were equivalent to other active therapies (SMD 0.14, CI -0.18 to 0.46, k=15, N=526). Outcomes were maintained at follow-up for group BA and moderators of treatment outcome were limited. The dropout rate for group BA (14%) was no different from other active treatments for depression (17%). Further research is required to refine the conditions for optimum delivery of group BA and define robust moderators and mediators of outcome. However, BA delivered in groups produces a moderate to large effect on depressive symptoms and should be considered an appropriate front-line treatment option.

Keywords: depression; behavioral activation; group delivery; meta-analysis; efficacy

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When a person is depressed, a widely observed symptom is behavioral avoidance, with withdrawal and reduced activity often contributing to the maintenance of low mood (Curran, Ekers, Mcmillan, & Houghton, 2012). Given this behavioral component, behavior change has long been a treatment target in the psychotherapy of depression. The initial treatment sessions of cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979) focus on behavioral techniques (i.e., activity scheduling) in order to initially lift mood, with evidence of associated early change in depressive symptoms (Ilardi & Craighead, 1994). Purely behavioral treatments for depression that share core techniques around increasing activation and eliciting positive reinforcement have existed since the 1970s.

Treatments can be clustered under four models: Lewinsohn's *pleasant events*, focusing on increasing access to pleasant events through activity scheduling (Lewinsohn, Sullivan, & Grosscup, 1980); Rehm's

self-control therapy (SCT), comprising three key elements of self-monitoring, self-evaluation, and self-reinforcement (Rehm, 1984); Martell's *contextual behavioral activation* (BA), derived from the initial BA segment of Beck's cognitive behavioral therapy (CBT) for depression manual (Martell, Addis, & Jacobson, 2001); and Lejuez's *behavioral activation treatment for depression* (BATD; Lejuez, Hopko, & Hopko, 2001). Early versions of BA applied relatively simple methods (e.g., pleasant events), while more recent developments of BA (e.g., contextual BA) are more complex. Core differences revolve around the activation approaches used to increase response-contingent positive reinforcement. SCT elaborates on the original *pleasant events* model by emphasizing the role of self-control in attenuating negative consequences of depression and using self-management skills to reinforce positive behavior change. BATD further expands on the pleasant events approach by relating goals to major life areas (relationships, hobbies etc.) and using activity hierarchies to focus on rewarding achievement of activity goals. C*ontextual* variants also incorporate values work, but have an additional emphasis on the function of avoidance and approach behaviors as a key strategy for overcoming depression (Kanter et al., 2010).

A central aspect of the BA evidence base is Jacobson's component study (Jacobson et al., 1996), as this emphasized that the cognitive elements of CBT were not necessary to achieve a good outcome with depressed patients. This evidence enabled BA to emerge as a stand-alone depression treatment (Martell et al., 2001). Subsequent BA outcome research has demonstrated that BA is an effective treatment, producing equivalent outcomes to CBT (Cuijpers, van Straten, & Warmerdam, 2007; Dimidjian et al., 2006; Ekers et al., 2014; Mazzucchelli, Kane, & Rees, 2009; Richards et al., 2016). A recent large-scale RCT found that the economic benefits of BA are also considerable, as noninferior clinical outcomes in comparison to CBT were achieved at a 21% reduced cost (Richards et al., 2016). However, the evidence base for BA is primarily based on individual treatment, with much less focus on the acceptability and effectiveness of group BA delivery.

The importance of understanding the potential of BA as a group therapy relates to its delivery as well as its potential effects. BA works by adopting an "outside-in" treatment approach, using pragmatic behavioral techniques to increase access to sources of positive reinforcement that in turn then reduce associated depressive thoughts and feelings (Curran et al., 2012). BA is therefore often characterized as a pragmatic and parsimonious treatment for depression (Jacobson et al., 1996). As fewer treatment competencies are required, therapists can be trained in a relatively short time (Ekers, Richards, McMillan, Bland, & Gilbody, 2011). The relative simplicity of BA also makes it well suited to group adaptation, as behavioral treatment principles can be easily taught, grasped, and implemented (Dimidjian, Barrera, Martell, Muñoz, & Lewinsohn, 2011). Investigation of indirect comparisons of BA treatment mode have indicated that individual and group delivery treatment effects do not differ significantly, with group BA producing a moderate effect estimate ($g = 0.62$; Ekers et al., 2014). During group treatment, patients can additionally benefit from the peer support, normalizing, and the learning opportunities created by group dynamics (Yalom & Leszcz, 2005). Groups, if acceptable to patients, are also organizationally efficient, as they optimize scarce therapeutic resources through low therapist-to-patient ratios (Kellett, Clarke, & Matthews, 2007).

A meta-analysis of group-based BA effectiveness has been reported recently (Chan, Sun, Tam, Tsoi, & Wong, 2017), but had a broad raft of methodological problems. Only seven randomized controlled trials (RCTs) were identified, which does not represent the full evidence base of clinical trials of group BA (as will be seen below). Equally importantly, the seven studies included were actually *individual* BA (Carlbring et al., 2013; Dimidjian et al., 2006; Ekers et al., 2011; Gawrysiak, Nicholas, & Hopko, 2009; Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Moradveisi, Huibers, Renner, Arasteh, & Arntz, 2013; Pagoto et al., 2013). Finally, no mention of treatment acceptability issues was made. Any clinical conclusions concerning group BA drawn from the Chan et al. (2017) meta-analysis are therefore seriously flawed.

This meta-analysis therefore focuses on the acceptability and efficacy of group BA compared to standard treatment or waitlist controls and other active therapies and seeks to identify key moderators of outcome. Identifying treatment moderators helps to establish factors that account for variations in treatment effect (i.e., under what conditions and for which patients group BA is most effective). Potential moderators include *intervention characteristics* (such as type of BA model or number of sessions) and *patient characteristics* (such as population and depression severity). If differing BA models are not equally effective, it could suggest that different levels of treatment model complexity moderate outcome, and can indicate which models may be more suitable to group adaptation. With regards to amount of treatment, what is the optimum number of group BA sessions? Providing more treatment than required is wasteful of resources, whereas not providing enough treatment risks creating a 'revolving door' for therapy services (Hansen, Lambert, & Forman, 2002). The

dose-response literature suggests a negatively accelerated association between number of sessions and improved outcome, with estimates of 13–18 sessions required to achieve a 50% recovery rate (Hansen et al., 2002; Harnett, O'Donovan, & Lambert, 2010). However, BA has shown significant reductions in depression after much briefer periods of treatment (Armento, McNulty, & Hopko, 2012; Gawrysiak et al., 2009; Hopko, Robertson, & Carvalho, 2009). Meta-analytic investigations of the effectiveness of psychotherapy for depression has shown limited association with the number of sessions, advocating the implementation of briefer treatments (Cuijpers, Huibers, Daniel Ebert, Koole, & Andersson, 2013).

In terms of population-related moderators, which patients are most suitable for group BA? Establishing patient suitability is important as the acceptability of BA is based on assumed ease of application. It has been suggested that BA may provide a useful treatment option for varied and diverse patients, often from underrepresented patient populations (Dimidjian et al., 2011). Similarly, patients can present with differing severities of depression, but the differential effects of baseline severity on group BA treatment outcome are currently unclear. The previous consensus was that severely depressed patients tend to see better outcomes when treated with pharmacotherapy, whereas psychotherapy is indicated when treating mild to moderate depression (Elkin et al., 1995). Recently, this consensus has been questioned, as numerous studies have been unable to demonstrate baseline severity moderating treatment outcome (Driessen, Cuijpers, Hollon, & Dekker, 2010; Weitz et al., 2015). Thus, psychotherapy appears to be an appropriate treatment for severe depression. BA appears particularly well suited for treating severe depressive phases, as the severely depressed patient may be unable to engage in cognitive work, or may indeed find the work a depressive trigger due to heightened guilt and self-blame (Dimidjian et al., 2006).

Ioannidis and Lau (1999) noted that the meta-analytic method was best employed when summarizing, synthesizing, and quantifying an evidence base that is made up of extant studies with high methodological quality. As RCTs champion internal as opposed to external validity, then RCTs ensure high methodological quality (Barkham, Stiles, Lambert, & Mellor-Clark, 2010). This meta-analysis therefore solely focuses on RCTs that have been conducted evaluating the effiacacy of group BA, to ensure that the quantitative synthesis was on the best avaliable evidence. To summarize, this meta-analysis had three aims: (a) assess the efficacy of group BA when compared to passive and active controls, in terms of depression outcomes and recovery rates; (b) explore moderators of outcome in terms of intervention and patient variables; and (c) define the acceptability of group BA by calculating dropout rates in comparison to passive and active controls.

Method

IDENTIFICATION AND SELECTION OF STUDIES

First, previous meta-analyses of BA were examined and cross-referenced to identify any group-based intervention studies. Second, a comprehensive electronic search was conducted to identify literature published up until October 2016, which was modified for each of four databases used (MEDLINE, PsycINFO, Cochrane Library and CINAHL). Search terms (expanded using alternative synonyms, and both U.S. and U.K. spellings) for (a) *behavioral activation/therapy* (including *activity scheduling/pleasant events*), (b) *depression,* and (c) *treatment efficacy* were combined using a mixture of MeSH, title, abstract, keywords and text word searches. Filters to human and adult populations were applied (see Appendix A for search strategy). Third, reference lists of identified articles and previous BA reviews were manually searched to identify any additional studies. The primary reviewer screened the initial title and abstracts and reviewed the full texts of all identified studies. Uncertainty regarding study eligibility was debated with two other readers to reach a consensus decision.

