

SECONDARY PREVENTION OF DEPRESSION IN PRIMARY CARE

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In order to analyze the efficacy, effectiveness and efficiency of several programmes for the secondary prevention of depression, three group interventions were developed in Primary Care Centres: cognitive-behavioural therapy, promotion of coping resources therapy (simply paying attention to abilities, without training) and social support. The sample was made up of 60 people with mild-to-moderate depressive symptoms, randomly assigned either to one of the treatments or to a control group (waiting list). The psychopathology, quality of life and attendance at mental health services variables were assessed at pretest, post-test and two follow-up assessments, 6 and 12 months after completion of the programmes. Outcomes: both therapies showed more efficacy, effectiveness and efficiency than social support, which in turn yielded a better outcome than waiting list.

En este estudio se analizaron la eficacia, efectividad y eficiencia en relación a la prevención secundaria de la depresión de tres intervenciones: terapia cognitivo-conductual, potenciación de recursos personales (atención selectiva a habilidades, sin entrenamiento) y apoyo social. La muestra fue de 60 sujetos con síntomas depresivos moderados, que se asignaron aleatoriamente a los tratamientos o a un grupo control (lista de espera). Las intervenciones se llevaron a cabo en Centros de Atención Primaria en formato grupal. Se midieron variables psicopatológicas, de calidad de vida y de asistencia a recursos especializados de salud mental en el pretest, el postest y dos seguimientos (6 y 12 meses). Resultados: la terapia cognitivo-conductual y la potenciación de recursos son eficaces, efectivas y eficientes, más que el apoyo social, y éste más que la lista de espera.

Depression is one of the health problems giving most cause for concern in Western society. The commonest psychopathological symptoms are depressive ones. Likewise, depressive disorders are the third most common psychopathology, with a life prevalence of between 2% and 25%, both in the United States and in Spain (Ayuso-Mateos et al., 2001; Kaplan & Sadock, 1999). These problems produce an enormous strain on primary care centres and mental health centres in Spain. Between 15 and 40% of primary care centre patients present psychological disorders, and 25% of them have depression (Bernardo, 2000).

Depressive disorders commonly involve relapses, chronicity and serious repercussions, including suicide. Between 40 and 85% of people with major depression experience at least one relapse in their lives. Of those who commit suicide, between 50% and 70% have a medical history that includes some depressive disorder (Coon & Thompson, 2003; González, Ramos,

Caballero & Wagner, 2003; Emslie, Mayes, Laptook & Batt, 2003; Merrill, Tolbert & Wade, 2003).

Although there are a wide range of theories for explaining depression, it is assumed here that this psychopathology derives largely from people's lack of strategies (or the inadequacy of those strategies) for coping with life problems. The proliferation of psychotherapeutic approaches for treating depression is overwhelming, but not all of them are sufficiently supported by scientific studies. After an exhaustive review it can be concluded that the psychotherapies that have best proven their efficacy for depression are behaviour therapy, cognitive therapy and interpersonal therapy, and that the group format is as efficacious or more so than the individual one, but more effective and efficient. With regard to social support groups it cannot be concluded whether they equal or inferior to previous psychotherapies (Jacobson & Hollon, 1996; Labrador, Echeburúa & Becoña, 2000; Pérez & García, 2003; Shapiro, Barkham, Rees, Hardy, Reynolds & Startup, 1994; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

On the other hand, the specific therapeutic elements of the treatments is an issue that has not been definitively resolved insofar as the variables they address do not

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appear to change more specifically than others not initially addressed. It would appear preferable to select interventions not so much according to the deficits or problems participants present, but rather according to the potentialities and resources they already possess (Vallejo, 1998). In sum, there seems to be a need for further research with a view to identifying which variables of the person, the context and the treatments can show a predictive value of the efficacy of treatments.

The presence of preventive programmes is scarce in primary care. Nevertheless, the majority of public health services in Western countries have assumed as the principal axis of their work the community mental health model, one of whose central pillars is prevention. Studies on the secondary prevention of depression report positive results with adolescents (Beardslee, Gladstone, Wright & Cooper, 2003; Kataoka et al., 2003), with women, especially post-partum and menopausal (Howard, Hoffbrand, Henshaw, Boath & Bradley, 2003) and with the elderly (Cohen, 2002). The interventions are similar to those used in "curative" treatments, and mostly cognitive-behavioural, so that what functions for recovering from depression appears to function to the same extent for preventing its worsening and relapses (Benedito, Carrió, del Valle & Domingo, 2005). Nevertheless, the norm, at least in Spain, in dealing with minor depression is a brief primary care consultation and the prescription of antidepressants.

