

Effectiveness of Short-Term Dynamic Group Psychotherapy in Primary Care for Patients with Depressive Symptoms

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An open prospective controlled study was designed to compare the efficacy of short-term dynamic group psychotherapy with the standard treatment in patients with depressive symptoms attended in the primary care setting. A total of 115 patients with depressive symptoms were assigned to receive psychotherapy (75 min) over 9 months (37 to 39 sessions) ($n = 70$) or the standard care ($n = 45$). Outcome measures were the differences between baseline and post-treatment in the 17-item Hamilton Depression Rating Scale (HDRS), Hamilton Anxiety Rating Scale (HAM-A) and the Short-Form Health Survey (SF-12) questionnaire in the two study groups. At the end of dynamic group psychotherapy, statistically significant improvements in the mean scores of all questionnaires were observed, whereas in control patients, significant improvements were only observed in the HDRS-17 scale and in the Mental Component Summary score of the SF-12. The mean changes after treatment were also higher in the psychotherapy group than in controls in all outcome measures, with statistically significant differences in the mean differences in favour of the psychotherapy group. In summary, implementation of short-term dynamic group psychotherapy run by experienced psychotherapists for patients with depressive symptoms attended in routine primary care centres is feasible and effective.

Key Practitioner Message

- Short-term dynamic group psychotherapy was delivered as a non-pharmacological intervention to improve depressive symptoms.
 - Statistically significant differences as compared with a control group were observed in 17-item Hamilton Depression Rating Scale (HDRS), Hamilton Anxiety Rating Scale (HAM-A) and the Short-Form Health Survey (SF-12) questionnaire.
 - Implementation of short-term dynamic group psychotherapy run by experienced psychotherapists for patients with depressive symptoms attended in routine primary care centres is feasible and effective.
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Keywords: Dynamic Group Psychotherapy, Primary Care, Depressive Symptoms, Prospective Controlled Study

INTRODUCTION

Depressive disorders and their management is a great concern because of the high prevalence and high burden in terms of disability, treatment costs, effects of families and carers, and loss of workplace productivity (Sobocki, Jönsson, Angst, & Rehnberg, 2006; Mathers & Loncar, 2006; Gustavsson *et al.*, 2011). Depression is a leading

cause of disability worldwide and a major contributor to the global burden of disease (Ferrari *et al.*, 2013; Miller, Dell'Osso, & Ketter, 2014; WHO, 2015). Patients with mental disorders receive treatment mostly in the context of primary care (Serrano-Blanco *et al.*, 2010). More than 80% of patients with depression are managed and treated in primary care, with those seen in secondary care being skewed towards much more severe disease (Timonen & Liukkonen, 2008). Depressed hospitalized patients differ considerably in clinical characteristics from psychiatric outpatient depressives, and clinical features influence the family physician's decision to treat with antidepressants (Lampe, 2012). Although primary care remains a major

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access point for the management of depression, significant shortcomings have been recognized in detection, prescription of adequate antidepressant treatment and achievement of remission (Pence, O'Donnell, & Gaynes, 2012; Unützer & Park, 2012; Lesage, 2015). By focusing mainly on somatic complaints and diseases, general practitioners often fail to identify an underlying mental disorder (Minović *et al.*, 2015). Also, clinically significant depressive symptoms are highly prevalent in primary care patients, but the percentage of patients citing depression as a reason for visit is markedly low (Zung, Broadhead, & Roth, 1993). In primary care settings, it has been shown that screening programmes without substantial staff-assisted depression care supports are unlikely to improve outcomes (O'Connor, Whitlock, Beil, & Gaynes, 2009).

Most primary care physicians initiate and monitor treatment of depression with various pharmacological agents, but owing to time limitation, lack of knowledge or inexperience they are often unable to provide effective non-pharmacological therapeutic modalities to their patients, although psychotherapeutic interventions are recommended by clinical practice guidelines (American Psychiatric Association, 2000a; National Institute for Health and Care Excellence, 2010). In fact, depression can be effectively monitored in primary care if physicians follow established guidelines and systematically track progress (Manning & Jackson, 2015). Likewise, implementation of a multi-component programme with clinical, educational and organizational procedures in primary care has proven to be effective (Aragones *et al.*, 2012).

Dynamically oriented psychotherapies are effective interventions in a variety of mental disorders, including depression. A recent meta-analysis in which 23 studies of short-term psychodynamic psychotherapy for depression were evaluated showed a significant decrease in depressive symptoms compared with control conditions (Driessen *et al.*, 2010). In a randomized pilot investigation, moderate-to-large effect sizes in favour of a brief dynamic psychotherapy as compared with treatment as usual were reported in patients with moderate-to-severe depression in the community mental health system (Gibbons *et al.*, 2012). However, detailed and reliable data characterizing community-based psychodynamic group therapy in the real-world setting is limited (Garland *et al.*, 2010; Lorentzen & Ruud, 2014). Moreover, clinical trials assessing the effectiveness of psychodynamic psychotherapy in patients with depressive symptoms selected by the family physician and carried out in the primary care setting are lacking.