INCLUSION CRITERIA

RCTs of group BA, with adults aged 18 and over with a depressive disorder or elevated symptoms of depression (assessed via a clinical screening interview or self-rated symptoms scored above a defined clinical cutoff on a standardized measure of depression). There was no limitation in terms of comorbidity, as long as depression was a primary presenting problem. Studies containing child and adolescent participants, individuals with intellectual disability and participants with subclinical symptoms of depression were excluded. The methods of studies were analyzed, and the intervention was labelled BA if, and only if, the study delivered a purely behavioral treatment. Studies were labelled BA when the treatment focused on the functional analysis of behavior (in the absence of changing cognitions) and resultant behavioral change, in the pursuit of increasing positive mood. Therefore, mood-activity monitoring, activity scheduling, and behavioral activation comprised the behavioral treatment components. The Mazzucchelli et al. (2009) BA treatment definitions were used for this review: *pleasant events* (Lewinsohn et al., 1980); *self-control* (Rehm, 1984); *contextual* (Martell et al.,

2001); and *BATD* (Lejuez et al., 2001). Minimum group size was defined as three or more participants in a group in a study. There was no limit on treatment duration or setting.

Comparators included any passive control, treatment as usual (TAU), or active treatment. *Control* comparators provided patients with a *waitlist, TAU* consisted of standard routine care in clinical practice settings, such as inpatient or primary care physicians/general practitioner care and *active treatment* comparators were other psychotherapies delivered in a therapeutic format that made an additional active attempt to improve depression, including cognitive therapy (CT), cognitive behavior therapy (CBT), problem-solving therapy, supportive therapy and nonspecific psychotherapy. No language restrictions were applied, but a publicly available English-language translation of the paper was an inclusion criteria. Unpublished studies and dissertations were included if available. Those studies that did not provide sufficient data to calculate effect sizes were excluded.

OUTCOME MEASURES

Primary Outcome

The primary outcome measure was depressive symptomology measured by any psychometrically validated self-report or clinician-rated measure. A preferred measures hierarchy was used for studies that contained multiple depression outcome measures, so that a single effect size per comparison was calculated. Comparisons of self-report and clinician-rated measures demonstrate that clinician-rated outcomes generate larger effect sizes (Cuijpers, Li, Hofmann, & Andersson, 2010). Where studies used both self- and clinician-reported outcomes, self-reported outcomes took precedence in order to allow a more conservative estimate of treatment effect. The most commonly used self-report measure (i.e., BDI or BDI-II) was selected. When no self-report measure was available, clinician-rated measures were selected; the Hamilton Rating Scale for Depression (HRSD) took precedence.

Secondary Outcomes

When available, information on dropout and recovery rates was extracted as dichotomous data. Dropout rates were used as a proxy for treatment acceptability. This was defined as the percentage of noncompleters during group BA and control conditions. Noncompleters were determined by the original study authors' definition. Recovery rates were the percentage of patients at end of treatment and/or follow-up who scored below the specified clinical threshold on the primary outcome measure. Recovery definition was determined by the original study authors' definition.

QUALITY ASSESSMENT

Methodological quality was assessed using the Cochrane Risk of Bias tool (Cochrane Collaboration, 2011). Due to difficulties blinding participants and personnel in psychotherapy trials, studies were only assessed on four of the risk of bias elements: randomized allocation, allocation concealment, blind outcome assessment, and data attrition. Each element was rated for low, high, or unclear risk of bias and each study given a score based on the number of elements meeting criteria of low risk of bias (max score of four; higher scores indicating lower risk of bias). The primary author assessed all the studies and an independent rater assessed 50%. Interrater reliability was calculated using Cohen's kappa (Cohen, 1960) (where .21–.40 = fair agreement; .41–.60 = moderate agreement; .61–.80 = substantial agreement; .81–1.0 = almost perfect agreement; Landis & Koch, 1977). The kappa between the primary and independent rater was $k = .73$, indicating substantial agreement. Discrepancies in ratings were resolved through discussion to produce a final quality rating for each study.

EFFECT SIZES

Where data were available, outcomes for depression, recovery, and dropout rates were extracted at posttreatment and follow-up (8 weeks or the closest possible time point).

Standardized mean differences (SMDs) and standard error (SE) terms were computed for the difference between conditions for each comparison between BA and a comparator condition. SMDs (Cohens *d*) were calculated by subtracting the mean posttreatment score of the comparator condition from the mean posttreatment score of the BA intervention and dividing the result by the pooled standard deviation (SD) of both conditions posttreatment. Due to the risk of small-sample bias, the *J* correction was applied to convert SMDs to Hedges's *g* (Hedges & Olkin, 1985). Effect sizes were interpreted according to Cohen's criteria, where 0.2 is indicative of a small effect, 0.5 a moderate effect, and 0.8 a large effect (Cohen, 1992). Dichotomous data for recovery and dropout rates were calculated as odds ratios (OR; i.e., the percentage of recovery or dropout from group BA in comparison to passive or active controls).

A hierarchical procedure was applied to effect size calculations—means and SDs were used wherever possible, followed by effect size data, dichotomous data, and finally *t* or *F*-scores. Controlled studies with subgroups or multiple arms that were comparable

were collapsed into one group using Cochrane's recommended method (Cochrane Collaboration, 2011). Studies with multiple comparators within one comparison that could not be collapsed were included separately, with the number of participants in the shared intervention group split evenly across comparisons. For example, pair-wise comparisons of group BA with both CT and nondirective therapy from Shaw (1977) were both entered into the active therapy meta-analysis (means and SDs unchanged), with the number of patients who received group BA divided out equally between the two, to ensure patients were not included twice (Cochrane Collaboration, 2011).

META-ANALYSIS

Data were synthesized using Meta-Essentials (Suurmond, van Rhee, & Hak, 2017). Pooled effect sizes and 95% confidence intervals were computed using the inverse of the variance to weight the effect estimates (i.e., outcomes in favor of BAG were indicated by a positive effect size). Due to the expected level of heterogeneity resulting from different comparator types, a random-effects model was used to account for within- and between-study variance. Statistical significance was set at an alpha value of 0.05. Heterogeneity was investigated using the I^2 statistic to indicate percentage of variation and the accompanying Q statistic to report the statistical significance. Heterogeneity benchmarks (Higgins, Thompson, Deeks, & Altman, 2003) were used to identify low (25%), moderate (50%), and high study heterogeneity (75%). Pooled effect sizes were then converted into numbers needed to treat (NNT; Kraemer & Kupfer, 2006). NNT provides an estimate of the number of patients who would need to be treated by the group BA intervention to produce one additional beneficial outcome over a comparator condition.

SUBGROUP AND MODERATOR ANALYSIS

Sources of heterogeneity within comparisons were investigated using planned subgroup and moderator analyses. Subgroup analysis was used to investigate four categorical variables: control/therapy type (waitlist/TAU and CBT/other psychotherapy); assessment type (clinical interview/elevated symptoms above clinical cutoff); type of BA (pleasant events/self-control/contextual/BATD); and population (young adults/adults/older adults). Meta-regression was used to investigate five continuous variables: study quality (0–4 risk of bias items); baseline depression (standardized Z-scores); gender (proportion of males); number of group sessions and group size. The beta-coefficient significance threshold was adjusted to $p < 0.01$ to account for multiple testing (Thompson & Higgins, 2002), and a minimum of 10 studies was required to investigate moderators within comparisons (Cochrane Collaboration, 2011).

PUBLICATION BIAS

Where there were sufficient numbers of studies ($k > 10$), publication bias was assessed via visual inspection of asymmetry on a funnel plot of SEs against effect sizes. Additional statistical analysis of study distribution asymmetry was undertaken using the funnel plot regression method (Macaskill, Walter, & Irwig, 2001). Trim and Fill imputation of missing data gave an adjusted estimate effect, accounting for publication bias (Duval & Tweedie, 2000).

Results

STUDY SELECTION

After the removal of duplicates, searches identified 5,335 records to be screened (Figure 1). Title and abstract screening identified 78 articles to be retrieved for full-text review. Upon review, 59 were excluded (reasons outlined in Figure 1), leaving a total of 20 studies meeting the inclusion criteria. One remaining study was identified as an outlier and excluded [20] from the quantitative synthesis. This was due to a very large effect size ($d = 5.76$) in favor of group BA compared to waitlist. Removal of this single study was conservative and favored the null hypothesis; this was deemed appropriate to reduce the risk of overestimation of overall effect of BA.

Study details and quality ratings are available in Appendix B. Of the $N = 19$ studies included, quality ranged from zero to three quality standards met (max four). Overall study quality was poor. In particular, nearly all studies provided unclear descriptions of randomization and concealment procedures (see Appendix C for full quality ratings). Only one study was classed as high quality (met three or more quality criteria). Eight studies were deemed medium quality (met 1–2 quality criteria), while the remaining 11 studies were classed as low quality (met 0 quality criteria).