The objective of the present research was to analyze the efficacy, effectiveness and efficiency of the three interventions applied in group format by a psychologist at Primary Care Centres: (a) cognitive-behavioural therapy (CBT); (b) promotion of personal resources (PPR), and (c) social support (SS). These interventions were compared with one another and with a control group on waiting list (WL) with regard to prevention of exacerbation, relapses and attendance at mental health centres specializing in people with moderate depressive symptoms. The choice of CBT and SS is backed up by the utility that these procedures have shown in the scientific literature; also, their application was in line with the specifications characterizing such interventions for the treatment of depressive behaviour. The PPR intervention was applied in view of our interest in studying separately the promotion of skills already acquired by the participant and the instruction and training of new skills. Thus, it was designed to provide selective attention to the participant's coping resources without instructing and/or training new skills in a specific way.

METHOD

Participants

The sample was made up of 60 users of Primary Care Centres in the municipal districts of Oviedo and Aller (Asturias, Spain). Inclusion criteria were: (a) age between 25 and 55 years; (b) sustained presence of symptoms on the depressive spectrum to a moderate and unusual degree for the person; (c) motivation for change expressed by the participant and informed consent (for the GP and for the psychologist). Exclusion criteria were: (a) receiving specialized mental health treatment or presenting criteria for immediate referral to the Mental Health Centre; (b) meeting all the criteria of a depressive diagnosis on the DSM-IV; and (c) presenting a significant alteration in socio-employment functioning.

Experimental participants were first pre-selected by the GP in their normal surgeries at the Health Centre over a period of three months, and then selected by a clinical psychologist in individual interviews at the same centre. Thus, of the 80 people pre-selected by doctors according to the criteria presented above, after the interviews with the psychologist, in which fulfilment of the criteria was re-examined, the final figure was 60. Subsequently, this same psychologist proceeded to carry out the pretest assessment and random assignment to the four experimental groups.

The professionals involved in the study were: (a) the GPs who preselected the sample; (b) the clinical psychologist, who carried out the assessments and was the therapist of the CBT group and the PPR group; and (c) a psychologist with experience in dynamization of self-help groups, who was the therapist of the social support (SS) group.

Materials

In the four assessments of the experimental participants (pretest, post-test, and follow-ups at 6 and 12 months), the following instruments were used:

- *Interview protocol* developed ad hoc. This protocol included Holmes and Rahe's (1967) Social Readjustment Rating Scale (SRRS), on which the higher the score the more the negative life events experienced by the participant.
- *Beck Depression Inventory (BDI)* (Beck, Rush, Shaw & Emery, 1983). Higher scores would indicate greater degrees of depression. The BDI attains a test-retest reliability of 0.70, a two-halves reliability of 0.93 and an internal consistency (Cronbach's alpha) of 0.87; its concurrent validity with the Hamilton and

Zung scales or with experts' judgements ranges from 0.50 to 0.80 (Bulbena, Berrios & de Larrinoa, 2000).

- *Cuestionario de Calidad de Vida* (CCV; Quality of Life Questionnaire) (Ruiz & Baca, 1993). With this instrument, the higher the score, the greater the degree of quality of life. The authors of this questionnaire report a test-retest reliability of close to 0.97, an internal consistency (Cronbach's alpha) of 0.94 and a concurrent validity with Hamilton's depression and anxiety scales of close to 0.74 (Ruiz & Baca, 1993).
- *Cognitive Triad Inventory* (CTI) (Beckham, Leber, Watkins, Boyer & Cook, 1986). The higher the score, the lower the presence of negative cognitions. The authors of this questionnaire found an internal consistency of $\alpha=0.95$, a moderate discriminant validity (0.13) and a concurrent validity of 0.67 with respect to other self-reports of self-esteem and despair, including the BDI (Beckham, Leber, Watkins, Boyer & Cook, 1986).
- *Escala de Expresión Social-Parte Motora* (EES; Social Expression Scale-Motor Part) (Caballo, 1993). The higher the score on this questionnaire, the greater the respondent's social competence. Its author found a test-retest reliability of 0.92, a similar internal consistency and a concurrent validity of 0.87 with respect to the College Self-Expression Scale (CSES) by Galassi, DeLo, Galassi and Bastien (Caballo, 1993).
- *Autoregistro de actividades y estado de ánimo* (AAE; Self-record of activities and mood), scored from 0 (sad) to 10 (happy) over a period of 7 days, developed ad hoc.