Therefore, the objective of the present study was to evaluate through a prospective controlled clinical study, the effectiveness of a short-term dynamic group psychotherapy performed in the primary care setting and addressed to patients with depressive symptoms referred to dynamic group psychotherapy by family physicians themselves.

The final goal was to determine whether results obtained in an investigation close to the patient's social and clinical reality may help to design evidence-based specific effective interventions to improve the outcome of depression.

METHOD

Participants

A prospective open-label prospective and controlled study was designed to test the hypothesis that short-term dynamic group psychotherapy delivered in the primary care setting could improve symptoms and quality of life in patients with depressive symptoms attended by the family physician. Between 2011 and 2013, patients aged 25 years or older with depressive symptoms attended by family physicians working in six primary care centres of Santa Coloma de Gramenet, Barcelona (Spain) were eligible. Santa Coloma de Gramenet is an urban area adjacent to the city of Barcelona, with a total population of 126 000 inhabitants. Patients with history or current use of cannabis, cocaine, heroin and alcohol were excluded from the study, as were patients with borderline personality disorder, psychotic symptoms (delirium, hallucinations), cognitive impairment of organic cause and fibromyalgia. The Mini-Mental State Examination (MMSE) was administered to all patients older than 65 years of age to exclude age-related cognitive dementia. The study was approved by the Ethics Committee of Parc de Salut Mar, and written informed consent was obtained from all patients.

Study Procedures

Informative sessions were carried out at each primary care centre. The objective of these sessions was to explain the audience the characteristics of group therapy for patients with depressive symptoms, how it works and how it can help.

Patients with depressive symptoms who met the inclusion criteria were assigned to psychodynamic psychotherapy (intervention) when they were referred by their family physician within the time of recruitment of a group therapy. A total of eight psychotherapy groups across the 3-year study period, with 75-min weekly sessions were established. Duration of treatment was 9 months (37–39 weeks). Typically, groups included eight or nine participants and were closed to new participants after the third session. Patients were stratified by ages (decades) for treatment, so that psychotherapies were homogeneous within a given age range. Instructions regarding the range of age that patients should have to be included in psychotherapy groups were given to family physicians by electronic mail. Patients who were not referred within the

time of recruitment of a group therapy were included in a control group. The family physician was unaware of the group (intervention or control) to which the patient was finally included. All patients were initially interviewed by a psychiatrist for clinical evaluation, to establish diagnoses according to DSM IV criteria, and to complete the study instruments. After 9 months, patients and controls were interviewed again to assess the clinical outcome.

Treatment

All dynamic psychotherapy sessions were performed in two primary care centres. At the initial interview (assessment visit), participants were explained that group psychotherapy was a space that was sought that everyone could think about and communicate their feelings. The objective of the group was to listen, be heard and to understand what was explained. At the same time, this was an opportunity to have a group experience and to understand what happens in the group. Verbal or written information was not provided.

The conceptual model followed the principles of psychodynamic psychotherapy described by Blagys and Hilsenroth (2000) emphasizing the following areas (with the level of empirical support given in parentheses): (1) a focus on affect and the expression of patient's emotions (strong support), (2) and exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy (strong support), (3) the identification of patterns in patients' actions, thoughts, feelings, experiences and relationships (strong support), (4) an emphasis on past experiences (strong support), (5) a focus on a patients' interpersonal experiences (strong support), (6) an emphasis on the therapeutic relationship (moderate support), and (7) an exploration of patients' wishes, dreams or fantasies (moderate support).

The group psychotherapy technique is based on the concept of the group as a unit of thought, shared most of the time unconsciously, which allows highlighting the individual characteristics of each member of the group (Bion, 1961). The role of the therapist to help the group to carry out the task has been explicitly elaborated in the initial interview. Within the framework described, therapists try to clarify participants' distressing situations, facilitate communication and interpret the unconscious group dynamics, with the aim to enable participants to gain more insight. In this way participants can achieve a better understanding of themselves, improve interpersonal relationships, evolve improving symptoms and reach more adaptive attitudes in everyday life. Treatment is not exclusively directed to specific disorders.

Nondirective psychotherapy was conducted by a psychiatrist-psychotherapist (aged 56 years at the beginning of the study) with more than 20-year experience in

group psychotherapy and with the collaboration of different less experienced co-therapists in five of the eight psychotherapies. Psychotherapists met regularly after psychotherapy to assess the progress of treatment as well as to discuss Yalom's therapeutic factors, particularly group cohesiveness, hope and interpersonal relationships (Yalom, 2005). All the sessions were recorded on DVD to verify a posteriori adaptation to manuals of group psychotherapy and to perform further studies in the future. Moreover, sessions were supervised regularly by an external expert in group therapy.

Patients assigned to the control group were visited at least once a month by their family physician.