META-ANALYSIS OF GROUP BA

Study Characteristics

Nineteen studies were included across two meta-analytic comparisons. Group BA was compared to controls across 13 studies and active therapies in 12 studies across 15 comparisons. In the control comparisons, 9 studies compared BA with a waitlist control and 4 used TAU. TAU consisted of inpatient ($N = 3$) and outpatient ($N = 1$) standard treatment, with varying levels of daily to weekly contact during the study period. In the active therapy comparisons

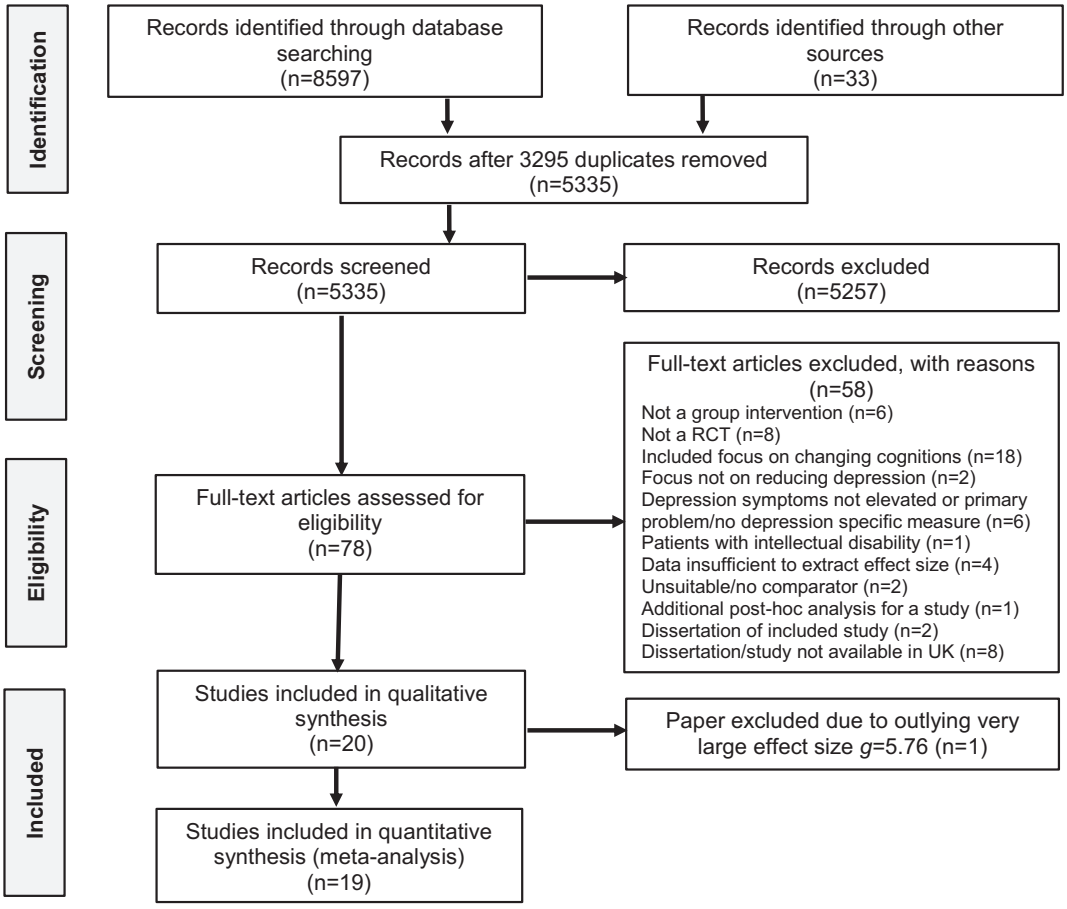

FIGURE 1 PRISMA flowchart of study selection.

CBT/CT was the most common comparison psychotherapy ($N = 5$). The treatment comparators included supportive psychotherapy, psychodynamic psychotherapy, nondirective psychotherapy, problem-solving, and assertiveness training. All comparator active therapies were delivered in a group format. Participants were recruited from the community ($N = 10$), Universities ($N = 3$) and clinical services ($N = 6$; outpatient $N = 2$, inpatient $N = 4$). Depression was diagnosed via clinical interview ($N = 17$) or self-report symptoms exceeding a depression measure clinical cutoff ($N = 2$). Depression symptomology was assessed via self-report ($N = 10$), clinician report ($N = 1$), or a combination ($N = 8$). The most commonly employed self-report outcome measure was the BDI or BDI-II ($N = 15$), and the most commonly employed clinician-rated outcome measure was the HRSD ($N = 7$). Follow-up duration ranged from 2–32 weeks across $N = 13$ studies. The mean follow-up period was 6 weeks.

BA group studies were conducted on adults in the general population ($N = 14$), students ($N = 3$) and older adults ($N = 2$). Mean depression severity at intake ranged between mild ($N = 6$), moderate ($N = 8$) and severe ($N = 4$). One study did not report sufficient information to establish baseline severity. Three studies focused on treating a primary problem of depression in conjunction with comorbid disorders (substance abuse and anxiety). BA treatment type included pleasant events ($N = 8$), self-control ($N = 6$), contextual ($N = 2$) and BATD ($N = 3$). Group sizes ranged from 3-10 participants with a mean of 7, treatment duration ranged from 2–12 sessions, with session duration ranging from 30–120 minutes. Dropout rates ranged between 0–33% but were unreported in 9 studies. Recovery rates ranged from 25-100% but were unreported in 12 studies. Recovery was defined by use of clinical cut-offs on measures (N = 5) and MDD diagnosis (N = 2). Intent-to-treat analysis was used in N = 4 studies, with the remaining 15 studies using completers analyses.

COMPARISON 1: GROUP BA VERSUS WAITLIST/TAU CONTROL COMPARATORS

Depression at Posttreatment: Group BA Versus Waitlist/TAU

Posttreatment outcomes from 13 studies contributed to this analysis, totaling $N = 461$ participants (group BA $N = 244$; control $N = 217$). The overall aggregated SMD was 0.72 (95% CI 0.34 to 1.10; Z =

4.15; $p < 0.0001$) in favor of group BA, suggesting a significant moderate to large effect (Figure 2). Group BA was effective at reducing depressive symptoms at treatment completion, when compared to waitlist and TAU controls. The NNT for group BA was 2.57; one out of every three patients experiences additional benefit from group BA when compared to controls at treatment completion. There was significant between-study heterogeneity contributing to moderate variation in effect (I^2 = 58%; Q = 28.72, p = 0.004).

Subgroup analysis and meta-regression results are displayed in Table 1. Significant variation in effect size was associated with type of control condition. A large effect was observed for waitlist controls, but the effect for group BA was small and nonsignificant when compared to TAU. Treatment effects were not significantly affected by assessment method, type of BA, or sample population. Moderate heterogeneity was evident in the majority of subgroups. Although not significant, moderating effects of study quality were in the direction of more favorable effects for group BA in lower-quality studies. Meta-regression analyses found initial depression severity, gender, number of sessions, and group size were not associated with improved treatment outcomes.

Funnel plot inspection gave a slight suggestion of asymmetry (see Appendix D). This indicates that smaller studies may have tended to produce larger effects in favor of group BA. The adjusted effect size produced by Trim and Fill imputation of missing data produced a slightly smaller moderate effect size (0.65, 95% CI 0.25 to 1.05). Testing the extent of asymmetry via funnel plot regression showed sufficient symmetry of study distribution (B = -0.004, $t(11) = -0.76$, $p = 0.47$).

Depression at Follow-up: Group BA Versus Waitlist/TAU

Four studies (waitlist $k = 1$; TAU $k = 3$) had follow-up comparisons with a total of $N = 129$ participants (group BA $N = 64$; control $N = 65$). There was a moderate pooled SMD of 0.69 (95% CI 0.19 to 1.19; $Z = 4.42$; $p < 0.0001$) in favor of the maintained effects of group BA at follow-up (Figure 2). Group BA therefore appeared effective at sustaining