Outcome Measures

Outcome measures included the 17-item Hamilton Depression Rating Scale (HDRS-17) and the Hamilton Anxiety Rating Scale (HAM-A), total and subscale Psychic Anxiety and Somatic Anxiety for the assessment of depression and anxiety, respectively, and the 12-item Short-Form Health Survey (SF-12) questionnaire for the assessment of health-related quality of life. The SF-12 measures eight health aspects, namely physical functioning, role limitations because of physical health problems, bodily pain, general health, vitality, social functioning, role limitations because of emotional problems and mental health. Two subscales are derived from the SF-12: the Physical Component Summary (PCS) and the Mental Component Summary (MCS). Higher scores represent better health (scores greater than 50 represent above average health status). Spanish validated versions of the HDRS-17 (Ramos-Brieva & Cordero, 1986), HAM-A (Lobo *et al.*, 2002), and SF-12 (Schmidt *et al.*, 2012) instruments were used. A score < 7 in the HDRS-17 represents an absence of depressive symptoms. Other data recorded included demographic (age, gender), diagnosis and antidepressant treatment prescribed by the family physician. Psychiatric diagnoses were established according to DSM-IV-TR criteria (American Psychiatric Association, 2000b).

Statistical Analysis

Categorical variables were compared with the chi-square (χ^2) test or the Fisher's exact probability test. Differences in the HDRS-17, HAM-A (total score, psychic and somatic subscales), and the Physical and Mental Components Summary scores (PCS/MCS) of the SF-12 between baseline and post-treatment (at 9 months) in the intervention and control groups were analysed with the Student's *t*-test for independent data. Mean differences of changes were analysed with the Student's *t*-test for paired data. The size effect (standardized mean effect) was expressed as

Cohen's *d*. The relationship between initial severity of depression and anxiety and improvement after treatment was assessed with the Pearson's 'product-moment correlation coefficient (*r*). Analyses were performed in the intention to treat (ITT) data set (patients who attended at least one group psychotherapy session and controls evaluated at baseline) with the last observation carried forward (LOCF) technique for missing data, and in the per-protocol (PP) data set (patients who completed all dynamic group psychotherapy sessions and patients in the control group evaluated at 9 months). Statistical significance was set at $p < 0.05$. Data were analysed with the SPSS-20 statistical programme.

RESULTS

The patient flow is shown in Figure 1. A total of 122 patients referred by the family physician, 7 did not meet the inclusion criteria at the initial interview. Of the remaining 115 patients, 70 started dynamic group psychotherapy and 45 were included in the control group. Twelve patients (17.1%) in the psychotherapy group and 14 (31.1%)

in the control group did not complete the 9-month study period. Therefore, 58 patients completed all psychotherapy group sessions and 31 patients in the control group were evaluated at 9 months. The ITT data set included 115 patients (dynamic group psychotherapy 70, controls 45) and the PP data set included 89 patients (dynamic group psychotherapy 58, controls 31).

As shown in Table 1, the percentages of men and women were higher and lower, respectively, in the psychotherapy group than those in the control group ($p = 0.038$) but differences in age and psychiatric diagnosis were not observed. Also, no significant differences were found between patients who completed the study and those who did not regarding baseline demographic variables, psychiatric diagnoses and mean scores of anxiety, depression and quality of life.

Except for two patients treated with benzodiazepines, the remaining patients were treated with selective serotonin re-uptake inhibitors (SSRIs) or serotonin and norepinephrine re-uptake inhibitors (SNRIs in five patients) at least for 3 months before the assessment interview. Only 21% of the patients had been visited in specialized centres on one or more occasions.

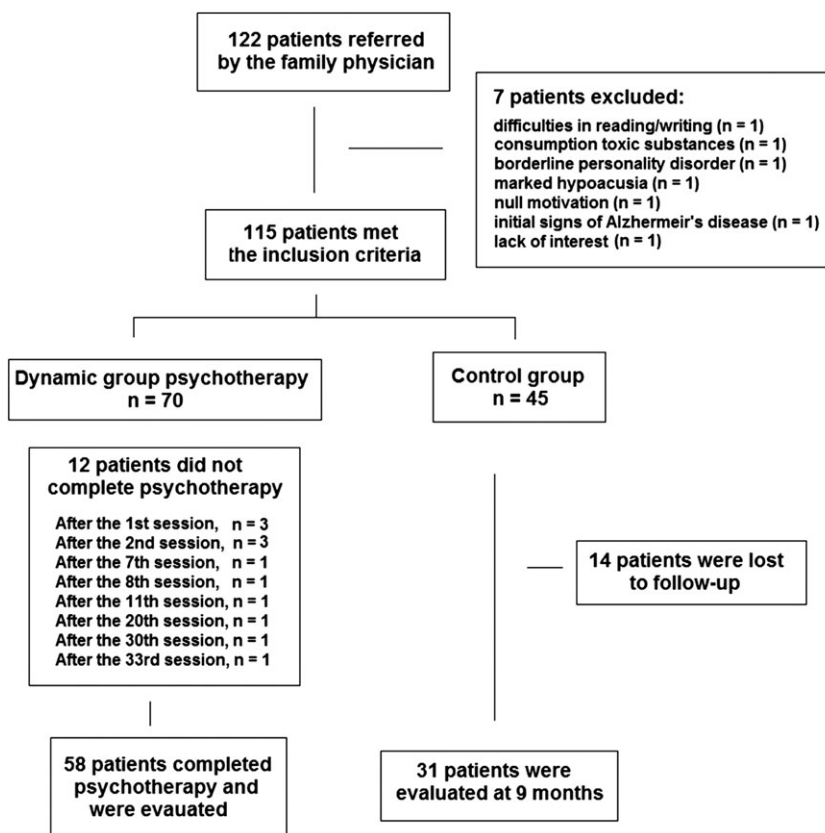


Figure 1. Flow chart of the patients included in the dynamic group psychotherapy and in the control group