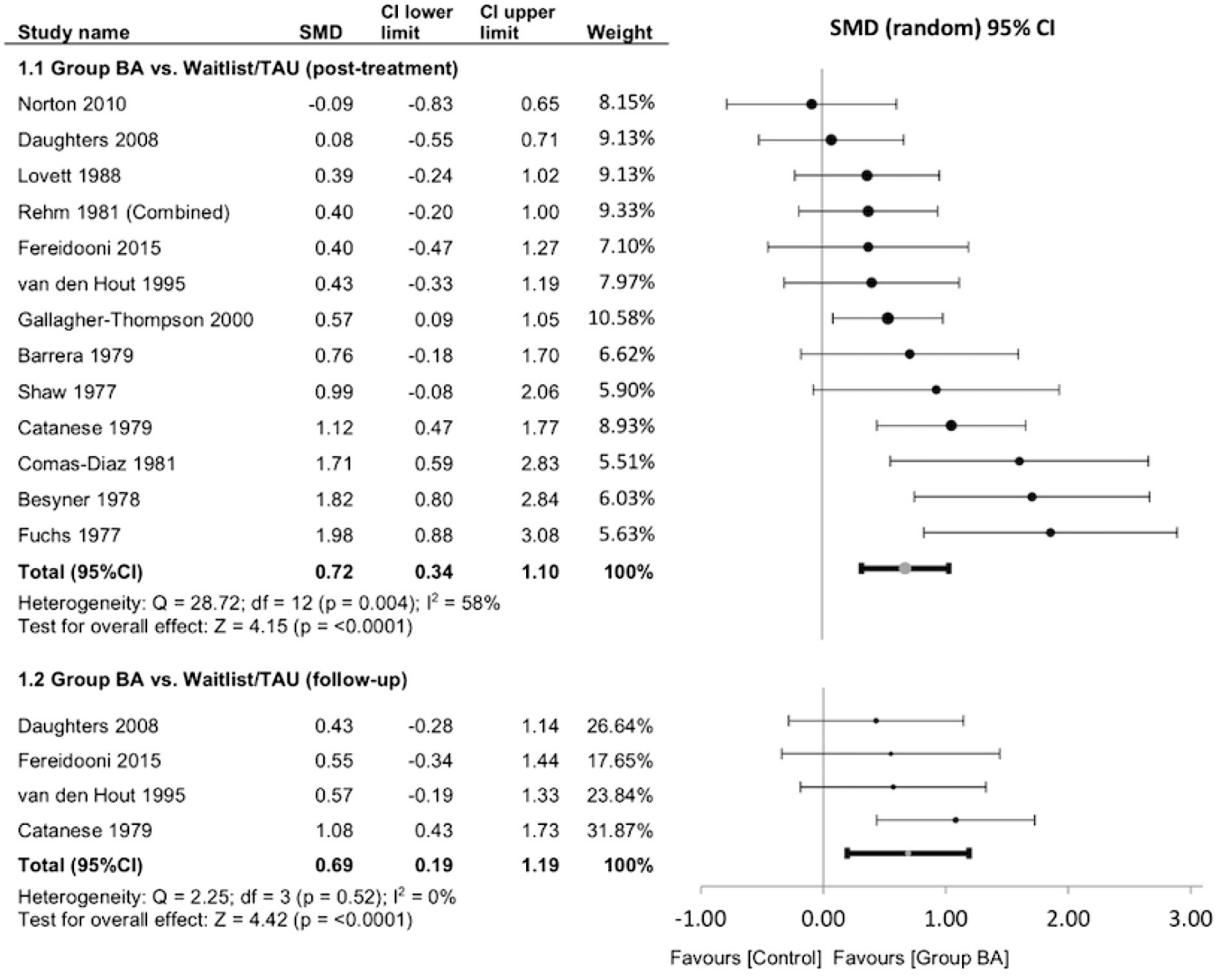

FIGURE 2 Forest plot of posttreatment and follow-up depression symptom effect sizes for group BA versus waitlist/TAU.

Table 1
Subgroup and Meta-Regression Analysis of Group BA Versus Controls (Posttreatment)

Subgroup analysis		**No. of Comparisons**	**SMD (*g*)**	**95% CI**	**I^2(%)[a]**	**P (between subgroups)**	**NNT**
Control type	Waitlist	9	1.02**	0.69 to 1.35	32	0.01**	1.89
	TAU	4	0.20	-0.28 to 0.68	0		8.89
Assessment method	Clinical interview	11	0.75*	0.38 to 1.12	55*	0.72	2.57
	> clinical cut-off	2	0.53	-0.68 to 1.73	84*		3.42
BA type	Pleasant events	7	1.01**	0.62 to 1.40	4	0.08	1.91
	Self-control	3	0.87**	0.27 to 1.46	63*		2.17
	Contextual	1	0.40	-0.64 to 1.44	-		4.49
	BATD	2	0.00	-0.71 to 0.70	0		-
Population	Adults general	10	0.81**	0.44 to 1.17	25	0.26	2.31
	Young adults	2	1.06*	0.24 to 1.89	0		1.83
	Older adults	1	-0.09	-1.23 to 1.05	-		-19.71
Meta-regression analysis		**No. of Comparisons**	**B-coefficient**	**95% CI**	**SE**	**P**	**NNT**
Quality (risk of bias)	(0-4 criteria)	13	-0.31	-0.69 to 0.07	0.18	0.08	-
Initial depression severity	(z scores)	13	0.02	-0.35 to 0.38	0.17	0.93	-
Gender	(% of males)	13	-0.01	-0.02 to 0.00	0.01	0.08	-
Number of sessions	(2-12 sessions)	13	-0.11	-0.23 to 0.01	0.06	0.05	-
Group size	(3-10 patients)	13	0.02	-0.20 to 0.23	0.10	0.86	-

Note: *significant at $p < .05$ threshold; **significant at Bonferroni adjusted $p < .01$ threshold. [a] P value of Q-statistic as I^2 does not have a test of significance; [b]Effect non-significant when controlling for control type. Positive effect size indicates in favor of group BA. Abbreviations: TAU: treatment as usual; SMD: standardized mean difference; CI: confidence interval; SE: standard error; NNT: Numbers needed to treat; BATD: behavioral activation treatment for depression.

improvement at follow-up compared to controls. The NNT was 2.67, indicating that at follow-up one out of every three participants experienced additional benefit from group BA compared to controls. Studies were statistically homogeneous (I^2 = 0%; Q = 2.25, p = 0.52), even when taking a higher significance level threshold ($p < 0.1$) to account for low power from the small number of studies. Limited variance between studies negated the need for further heterogeneity analysis. There were an inadequate number of studies ($k < 10$) to test for publication bias.

Recovery and Dropout Rates; Group BA Versus Waitlist/TAU

Two studies (waitlist k = 2) reported recovery rates for 118 participants (group BA N = 64; control N = 54). Recovery rates were significantly higher following group BA than waitlists (group BA 52%, control 28%), producing a significant odds ratio of 2.99 (95% CI 0.20 to 43.86; Z = 5.17; p = <0.001). More participants recovered after receiving group BA than those allocated to a waitlist condition. All studies were statistically homogeneous (I^2 = 0%; Q = 0.25, p = 0.62).

Five studies (waitlist k = 4; TAU k = 1) reported dropout rates for 325 participants (group BA N = 185; control N = 140). There was no difference in dropout rates between group BA (15%) versus control conditions (17%), with a nonsignificant odds ratio of 0.69 (95% CI 0.21 to 2.29; Z = 0.86; p = 0.20). Patient dropout rates were matched across group BA (15%), waitlist (18%) and TAU (14%). Between-study variance was minimal and not significant (I^2 = 24%; Q = 5.26, p = 0.26). Limited heterogeneity and the small number of studies reporting recovery and dropout outcomes constrained further investigation into sources of variation in effect sizes. The number of studies of group BA reporting recovery and dropout rates were insufficient to perform any publication bias tests.

COMPARISON 2: GROUP BA VERSUS OTHER ACTIVE PSYCHOTHERAPIES

Depression at Posttreatment in Group BA Versus Other Active Psychotherapies

Posttreatment outcomes from 15 comparisons contributed to this analysis, totaling N = 526 participants (group BA N = 254; active psychotherapies N = 272). There was no difference in the effect of group BA when compared to other psychotherapies, with a nonsignificant SMD of 0.14, tending towards being in favor of group BA (95% CI -0.18 to 0.46; Z = 0.87; p = 0.38) (Figure 3). Group BA was as effective at reducing depressive symptoms as other active psychotherapies. The NNT for group BA was 12.68.

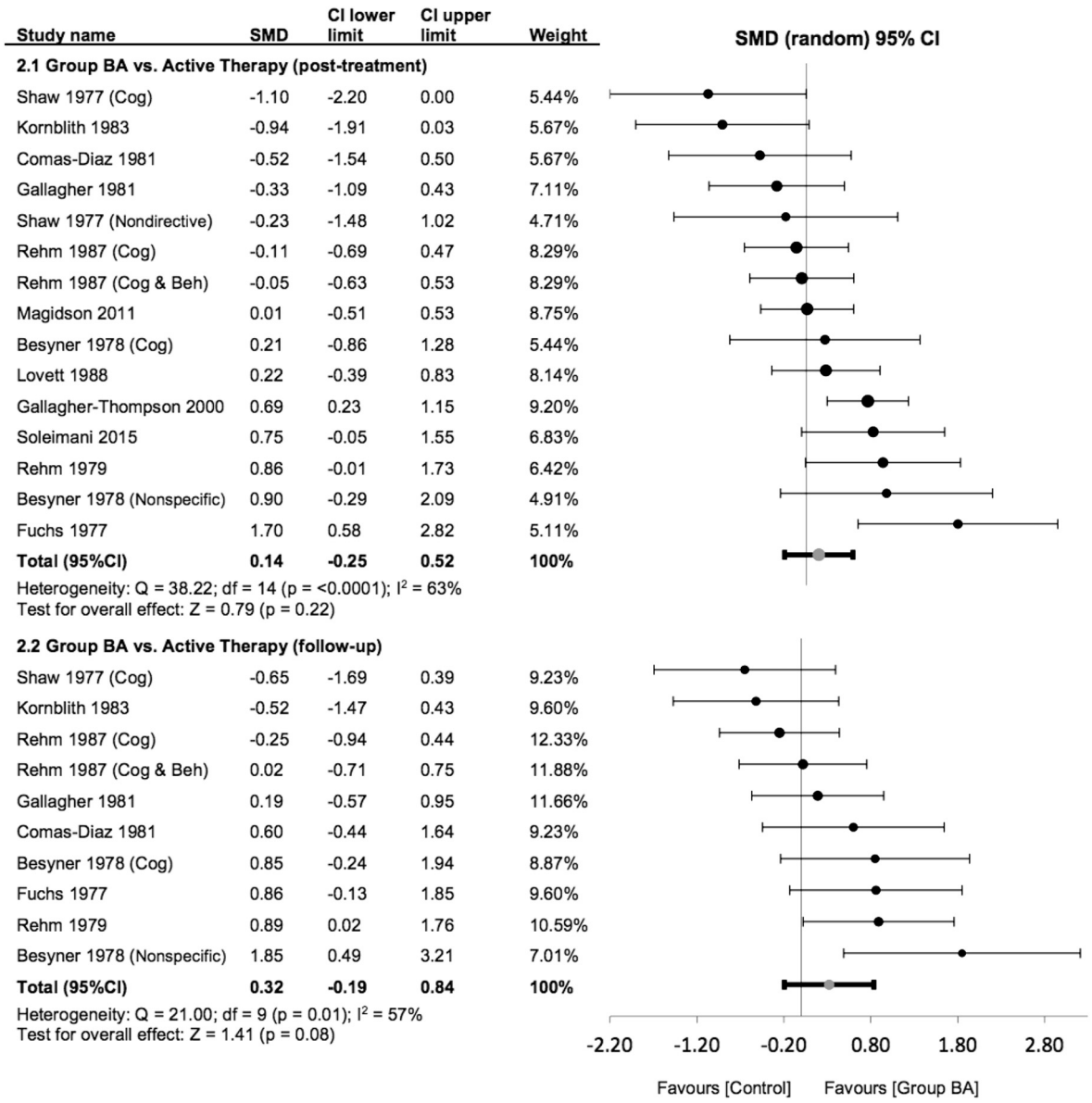

FIGURE 3 Forest plot of posttreatment and follow-up depression symptom effect sizes for group BA versus active treatment.

This indicates 1 out of every 13 participants would experience additional benefit posttreatment from being in a group BA treatment, when compared to other psychotherapies. Between-study heterogeneity was moderate and significant (I^2 = 63%; Q = 38.22, p = 0.0005).

Further investigation into variations in effect estimate is displayed in Table 2. Subgroup analyses of different psychotherapies found that group BA compared to CBT/CT therapies resulted in a minimal nonsignificant effect. When compared to other psychotherapies, group BA resulted in a small (nonsignificant) effect that leaned towards favoring it as a treatment. Significantly differing effect sizes were not evident when comparing different types of BA or the sample populations (all studies used clinical interviews, so assessment type was not assessed as a moderator). There was moderate heterogeneity present in most of the subgroups. Meta-regression analyses found limited evidence of variation in effect sizes according to study quality, initial depression severity, gender, number of sessions or group size.

Funnel plot inspection did not suggest evidence of asymmetry (see Appendix D), with funnel plot regression providing evidence of a symmetrical study distribution (B = 0.005, t(14) = 1.09, p = 0.30). Trim and Fill imputation estimated one study was missing and produced an adjusted overall effect estimate of 0.21 (95% CI -0.18 to 0.61), representing a slight increase in favor of group BA, albeit still not

Table 2
Subgroup and Meta-Regression Analysis of Group BA Versus Active Therapy (Posttreatment)

Subgroup analysis		**No. of Comparisons**	**SMD (*g*)**	**95% CI**	**I^2(%)[a]**	**P (between subgroups)**	**NNT**
Therapy type	CBT/CT	6	-0.10	-0.59 to 0.39	7	0.22	-17.74
	Other therapies	9	0.30	-0.10 to 0.70	30		5.95
BA type	Pleasant events	8	0.02	-0.45 to 0.49	11	0.74	88.62
	Self-control	5	0.23	-0.34 to 0.80	51		7.74
	Contextual	1	0.75	-0.53 to 2.03	-		2.48
	BATD	1	0.01	-1.13 to 1.15	-		177.24
Population	Adults general	11	0.24	-0.13 to 0.62	11	0.53	7.42
	Young adults	3	-0.12	-0.90 to 0.67	48		-14.79
	Older adults	1	-0.33	-1.55 to 0.89	-		-5.42
Meta-regression analysis		**No. of Comparisons**	**B-coefficient**	**95% CI**	**SE**	**P**	**NNT**
Quality (risk of bias)	(0-4 criteria)	15	-0.39	-0.91 to 0.12	0.24	0.10	-
Initial depression severity	(z scores)	14	-0.43	-1.01 to 0.16	0.30	0.15	-
Gender	(% of males)	15	0.00	-0.02 to 0.01	0.01	0.62	-
Number of sessions	(4-12 sessions)	15	-0.09	-0.22 to 0.04	0.07	0.17	-
Group size	(3-10 patients)	15	-0.09	-0.31 to 0.13	0.11	0.43	-

Note: *significant at $p < .05$ threshold; **significant at Bonferroni adjusted $p < .01$ threshold. [a] P value of Q-statistic as I^2 does not have a test of significance. Positive effect size indicates in favor of group BA. Abbreviations: CBT/CT: cognitive behavioral therapy/cognitive therapy; SMD: standardized mean difference; CI: confidence interval; SE: standard error; NNT: Numbers needed to treat; BATD: behavioral activation treatment for depression.

reaching significance. The removal of the smallest studies reduced the overall effect estimate to 0.08 (95% CI -0.33 to 0.50), indicating minimal influence of a small study effect. These observations indicate a minimal effect of publication bias and suggest the effect estimate appears reasonably robust.

Depression at Follow-up in Group BA Versus Other Active Psychotherapies

Eight studies performed 10 follow-up comparisons (CBT/CT $k = 5$; other therapy $k = 5$) with a total of 240 participants (group BA $N = 122$; active psychotherapies $N = 118$). There was a small SMD of 0.32 favoring group BA (see Figure 3), but this was not significant (95% CI -0.10 to 0.74; Z = 1.50; $p = 0.13$). Group BA and the other active psychotherapies therefore produced similar maintained treatment effects at follow-up. The NNT was 6.16, indicating that by follow-up 1 out of every 6 patients experienced additional benefit from group BA. Significant between-study heterogeneity was observed representing a moderate level of variance ($I^2 = 57\%$; Q = 21.00, $p = 0.01$). Five comparisons of group BA versus CBT/CT produced similar effects at follow-up (SMD = 0.07; 95% CI -0.41 to 0.55; Z = 0.27; $p = 0.78$). BA was compared to other psychotherapies in the remaining five studies at follow-up and showed a moderate (but nonsignificant) effect in favor of group BA (SMD = 0.59; 95% CI -0.09 to 1.69; Z = 0.27; $p = 0.09$). The small number of studies prevented any further exploration of moderating variables and publication bias.

Recovery and Dropout Rates During Group BA Versus Other Active Psychotherapies

Seven studies with nine comparisons (CBT/CT $k = 4$; other $k = 5$) reported recovery rates for 351 participants (group BA $N = 169$; other psychotherapies $N = 182$). There was no difference in recovery rates following group BA compared to other psychotherapies (69% during group BA versus 61% during other active psychotherapies) with a nonsignificant odds ratio of 1.30 (95% CI 0.41 to 4.07; Z = 0.44; $p = 0.66$). The recovery rate for group BA was comparable to that of other active psychotherapies. Group BA versus CBT/CT had a nonsignificant OR of 0.39 in favor of CBT/CT (95% CI 0.04 to 4.15; Z = 0.77; p = 0.44). Group BA versus all other therapies had a nonsignificant OR of 2.72 in favor of group BA (95% CI 0.83 to 8.85; Z = 1.66; $p = 0.10$). The studies were significantly heterogeneous ($I^2 = 61\%$; Q = 20.42, $p = 0.009$), but there were insufficient studies to examine moderators of variation in effect size or to test publication bias.

Seven studies (CBT/CT $k = 1$; other therapy $k = 6$) reported dropout rates for 370 participants (group BA $N = 206$; other psychotherapies $N = 164$). There was no difference between dropout rates during group BA (14%) versus other psychotherapies (17%), with a nonsignificant odds ratio of 0.71 (95% CI 0.37 to 1.34; Z = 1.06; p = 0.29). Between-study heterogeneity was minimal and nonsignificant ($I^2 = 0\%$; Q = 5.25, $p = 0.51$). Subgroup analysis of type of psychotherapy (CBT/CT or other psychotherapies) did not result in

significantly different dropout rates (CBT/CT OR = 0.62; other psychotherapy OR = 71; $p = 0.89$). Further moderator analysis and tests of publication bias were not conducted, due to insufficient number of studies.

Discussion

The objective of this meta-analysis was to quantify the acceptability and efficacy of BA when delivered in groups to treat depression and explore key potential moderators of outcome. To achieve this objective, only RCTs were selected and this enabled a comparison to be made with both passive and active controls. This analysis was conducted in order to provide guidance to commissioners and clinicians in terms of offering evidence-based treatments for depression. Particularly, this meta-analysis also has provided the first scientifically credible quantitative review of the evidence base for group BA, in contrast to the review conducted by Chan et al. (2017).

SUMMARY OF GROUP BA OUTCOMES

In relation to the first aim, the results provide support for the effectiveness of group BA in the treatment of depression across trial contexts. Compared to waitlist comparators, group BA facilitated significantly reduced depressive symptoms at treatment completion and at follow-up, improved recovery rates and equivalent dropout rates. One out of every three participants would expect to experience additional benefit from receiving group BA, when compared to waitlist. When solely compared to TAU, group BA did not add any additional benefit, with no significant differences in posttreatment outcomes. Compared to other routinely used psychotherapies for depression (including CBT), group BA produced equivalent outcomes at treatment completion and at follow-up, with matched recovery and dropout rates. The results therefore indicate that group BA offers an acceptable, equivalent, and useful treatment option in the treatment of depression, both in the short and medium term.