Table 1. Demographic features and psychiatric diagnosis in the study groups at the time of recruitment

	Psychotherapy group (n = 70)	Control group (n = 45)	p Value
Gender			
Males	25 (35.7)	8 (17.8)	.038
Females	45 (64.3)	37 (82.2)	
Age, years, mean (SD)	49.1 (15.04)	48.4 (12.3)	.803
Diagnoses			
Dysthymia	14 (20)	7 (15.5)	.492
Cyclothymia	0	1 (2.2)	
Major depressive disorder	36 (51.4)	27 (60)	
Adjustment disorder	20 (28.6)	10 (22.2)	
	Completed the study (n = 89)	Did not complete the study (n = 26)	
Gender			
Males	25 (28.1)	8 (30.8)	.790
Females	64 (71.9)	18 (69.2)	
Age, years, mean (SD)	48.5 (13.6)	50.0 (15.6)	.624
Diagnoses			
Major depressive disorder*	49 (55.1)	15 (57.4)	.543
Dysthymia	19 (21.3)	3 (11.5)	
Adjustment disorder	21 (23.6)	8 (30.8)	
HAM-A, mean (SD)			
Psychic anxiety	16.12 (4.78)	15.38 (3.99)	.433
Somatic anxiety	12.08 (5.90)	12.38 (5.12)	.797
Total score	28.15 (9.30)	27.53 (8.04)	.737
HDRS-17 total score, mean (SD)	20.23 (5.26)	19.38 (6.03)	.581
PCS score, mean (SD)	41.13 (8.70)	42.15 (10.27)	.647
MCS score, mean (SD)	30.34 (8.33)	31.19 (10.83)	.712

*Included one case of cyclothymia.

Data as numbers and percentages in parenthesis unless otherwise stated.

Table 2 shows the mean (SD) values of the HDRS-17, HAM-A (total score, psychic and somatic subscales), and the PCS and MCS scores of the SF-12 at baseline and at the end of treatment in the intervention and the control groups both in the analyses of the ITT and PP data sets. At baseline the study sample was homogeneous with high scores in the depression and anxiety scales and low quality of life. At the end of dynamic group psychotherapy, statistically significant improvements in the mean scores of all questionnaires were observed, both in the ITT and PP populations. In control patients, significant improvements were only observed in the HDRS-17 scale and in the MCS score of the SF-12.

In both the ITT and PP data sets, the mean (SD) changes after treatment were also higher in the psychotherapy group than in controls in all outcome measures, with statistically significant differences in the mean differences in favour of the psychotherapy group: HAM-A total anxiety, 10.57 (95% confidence interval [CI] 7.50–13.64, $p < 0.001$); HDRS-17, 7.63 (95% CI 5.25–10.02, $p < 0.001$); PCS, 3.95 (95% CI 0.49–7.41, $p = 0.026$) and MCS, 7.73 (95% CI 3.38–12.09, $p = 0.001$) (Table 3). Large effect sizes were found for improvements in total anxiety ($d = 1.25$) and depression ($d = 1.23$) and medium effect sizes for improvements in PCS ($d = 0.45$) and MCS ($d = 0.64$).

As shown in Figures 2 and 3, there was a statistically significant relationship between severity of anxiety and depression at baseline and improvements after treatment in the PP population ($r = -0.670$, $p < 0.001$ for total anxiety; $r = -0.692$, $p < 0.001$ for depression). In the ITT population, the relationship between severity of anxiety and depression at baseline and improvements after treatment was also statistically significant ($r = -0.591$, $p < 0.001$ for total anxiety; $r = -0.504$, $p < 0.001$ for depression).

At the end of the study, the percentage of patients with absence of depressive symptoms (score < 7 in the HDRS-17) was 44.8% (26/58) in the dynamic group psychotherapy and 12.9% (4/31) in the control group ($p < 0.001$).

To assess whether psychotherapy was consistent with characteristics of dynamic psychotherapy reported by Blagys and Hilsenroth (2000), a random sample of two sessions recorded on DVD was evaluated by four independent experts in psychotherapy. Of the 138 interventions carried out by therapists in the two sessions, the four experts agreed that 89% of the content corresponded to the characteristics established by Blagys and Hilsenroth (2000).

DISCUSSION

The present study evaluates the effect of adding dynamic group psychotherapy to pharmacological treatment for patients with depressive symptoms attended in the primary care setting. Short-term dynamic psychotherapy (weekly sessions over a 9-month period) conducted by experienced psychotherapists and delivered at the primary care centres was effective in reducing symptoms of anxiety and depression, as well as improving health-related quality of life. The effect size was very large for anxiety and depression and moderate for quality of life. The moderate effect size for the PCS and MCS of the SF-12 may be explained by the presence of two psychotherapy groups with patients older than 65 years of age, in which the presence of other chronic conditions is common. Also, the observation of a significant correlation between severity of anxiety and depression at baseline and improvement after treatment indicates that dynamic group psychotherapy is

Table 2. Mean (SD) scores at baseline and at the end of the study in patients undergoing dynamic group psychotherapy and in controls

	Dynamic group psychotherapy				Control group			
	No. patients	Baseline	Post-treatment	<i>p</i> Value	No. patients	Baseline	At 9 months	<i>p</i> Value
HAM-A								
Psychic anxiety								
ITT data set	70	15.43 (4.14)	10.13 (4.69)	<.001	45	15.73 (4.25)	15.02 (5.23)	.182
PP data set	58	15.62 (4.19)	9.22 (4.33)	<.001	31	14.94 (3.59)	13.9 (4.95)	.184
Somatic anxiety								
ITT data set	70	12.53 (5.34)	6.87 (4.55)	<.001	45	11.71 (4.61)	12.06 (5.91)	.697
PP data set	58	12.74 (5.38)	5.91 (3.79)	<.001	31	11.98 (5.24)	12.22 (6.05)	.699
Total score								
ITT data set	70	27.80 (8.39)	17.0 (8.25)	<.001	45	27.47 (8.25)	27.24 (10.18)	.830
PP data set	58	28.19 (8.64)	15.16 (7.25)	<.001	31	26.29 (6.73)	25.97 (9.83)	.831
HDRS-17 total score								
ITT data set	70	19.26 (6.03)	9.73 (6.38)	<.001	45	20.07 (5.59)	18.18 (6.36)	.029
PP data set	58	19.31 (6.21)	7.81 (4.67)	<.001	31	19.52 (5.79)	16.77 (6.45)	.028
PCS score								
ITT data set	70	41.37 (10.1)	44.19 (10.21)	.010	45	42.79 (9.73)	43.29 (11.52)	.428
PP data set	58	41.89 (10.36)	45.29 (10.27)	.010	31	42.64 (10.3)	40.99 (10.8)	.431
MCS								
ITT data set	70	31.78 (11.3)	42.43 (10.89)	<.001	45	29.78 (8.47)	33.18 (11.13)	.020
PP data set	58	31.71 (12)	45.17 (10.13)	<.001	31	30.21 (8.39)	35.16 (11.6)	.019

HAM-A = Hamilton Anxiety Rating Scale. ITT = intention to treat. PP = per protocol. HDRS-17 = 17-item Hamilton Depression Rating Scale. PCS = Physical Component Summary. MCS = Mental Component Summary.

a valuable complementary strategy for patients with severe disease. The fact that similar results were obtained in the PP and ITT analyses (in ITT analysis the estimation of the treatment effect is more conservative) adds strength to the present findings.

In our country, it has been reported that about 70% of patients with mental health disorders are exclusively treated by family physicians (Serrano-Blanco *et al.*, 2010). Although depressive disorders are the most common mental health problems in the community setting, screening instruments are not diagnostic tools and their use may overestimate the prevalence of depression (Bros Cugat & Jara Martin, 2015). Despite strong efforts, the diagnosis and management of depression bring many challenges in the primary care setting. There is no evidence from randomized controlled trials (RCTs) of better health outcomes as a result of screening for depression. In fact, there are numerous factors suggesting that depression screening, even with collaborative depression care, may not be beneficial for patients. These include the high rate of patients already treated, uncertainty about the ability of depression screening tools to accurately identify previously unrecognized patients and relatively small treatment effects among patients with less severe depression who would be most likely to be identified through screening. According to recommendations of the Canadian Task Force on

Preventive Health Care (CTFPHC), routine screening would expose some patients to avoidable risks and would pose a significant cost burden (Thombs & Ziegelstein, 2013). Also, the United States Preventive Services Task Force (USPSTF) recommendation to screen adults for depression in primary care settings when staff-assisted depression management programmes are available is not supported by evidence from any RCTs that are directly relevant to the recommendation (Thombs *et al.*, 2014). In our study, no routine screening method was used. Patients with depressive symptoms were evaluated by the family physician and diagnosis of depression confirmed by criteria of the DSM-IV-R. Then, patients who gave consent were referred to dynamic group psychotherapy.

In terms of potential limitations, the non-blinded evaluation of patients and the unknown number of patients who were approached by the family physician and refused treatment should be considered. However, in order to cause a minimum interference in referrals, patients were assigned to psychodynamic psychotherapy when they were referred by the family physician within the time of recruitment of a group therapy, otherwise they were included as controls. Also, data were obtained from validated symptom-oriented measures and in real-world clinical practice. The high percentage of women and the distribution of diagnosis of severity of disease are

Table 3. Mean (SD) changes after treatment and mean differences in the two study groups