The moderate to large effects in the reduction of depressive symptoms and increased clinical recovery rates suggest that BA principles translate well into group format settings. The translation of BA theory to group delivery supports the notion that the principles of BA remain simple and parsimonious to deliver, regardless of context (Jacobson et al., 1996). The magnitude of the group BA treatment effect compared to controls is similar to the effect observed (SMD 0.70–0.87) for individually delivered BA (Cuijpers et al., 2007; Ekers et al., 2014; Mazzucchelli et al., 2009) and slightly larger than the Ekers et al. delivery format moderator estimate (Ekers et al., 2014). Likewise, the group BA treatment effect is comparable to the individual BA versus other treatments effect (SMD 0.13; Cuijpers et al., 2007). Furthermore, benefits of group BA were still evident at follow-up, suggesting durability of outcomes for this behavioral intervention. Therefore, it is reasonable to conclude that allocating to group BA is not detrimental to patient outcome, and that participants are as likely to engage in group treatment as individual work.

The lack of significantly different group BA outcomes compared to TAU is in contrast to effects seen for individually delivered BA (Ekers et al., 2014) and suggests TAU had a comparatively potent effect in the available studies. All but one of the present TAU studies were conducted in inpatient settings, so it may be that features of inpatient routine care bear similarities with active treatments and provide sufficient potency that is not improved on by group BA. Interestingly, while posttreatment outcomes did not support an added benefit of group BA over TAU, the significant follow-up effects of group BA versus controls were driven by comparisons with TAU. Although follow-up only comprised four studies, a similar pattern (although not quite significant) was seen for posttreatment to follow-up outcomes versus non-CBT therapies. It implies that group BA's advantage over these types of treatments may be in providing more durable beneficial effects in a format that is simpler to disseminate.

MODERATORS OF GROUP BA EFFECTIVENESS

Analysis of the variation between studies enabled investigation of moderators of group BA effectiveness in order to explore factors that contribute to the treatment effect. While such moderator analyses highlight the magnitude of treatment effect associated with certain patients, treatments and methodological factors, they do not infer causality (Cochrane Collaboration, 2011). In addition, interpretation needs to be undertaken with caution, as some subgroup arms only had a small number of studies and the high correlation of some variables (e.g., TAU and inpatient settings/BA types) potentially produces unreliable and confounded observed effects.

Group BA was used in studies with a range of participants and varied clinical presentations, and the treatment effect when compared to controls or active therapies was not related to gender, initial depression severity, assessment method, or population. The finding that there was no association between the size of treatment effect and initial depression severity is in line with extant evidence (Driessen et al., 2010; Weitz et al., 2015), and contradicts original conclusions that psychotherapy effects are larger for less severe depression (Elkin et al., 1995). The current results imply that, regardless of baseline severity of depression, participants can experience benefit from

group BA. Behavioral techniques are easily grasped and implemented by patients, even when (for example) cognitive functioning is impaired during depressed episodes (Lam, Kennedy, McIntyre, & Khullar, 2014). Differences between age population subgroups were not significant, but two of the subgroup arms were very small for control and the active psychotherapy comparisons. Inspection of the size of the effects suggested some variation; group BA was very effective for young adults and adults (versus controls), but much less effective in older adults. It may be the case that BA in groups with older adult participants needs to have relevant treatment adaptations applied, in order to retain clinical effectiveness (Pasterfield et al., 2014).

Various treatment delivery factors (group size, type of BA or number of sessions) were not associated with differences in effectiveness, when compared against controls or active therapy comparisons. Again, statistical interpretation may have been hampered by confounding variables and insufficient comparisons in the subgroup arms for types of BA. Nonsignificant variation in effect sizes for different types of BA was evident—simpler versions seem to produce the largest treatment effects, but without being statistically superior. However, the majority of the simpler, older protocols were compared to waitlist controls, while the newer, more complex protocols were compared to TAU. The lack of a definitive advantage of one version of BA highlights that the behavioral treatment model will need further refining and testing to determine the optimal conditions for group delivery.

Number of sessions was not significantly associated with the size of the treatment effect—increasing the number of group sessions did not produce better outcomes. This finding is in line with Cuijpers et al.'s meta-regression analysis (2013) and supports the argument that group BA interventions only need to be brief. Control type did produce differences in treatment effects; waitlist comparisons resulted in a large effect, but TAU comparisons only had a small beneficial effect in favor of group BA. Similar effects have been seen for other types of psychotherapy (Cuijpers, Van Straten, Bohlmeijer, Hollon, & Andersson, 2010; Cuijpers, Berking, et al., 2013; Cuijpers, Huibers, et al., 2013) and highlight the importance of the type of comparator in determining a relevant estimate of effect.

ACCEPTABILITY

The low dropout rate for group BA found in this study (14%) implies BA delivered in a group can be well tolerated by patients. A meta-analysis of dropout from one-to-one treatment for major depression found an overall weighted dropout rate of 20% (Cooper & Conklin, 2015). Treatment completion is fundamental to ensure the full benefit of treatment is received, which is especially pertinent as early termination of psychotherapy is related to poorer outcomes (Cahill et al., 2003; Hansen et al., 2002). Any claims of the organizational efficiency benefits of group delivery are offset if group attendance is poor. However, the dropout rates observed for group BA in comparison to the active controls (17%) suggests that group delivery does not suppress attendance. The equivalence of the dropout rates recorded supports the notion that BA in a group format is an acceptable treatment and mirrors meta-analytic findings for individual BA (Ekers, Richards, & Gilbody, 2008).

CLINICAL AND ORGANIZATIONAL IMPLICATIONS

Access to clinically effective group interventions generates a range of organizational benefits, in relation to efficient use of facilities, high therapist-to-patient ratios and potential reductions to treatment wait-times (Piper, 2008). Recent evidence (Richards et al., 2016) also noted the health economic advantage of BA when delivered on a one-to-one basis. Demand for psychotherapeutic treatment for depression is consistently high, and services can struggle to meet this demand while simultaneously ensuring high-quality care (Kazdin & Blase, 2011). Front-line depression treatments in clinical services should balance the evidence of clinical effectiveness with issues relating to ease of access, acceptability, and efficient use of scarce resources (i.e., balancing both effectiveness and reach). When evaluating a treatment, it is also recommended that it should be compared to the current gold-standard treatment (David, Cristea, & Hofmann, 2018). Compared to CBT, BA has an advantage of a potentially simpler, shorter training for therapists (or even nonspecialists; Ekers et al., 2011). This advantage may be particularly relevant in low-income countries, where depression contributes highly to the burden of disease but mental health resources are extremely limited (Patel, 2012; Richards et al., 2016).

There were no differences in subgroup clinical outcomes or dropout rates when group BA was compared to group CBT (or CT variations) at posttreatment and follow-up. As originally highlighted by Jacobson et al. (1996), this meta-analysis echoes that therapy focused on changing depressogenic cognitions directly might be therapeutically redundant during the treatment of depression. In fact, the comparability of group BA and all other active psychotherapy outcomes is consistent with a large body of evidence that suggests all therapies are as effective as each other (Cuijpers, 2017). Such findings

point to common factors shared between therapies producing the treatment benefits (such as therapeutic relationship, demand characteristics), rather than the protocol-specific techniques (Wampold, 2015). If this is the case, it raises questions about CBT as the gold-standard treatment for depression. CBT is recommended as the best treatment for depression (National Institute for Health and Clinical Excellence [NICE], 2016), although the evidence does not always support that CBT provides treatment effects above and beyond other treatments. In light of the potential dissemination and economic advantages of BA over CBT, conducting a noninferiority meta-analysis would be a valuable next step.

The treatment effect estimates produced by this meta-analysis are based on RCT evidence, but to what degree do these findings translate into real-world settings? While testing the efficacy of group BA using RCTs is of primary importance, it does not necessarily indicate how effective such group therapy is when delivered in naturalistic settings (Rothwell, 2005). The internally valid conditions of an RCT (e.g., patient exclusion, therapist supervision, and treatment fidelity) differ widely from the externally valid conditions of routine practice (e.g., the comorbidity of typical patient populations; Seligman, 1995). While some evidence suggests the outcomes achieved during routine practice are comparable to RCTs (Gibbons et al., 2010; Westbrook & Kirk, 2005), others have found inferior outcomes for naturalistic settings (Barkham et al., 2008; Schindler & Hiller, 2010). Whether the outcomes recorded here can be replicated in routine practice is currently unclear.

LIMITATIONS

There is a range of limitations to consider for this meta-analysis. One reviewer screened and extracted all the data, which could introduce potential bias in the data. The number of BA group studies was limited, with the majority of studies also having relatively small sample sizes (Turner, Bird, & Higgins, 2013). For primary outcomes, the number of comparisons was suboptimal for most subgroup analyses of posttreatment outcomes and, as discussed above, the resulting moderator interpretations were somewhat restricted. Even fewer studies conducted follow-up depression assessments. The follow-up periods that were reported were generally short and so were too brief to provide a truly valid assessment of the durability of group BA. The measurement period for follow-up assessments was typically between 4–12 weeks, and this should be increased to at least 1 year in future group BA outcome research. As depression has a chronically relapsing nature, whether the effects of group BA compared to controls or active therapies can be retained in the long-term is still unclear (Steinert, Hofmann, Kruse, & Leichsenring, 2014). Longitudinal tracking of outcomes following group BA, relapse rates, and any need for further intervention (e.g., behavioral "top-up" sessions) would supplement the durability evidence base for group BA. Recovery and dropout data were not widely reported, meaning investigations of moderators and publication bias were not possible for those outcomes. Future group BA outcome studies should report core information on recovery and dropout rates as standard and also report average session attendance. In terms of future controlled research, then a randomized patient preference trial (Howard & Thornicroft, 2006) directly comparing individual versus group BA would strengthen the evidence base as indirect comparisons can be confounded by factors unrelated to the treatment effect (e.g., different sample populations, comparisons of effects versus differing levels of control group rigor; Song et al., 2009).