	Mean (SD) changes after treatment				Mean differences (95% confidence interval)	<i>p</i> Value
	No. patients	Psychotherapy group	No. patients	Control group		
HAM-A						
Psychic anxiety						
ITT data set	70	-5.30 (5.36)	45	-0.71 (3.52)	4.58 (2.94 to 6.23)	<.001
PP data set	58	-6.39 (5.26)	31	-1.03 (4.22)	5.36 (2.94 to 6.23)	<.001
Somatic anxiety						
ITT data set	70	-5.65 (5.56)	45	0.24 (4.18)	5.90 (4.09 to 7.70)	<.001
PP data set	58	-6.82 (5.42)	31	0.35 (5.06)	7.18 (4.83 to 9.52)	<.001
Total score						
ITT data set	70	-10.08 (9.69)	45	-0.22 (6.89)	10.57 (7.50 to 13.64)	<.001
PP data set	58	-23.03 (9.16)	31	-0.32 (8.35)	12.71 (8.77 to 16.64)	<.001
HDRS-17 total score						
ITT data set	70	-9.52 (6.71)	45	-1.88 (5.59)	7.63 (5.25 to 10.02)	<.001
PP data set	58	-11.50 (5.61)	31	-2.74 (6.59)	8.75 (6.11 to 11.39)	<.001
PCS score						
ITT data set	70	2.82 (8.90)	45	-1.34 (9.50)	3.95 (0.49 to 7.41)	.026
PP data set	58	3.40 (9.69)	31	-1.64 (11.48)	5.05 (0.47 to 9.62)	.031
MCS						
ITT data set	70	11.14 (14.1)	45	3.40 (9.47)	7.73 (3.38 to 12.09)	.001
PP data set	58	13.45 (14.7)	31	4.94 (11.13)	8.5 (2.57 to 14.3)	.005

HAM-A = Hamilton Anxiety Rating Scale. ITT = intention to treat. PP = per protocol. HDRS-17 = 17-item Hamilton Depression Rating Scale. PCS = Physical Component Summary. MCS = Mental Component Summary.

consistent with data reported in other studies (Ruiz, Silva, & Miranda, 2001; Blackmore *et al.*, 2009). The fact that age limit was not an inclusion criteria may explain the high mean age of our patients (49.1 years), and it has been shown that dynamic group psychotherapy is beneficial for elderly people (Canete, Stormont, & Esquerro, 2000).

Patients discontinued group therapy mostly during the first sessions, as previously reported (Blackmore, Tantam, Parry, & Chambers, 2012), although a more comprehensive assessment of the indication of psychotherapy or in-depth evaluation of the patients' motivation may reduce the number of patients lost to continue with treatment.

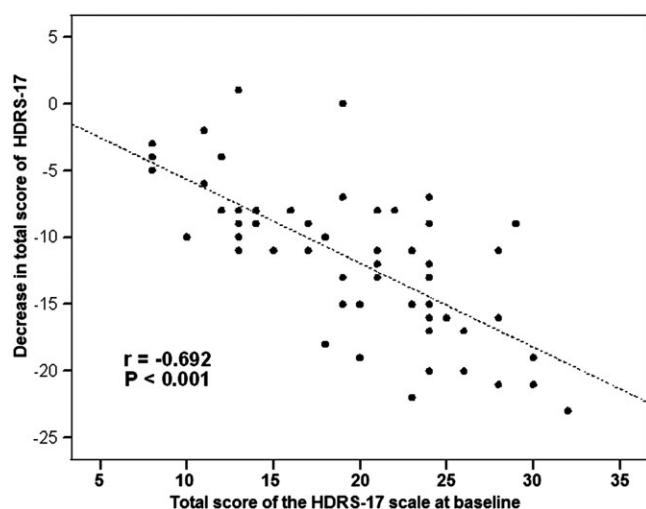


Figure 2. Correlation between severity of depressive symptoms at baseline and improvement after treatment (PP population)

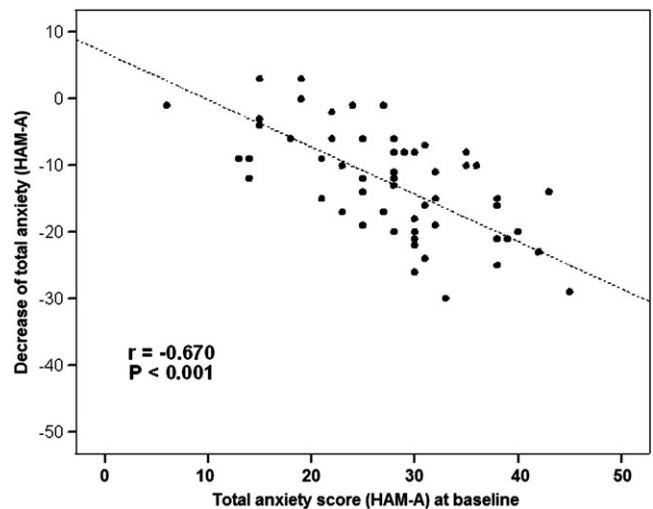


Figure 3. Correlation between severity of anxiety at baseline and improvement after treatment (PP population)

The number of patients lost to follow-up was greater among controls. One of the reasons may be the lack of contact with the research team over a long period of 9 months.

Different studies, including an excellent systematic review (Blackmore *et al.*, 2009), have provided evidence of the efficacy of dynamic psychotherapy across a variety of settings, conditions and measures (Crits-Christoph, 1992; Piper *et al.*, 2001; Shedler, 2010; Lorentzen, Ruud, Fjeldstad, & Høglend, 2013), but to our knowledge data on the usefulness of dynamic group psychotherapy in patients with depressive symptoms carried out by specialized psychotherapists in primary care centres have not been previously reported. A short-term dynamic group psychotherapy, with a total of 37 to 39 sessions (75 min weekly) was adequate to the needs of our public health care services and seems to be sufficient to improve symptoms notably. In a recent study, short- and long-term therapy seemed equally effective for typical outpatients seeking group psychotherapy (Lorentzen *et al.*, 2013).