The treatment effect reported for group BA in this meta-analysis may be subject to risk of some overestimation and imprecision. First, study quality was poor across all studies with only one study deemed to have a low risk of bias. The effect of study quality was not significant, but the lack of variation in study quality meant subgroup analysis had low power. In general, the moderating effect of study quality was in the direction of lower-quality studies producing larger effects in favor of BA. Therefore, the degree of suboptimal study quality may have contributed to an overstated overall treatment effect. It should be noted that the Cochrane risk of bias tool was used to aid comparability and consistency of Cochrane recommended methods, but it may not be the optimal tool to reflect quality issues in psychotherapy research. Use of a quality tool designed specifically for psychotherapy trials, such as the Randomized Controlled Trials of Psychotherapy Quality Rating Scale (RCT-PQRS; Kocsis et al., 2010), may be better suited to capture the most relevant validity factors.

Second, very few studies analyzed outcomes using the intention-to-treat method and observed effects were mostly based on per protocol analyses. Such "completer samples" are again at risk of overestimating treatment effects (Heritier, Gebski, & Keech, 2003). Third, the distribution of comparator types across studies was not ideal. With regards to control comparisons, the majority were waitlist conditions. Waitlist controls are prone to overestimating treatment effects in active comparators (Cuijpers, Van Straten, et al., 2010). The large difference in the group BA treatment effect compared to waitlists and TAU potentially reflects an overstated waitlist effect. It was also noted that the reporting of what TAU entailed

was often vague, which may have contributed to the heterogeneity detected in the studies and makes generalizability of the effect of TAU and group BA similarly difficult to interpret. During the active therapy comparisons, the types of other psychotherapies were very varied, which might have diluted their effect in comparison to group BA. Only CBT or CT treatments were compared in enough studies to allow comparisons by treatment type. However, as CBT is the frontline treatment for depression, this allowed subgroup comparison of group BA with the current gold-standard (David et al., 2018). Fourth, significant variation was evident across BA clinical trials, indicating moderate heterogeneity among studies, not accounted for by the use of a random-effects model or moderator effects. Results give an indication of the effectiveness of group BA, but the variability increases the statistical imprecision of the effect estimate. Finally, fewer than half the included studies included a treatment integrity check. This means that group BA might not have been delivered in a protocol-adherent way.

FUTURE RESEARCH DIRECTIONS

This evidence shows that group BA is an effective treatment. However, there is no single version of BA. Direct comparisons in clinical trials of the different versions of group BA are needed to establish the most effective behavioral approach. BA is promoted for its simplicity—therefore, adding complexity or extending treatment without improving outcomes is counterintuitive and needs testing if it is to be justified. Hence, the focus going forward in the group BA evidence base should be on identifying the most clinically effective and organizationally efficient model for BA to be delivered in a group setting and subsequent implementation into routine practice. This research could also embed longitudinal measures in the method, to allow analysis of what mediates the relationship between BA and outcome. Similarly, the suggestion regarding older adults having a poor response to group BA indicates that moderators of group BA outcomes (e.g., age) need further investigation. The moderating effect of homework compliance on treatment outcomes in relation to other therapies was restricted due to lack of data in the present review. Given the crucial link to BA outcome, this is an area that would merit additional research.

CONCLUSION

This review provides support for BA as a stand-alone treatment for depression, but has shown for the first time that a group delivery format can be adopted with confidence. Group BA appears to work across a broad population of participants, regardless of depression severity. Furthermore, group BA appears as clinically effective and acceptable as CBT, the front-line treatment for depression (NICE, 2016). In light of the high and increasing demand for depression treatment, BA should be considered as a front-line intervention, on a par with CBT. Future research should focus on establishing the optimal delivery, mediators, moderators, and long-terms effects of group BA, based on high-quality efficacy studies, and assess the degree to which outcomes then translate in routine practice settings.

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

Appendix A. Example Search Strategy

Table A1
PsycINFO search strategy

No.	Search Term	Results
1	Behavior Therapy/	13011
2	Group Psychotherapy/	18127
3	Behavioural adj activation.ti,ab	209
4	Behavioral adj activation.ti,ab	1283
5	activity schedul*.tw	239
6	Pleasant event*.tw	215
7	Pleasurable event*.tw	24
8	Rewarding event*.tw	58
9	Pleasant activit*.tw	151
10	Pleasurable activit*.tw	154
11	Rewarding activit*.tw	78
12	Behavior Therap*.ti,ab	10540
13	Behavioral Therap*.ti,ab	12112
14	Behaviour therap*.ti,ab	2239
15	Behavioural therap*.ti,ab	2784
16	Behavioral intervention*.ti,ab	7123
17	Behavioural intervention*.ti,ab	936
18	1 to 17 (combined with OR)	58438
19	Exp “Depression (emotion)”	23078
20	Exp Major Depression	108964
21	Depression.ti,ab	197549
22	Depressive.ti,ab	84048
23	Depressed.ti,ab	42813
24	Mood disorder*.ti,ab	12691
25	Depressive disorder*.ti,ab	24374
26	19 to 25 (combined with OR)	254971
27	psychotherapeutic outcomes/	4526
28	treatment effectiveness evaluation/	20480
29	clinical trials/	9924
30	Efficac*.ti,ab	117037
31	Effectiv*.ti,ab	339434
32	27 to 31 (combined with OR)	440064
33	18 AND 26 AND 32	4633
34	Limit to humans	4532
35	Limit to adults (18+)	2502
	Total	**2502**

Appendix B. Study Details

Table B1
Characteristics and quality ratings of the included studies

Study First Author	Year	Recruitment Setting	Population Age in years (mean) [range]	Sex (% male)	Interventions [*type of BA*]	Cell size at baseline	No. of sessions (duration in mins)	Measures	Initial depression severity	Follow-up (weeks)	BA Drop-out rate	Recovery Rate BA (response definition)	Risk of Bias Score (max 4)
[1] Fuchs	1977	Community	Adults (28.8) [18-48]	0	1. Self-control therapy [*self-control*] 2. Non-directive group 1. Waitlist (8 weeks)	12 12 12	6 (120)	BDI, MMPI-D	Moderate	6	33%	100% (<11 BDI)	0
[2] Shaw	1977	University	Young adults (20.1) [18-26]	31	1. Behavior modification [*pleasant events*] 2. Cognitive therapy 3. Non-directive group 4. Waitlist (4 weeks)	8 8 8 8	8 (120)	BDI, HRSD	Moderate	4	NR	25% (<10 BDI)	1
[3] Besyner	1978	Community	Adults (42.3) [NR]	29	2. Behavior therapy [*pleasant events*] 3. Cognitive therapy 4. Non-specific therapy 3. Waitlist (4 weeks)	14 10 10 16	4 (120)	BDI	Moderate	4	NR	NR	1
[4] Barrera	1979	Community	Adults (36) [NR]	50	1. Activity scheduling [*pleasant events*] 2. Waitlist (4 weeks)	10 10	8 (120)	BDI, MMPI-D	NR	4 & 28	NR	NR	0
[5] Catanese	1979	University	Young adults (NR) [NR]	~27	1. Overt reward [*pleasant events*] 2. Covert reward 3. Overt punishment 4. Covert punishment 5. Social influence 6. Waitlist (4 weeks)	26 25 25 21 26 32	2 (30)	BDI, SRDS	Mild	2	12%	NR	0
[6] Rehm	1979	Community	Adults (NR) [21-60]	0	1. Self-control therapy [*self-control*]	14 10	6 (120)	BDI, MMPI-D	Moderate	6	0%	79% (<11 BDI)	0

					2. Behavior assertion skills							
[7] Comas-Diaz	1981	Community	Low SES unemployed women (38) [NR]	0	1. Activity scheduling [*pleasant events*] 2. Cognitive therapy 3. Waitlist (4 weeks)	8 8 10	5 (90)	BDI, HRSD	Severe	5	NR	NR	0
[8] Gallagher	1981	Clinical (Outpatient)	Older adults (67.7) [NR]	45	1. Behavior therapy [*pleasant events*] 2. Supportive therapy	14 14	10 (90)	BDI, MMPI-D, SRDS	Moderate	5	14%	NR	0
[9] Rehm	1981	Community	Adults (39.2) [20-58]	0	1. Self-control therapy (combined) [*self-control]* 2. Waitlist (7 weeks)	41 15	7 (NR)	BDI, MMPI-D, HRSD	Moderate	No F-U	13%	NR	1
[10] Kornblith	1983	Community	Adults (37.9) [19-59]	0	1. Self-control therapy (combined) [*self-control]* 2. Psychodynamic therapy	34 5	12 (90)	BDI, MMPI-D, HRSD	Moderate	12	21%	65% (<BDI cut-off)	1
[11] Rehm	1987	Community	Adults (38.6) [NR]	0	1. Self-control therapy (behavioral target) [*self-control*] 2. Self-control therapy (cognitive target) 3. Self-control (cognitive-behavioral target)	35 35 34	10 (90)	BDI, MMPI-D, HRSD	Severe	24	NR	89% (no longer meet SADS/ RDC criteria for MDD)	0
[12] Lovett	1988	Community	Adults (59.3) [NR]	17	1. Increasing life satisfaction class [*pleasant events*] 2. Problem solving class 3. Waitlist (10 week)	23 20 19	10 (120)	BDI; RDC/SADS	Mild	No F-U	NR	NR	0
[13] Gallagher-Thompson	2000	Community	Adults (59.7) [31-81]	17	1. Increasing life satisfaction class [*pleasant events*] 2. Problem solving class 3. Waitlist (10 week)	56 59 46	10 (120)	RDC/SADS	Mild	No F-U	12%	79% (MDD RDC criteria)	0

(continued on next page)

Table B1

Study First Author	Year	Recruitment Setting	Population Age in years (mean) [range]	Sex (% male)	Interventions [*type of BA*]	Cell size at baseline	No. of sessions (duration in mins)	Measures	Initial depression severity	Follow-up (weeks)	BA Drop-out rate	Recovery Rate BA (response definition)	Risk of Bias Score (max 4)
[14] van den Hout	1995	Clinical (Outpatient)	Adults (34) [20-59]	39	1. Standard treatment plus self-control therapy [*self-control*] 2. Standard treatment	15 14	12 (90)	SDS; VROPSOM	Mild	13	NR	NR	0
[15] Daughters	2008	Clinical (Inpatient)	Adults (42.1) [NR]	63	1. LETS Act! plus standard treatment for substance abuse [*BATD*] 2. Standard treatment for substance abuse	20 19	6 (30-60)	BDI-II; HRSD	Moderate	2	5%	NR	1
[16] Norton	2010	Clinical (Inpatient)	Older adults 65+ (72) [65-81]	50	1. BATD plus standard hospital treatment [*BATD*] 2. Standard hospital treatment	24 25	8 (NS)	GDS	Mild	No F-U	NR	NR	3
[17] Magidson	2011	Clinical (Inpatient)	Adults (44.8) [NR]	66	1. LETS Act! [*BATD*] 2. Supportive counselling	29 29	5 (60)	BDI-II; HRSD-7	Mild	No F-U	4%	NR	2
[18] Soleimani	2015	University	Young adults (22.9) [NR]	26	1. Group BA [*contextual*] 2. Cognitive therapy	14 13	8 (90)	DASS-42 D & A sub-scale	Severe	No F-U	12.5%	71% (< DASS cut-off)	0
[19] Fereidooni	2015	Clinical (Inpatient)	Adults (32.2) [NR]	100	1. Group BA plus standard treatment [*contextual*] 2. Standard treatment and placebo (combined)	8 16	7 (NS)	BDI-II	Severe	8 & 32	NR	NR	1
Study not included in the meta-analysis													
[20] Zemestani	2016	University	Young Adults (24) [18-30]	36	1. Group BA [*contextual*] 2. Meta-cognitive group therapy 1. Waitlist (8 weeks)	15 15 15	8 (90)	BDI-II	Severe	12	0%	NR	2

Note: Abbreviations: NR: not reported; LETS Act!: Life Enhancement Treatment for Substance Abuse; BATD: behavioral activation treatment for depression; BDI-I/II: Beck Depression Inventory; MMPI-D: Minnesota Multiphasic Personality Inventory – Depression Scale; HRSD: Hamilton Rating Scale for Depression; SRDS: Zung Self-rating Depression Scale; RDC/SADS: Research Diagnostic Criteria/Schedule for Affective Disorders and Schizophrenia; VROPSOM: Dutch version of Depression Adjective Checklist; GDS: Geriatric Depression Scale; DASS-42: Depression Anxiety and Stress Scale; F-U: follow-up; MDD: Major Depressive Disorder.

Appendix C. Quality Ratings

Table C1
Methodological quality ratings for included studies rated using the Risk of Bias tool

Study	Year	Study Quality Risk of Bias Elements			
		Q1 Random allocation	Q2 Allocation concealment	Q3 Bind assessment	Q4 Data attrition
[1] Fuchs*	1977	?	?	-	-
[2] Shaw*	1977	?	?	+	-
[3] Besyner	1978	?	?	?	+
[4] Barrera	1979	?	?	-	-
[5] Cantanese	1979	?	?	-	-
[6] Rehm*	1979	?	?	-	-
[7] Comas-Diaz*	1981	?	-	-	?
[8] Gallagher	1981	?	?	-	-
[9] Rehm	1981	?	?	+	-
[10] Kornblith	1983	?	?	+	-
[11] Rehm*	1987	?	?	?	-
[12] Lovett	1988	?	?	?	-
[13] Gallagher-Thompson	2000	?	?	-	-
[14] van den Hout*	1995	?	?	?	-
[15] Daughters*	2008	?	?	+	-
[16] Norton*	2010	+	?	+	+
[17] Magidson*	2011	?	?	+	+
[18] Soleimani	2015	?	?	-	-
[19] Fereidooni*	2015	?	?	-	+
[20] Zemestani	2016	+	?	?	+

Note: (+) = Low risk of bias; (-) = High risk of bias; (?) = Unclear bias; *Indicates double rated studies

Appendix D. Publication Bias Funnel Plots

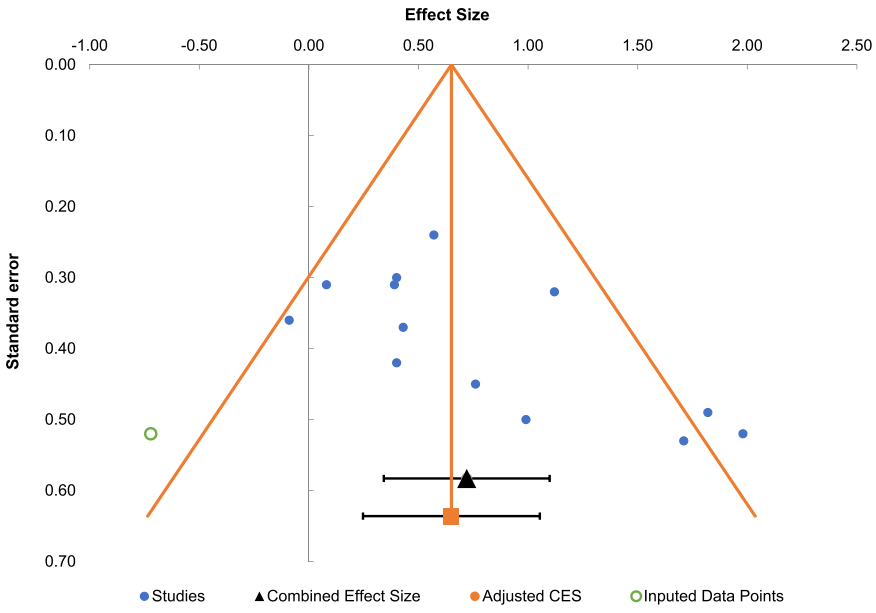

FIGURE D1 Funnel plot for group BA versus waitlist/TAU control post-treatment symptom level.

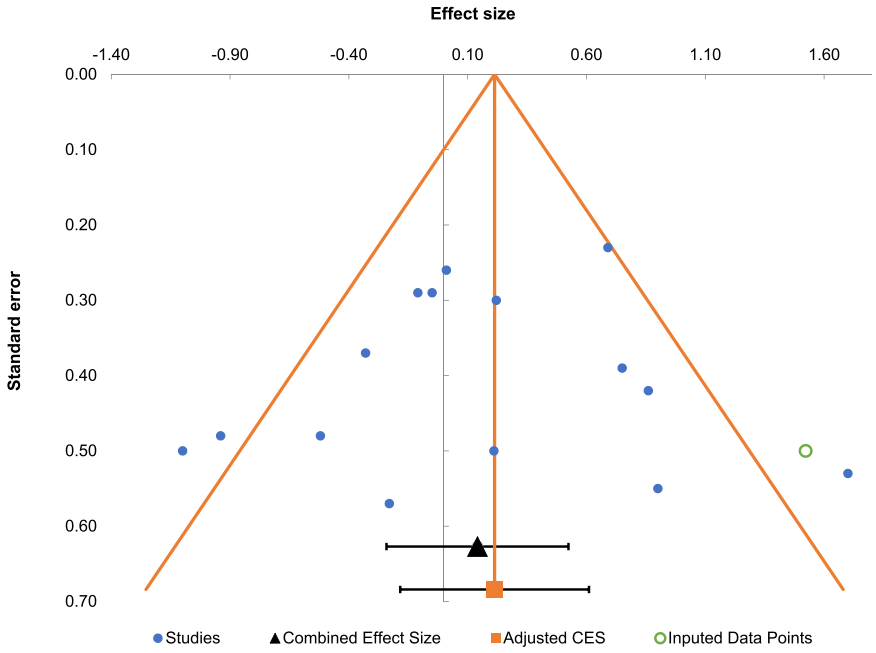

FIGURE D2 Funnel plot for group BA versus active therapy post-treatment symptom level.

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