The present study shows that implementation of short-term dynamic group psychotherapy run by experienced psychotherapists for patients with depressive symptoms attended in routine primary care centres is feasible and effective, with marked improvement in symptoms of depression and anxiety, as well as in quality of life. These findings, however, still need corroborating through other research with a larger number of patients in the Spanish population as well as in other patients attended in the primary health care systems of other countries. Assessment of the variability among therapists to distinguish results related to the therapists and results related to the method is also a suggestive research line. Based on the recordings, a qualitative study is currently being conducted, the preliminary results of which indicate improvements in the patients' capacity to symbolize and use of metaphors. Also the items of Blagys and Hilsenroth (2000) that appeared more frequently in our analysis are items (5) a focus on a patients' interpersonal experiences and (7) an exploration of patients' wishes, dreams or fantasies.

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CONFLICTS OF INTEREST

None.

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REFERENCES

- American Psychiatric Association (2000a). Practice guideline for the treatment of patients with major depressive disorder. *American Journal of Psychiatry*, 157(4 Suppl), 1–45.
- American Psychiatric Association (2000b). *Diagnostic and statistical manual of mental disorders* (4th edition Text Revision ed.) D.C.: Washington.
- Aragonès, E., Piñol, J. L., Caballero, A., López-Cortacans, G., Casaus, P., Hernández, J. M., Badia, W., & Folch, S. (2012). Effectiveness of a multi-component programme for managing depression in primary care: A cluster randomized trial. The INDI project. *Journal of Affective Disorders*, 142, 297–305. DOI:10.1016/j.jad.2012.05.020.
- Bion, W. R. (1961). *Experiences in groups*. London: Tavistock Institute Ed.
- Blackmore, C., Beecroft, C., Parry, G., Booth, A., Tantam, D., Chambers, E., Simpson, E., Roberts, E., & Saxon, D. (2009). A systematic review of the efficacy and clinical effectiveness of group analysis and analytic/dynamic group psychotherapy. Centre for Psychological Services Research, School of Health and Related Research, University of Sheffield, UK.
- Blackmore, C., Tantam, D., Parry, G., & Chambers, E. (2012). Report on a systematic review of the efficacy and clinical effectiveness of group analysis and analytic/dynamic group psychotherapy. *Group Analysis. The International Journal of Group-Analytic Psychotherapy*, 45, 49–69. DOI:10.1177/0533316411424356.
- Blagys, M. D., & Hilsenroth, M. J. (2000). Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice*, 7, 167–188.
- Bros Cugat, I., & Jara Martin, M. (2015). Screening tests of depression. Some reflections. *Atencion Primaria*, pii: S0212-6567(15)00003-7. DOI:10.1016/j.aprim.2014.05.018.
- Canete, M., Stormont, F., & Esquerro, A. (2000). Group analytic psychotherapy with the elderly. *British Journal of Psychotherapy*, 17, 94–105. DOI:10.1111/j.1752-0118.2000.tb00563.x.
- Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry*, 149, 151–158.
- Driessen, E., Cuijpers, P., de Maat, S. C., Abbass, A. A., de Jonghe, F., & Dekker, J. J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review*, 30, 25–26. DOI:10.1016/j.cpr.2009.08.010.
- Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J., Vos, T., & Whiteford, H. A. (2013). Burden of depressive disorders by country, sex, age, and year: Findings from the global burden disease study 2010. *PLoS Medicine*, 10, e1001547. DOI:10.1371/journal.pmed.1001547.
- Garland, A. F., Huriburt, M. S., Brookman-Frazee, L., Taylor, R. M., & Accurso, E. C. (2010). Methodological challenges of characterizing usual care psychotherapeutic practice. *Administration and Policy in Mental Health*, 37, 208–220. DOI:10.1007/s10488-009-0237-8.
- Gibbons, M. B., Thompson, S. M., Scott, K., Schauble, L. A., Mooney, T., Thompson, D., ... (2012). Supportive-expressive dynamic psychotherapy in the community mental health system: A pilot effectiveness trial for the treatment of depression. *Psychotherapy (Chicago, Ill.)*, 49, 303–316. DOI:10.1037/a0027694.

- Gustavsson, A., Svensson, M., Jacobi, F., Allgulander, C., Alonso, J., Beghi, E., et al. (2011). Cost of disorders of the brain in Europe 2010. *European Neuropsychopharmacology*, *21*, 718–779.
- Lampe, L. (2012). Diagnostic processes in mental health: GPs and psychiatrists reading from the same book but on a different page. *Australasian Psychiatry*, *20*, 3674–378.
- Lesage, A. (2015). Better treatment for depression. *Canadian Medical Association Journal*, *187*, 438.
- Lobo, A., Chamorro, L., Luque, A., Dal-Ré, R., Badia, X., & Baró, E. (2002). Validation of the Spanish versions of the Montgomery–Asberg Depression and Hamilton Anxiety rating scales. *Medicina Clínica*, *118*, 493–499.
- Lorentzen, S., & Ruud, T. (2014). Group therapy in public mental health services: Approaches, patients and group therapists. *Journal of Psychiatric and Mental Health Nursing*, *21*, 219–225.
- Lorentzen, S., Ruud, T., Fjeldstad, A., & Høglend, P. (2013). Comparison of short- and long-term dynamic group psychotherapy: Randomised clinical trial. *British Journal of Psychiatry*, *203*, 280–287. DOI:10.1192/bjp.bp.112.113688.
- Manning, J. S., & Jackson, W. C. (2015). Providing guideline-concordant assessment and monitoring for major depression in primary care. *Journal of Clinical Psychiatry*, *76*, e3. DOI:10.4088/JCP.13013tx7c.
- Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine*, *3*, e442. DOI:10.1371/journal.pmed.0030442.
- Miller, S., Dell'Osso, B., & Ketter, T. A. (2014). The prevalence and burden of bipolar depression. *Journal of Affective Disorders*, *169* (Suppl 1), S3–S11. DOI:10.1016/S0165-0327(14)70003-5.
- Minović, S. M., Erjavec, K., Poljičćanin, T., Vrabec, B., & Brečić, P. (2015). Prevalence of depressive symptoms associated sociodemographic factors in primary health care patients. *Psychiatria Danubina*, *27*, 31–37.
- National Institute for Health and Care Excellence (NICE), (2010). Depression: The treatment and management of depression in adults. Retrieved April 13, 2015, From <http://www.nice.org.uk/guidance/cg90/chapter/1-recommendations>
- O'Connor, E. A., Whitlock, E. P., Beil, T. L., & Gaynes, B. N. (2009). Screening for depression in adult patients in primary care settings: A systematic evidence review. *Annals of Internal Medicine*, *151*, 793–803. DOI:10.7326/0003-4819-151-11-200912010-00007.
- Pence, B. W., O'Donnell, J. K., & Gaynes, B. N. (2012). The depression treatment cascade in primary care: A public health perspective. *Current Psychiatry Reports*, *14*, 328–335. DOI:10.1007/s11920-012-0274-y.
- Piper, W. E., McCallum, M., Joyce, A. S., Rosie, J. S., & Ogradniczuk, J. S. (2001). Patient personality and time-limited group psychotherapy for complicated grief. *International Journal of Group Psychotherapy*, *51*, 525–552.
- Ramos-Brieva, J. C., & Cordero, A. (1986). Validación de la versión castellana de la escala de Hamilton para la depresión. *Actas Luso-Españolas de Neurología y Psiquiatría*, *118*, 324–334.
- Ruiz, A., Silva, H., & Miranda, E. (2001). Clinical and psychometric diagnosis of depression in patients in general medicine. *Revista Médica de Chile*, *129*, 627–633.
- Serrano-Blanco, A., Palao, D. J., Luciano, J. V., Pinto-Meza, A., Luján, L., Fernández, A., ... (2010). Prevalence of mental disorders in primary care: results from the diagnosis and treatment of mental disorders in primary care study (DASMAP). *Social Psychiatry and Psychiatric Epidemiology*, *45*, 201–210. DOI:10.1007/s00127-009-0056-y.
- Schmidt, S., Vilagut, G., Garin, O., Cunillera, O., Tresserras, R., Brugulat, P., ... (2012). Reference guidelines for the 12-Item Short-Form Health Survey version 2 based on the Catalan general population. *Medicina Clínica*, *139*, 613–625. DOI:10.1016/j.medcli.2011.10.024.
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*, 98–109.
- Sobocki, P., Jönsson, B., Angst, J., & Rehnberg, C. (2006). Cost of depression in Europe. *Journal of Mental Health and Policy Economics*, *8*, 87–98.
- Thombs, B. D., & Ziegelstein, R. C. (2013). Depression screening in primary care: Why the Canadian task force on preventive health care did the right thing. *Canadian Journal of Psychiatry*, *58*, 692–696.
- Thombs, B. D., Ziegelstein, R. C., Roseman, M., Kloda, L. A., & Ioannidis, J. P. (2014). There are no randomized controlled trials that support the United States Preventive Services Task Force Guideline on screening for depression in primary care: A systematic review. *BMC Medicine*, *12*, 13. DOI:10.1186/1741-7015-12-13.
- Timonen, M., & Liukkonen, T. (2008). Management of depression in adults. *British Medical Journal*, *336*, 435–439. DOI:10.1136/bmj.39478.609097.BE.
- Unützer, J., & Park, M. (2012). Strategies to improve the management of depression in primary care. *Primary Care*, *39*, 415–431. DOI:10.1016/j.pop.2012.03.010.
- World Health Organization. Depression. Retrieved, April 13, 2015, From <http://www.who.int/mediacentre/factsheets/fs369/en/>
- Yalom, I. D. (2005). *The theory and practice of group psychotherapy* (5th ed.) New York: Basic Books.
- Zung, W. W., Broadhead, W. E., & Roth, M. E. (1993). Prevalence of depressive symptoms in primary care. *Journal of Family Practice*, *37*, 337–344.