Also used were:

- An *intervention protocol* for each one of the groups in the study.
- A *self-record of activities, thoughts and everyday problems* for the CBT group sessions.
- *Lewinsohn's List of Pleasant Activities* and list of community resources drawn up ad hoc for the second session of the CBT group.

The following materials were provided for the GPs:

- An information document about the study.
- A guide to the preselection process, setting out in detail the inclusion and exclusion criteria.
- Periodical reports on each patient.

Variables

Independent variable (IV) was type of treatment to which the participant was assigned: CBT, PPR, SS or WL (control group).

In order to rate the efficacy, effectiveness and efficiency of the different treatments various criterion variables (CRV) were selected. Details of these appear in the *Results* section.

A range of control variables (COV) were taken into account, such as: (a) pretest scores on the Beck Depression Inventory (BDI), the Quality of Life Questionnaire (CCV), the Cognitive Triad Inventory (CTI) and the *Escala de Expresión Social-Parte Motora* (EES) and the Self-record of activities and mood (AAE); (b) social adjustment and motivation for change, reported by the participant in the pretest assessment; (c) life events and triggering factors, referred to by the participant in each one of the four assessments; (d) sociodemographic characteristics, physical health and perceived social support; (e) depressive and non-depressive symptoms; (f) antecedents of psychopathology, antecedents of mental health treatment and previous duration of the problem for which participant was referred to the study. These three last three types of variables were provided by the participant in the interview pretest.

Procedure

First of all, a clinical psychologist organized an information session with the GPs at each Primary Care Centre. Once the preselection of participants by the doctors was complete, the psychologist made the definitive selection in accordance with the assessment procedures and selection criteria described above.

The final sample was made up of 60 participants. Once they had been randomly assigned to the treatments, the three experimental interventions were carried out. Each consisted of six weekly, 1-hour sessions, at the three Primary Care Centres, in which the corresponding therapist and group of participants took part. It should be stressed that in all the treatment conditions the same therapeutic objectives were addressed: the management of life problems. What distinguished the interventions from one another were the procedures and therapeutic techniques employed in the pursuit of these objectives. Thus, and in all the groups, the sessions were oriented to coping with the following problems:

Session 1: occupation and distribution of time.

Session 2: negative thoughts.

Session 3: problems with decisional-making.

Session 4: problems related to interpersonal communication.

Session 5: family problems.

Session 6: relationship problems.

In the CBT group the intervention was carried out in accordance with the format and application of the techniques characteristic of Beck's (1983) cognitive therapy for depression.

In the PPR group it was attempted to promote and generalize the use of participants' own effective strategies for coping with the problems, which they had already incorporated in their behavioural repertoires, without instructing them and/or training them specifically in new strategies. Thus, the therapist asked participants how they dealt with the different problems raised in each session (what they did and how, and the utility they observed) and paid selective attention to those that emerged as most appropriate insofar as they were closest to those postulated by the cognitive-behavioural model (for example, «trying to distract oneself with something that requires concentration» is considered adaptive for coping with an excess of recurrent negative thoughts; on the other hand, «trying to use more willpower» is considered maladaptive for coping with abulia).

In the SS group the therapist chaired the debates on these same problems, with paying selective attention to the forms of coping mentioned, but simply promoting the interchange of experiences among participants.

Box 1 shows details of the content of the treatments. For a more detailed specification of the procedures, see González (2004).

In all the experimental groups the therapists measured variables referring to attendance and fulfilment of the objectives during the sessions.

After the experimental interventions, the clinical psychologist carried out, on the whole sample, the post-test assessment, consisting in an individual interview at the Health Centre and application of the BDI, CCV, ITC and EES tests, as well as the AAE. Of the 60 participants making up the initial sample, 58 completed the post-test.

Finally, the clinical psychologist carried out two follow-up assessments on all participants, one 6 months and the other 12 months after completion of the experimental groups phase. Each follow-up consisted in an individual interview at the Health Centre and application of the same instruments as in the post-test. Of the 58 participants who completed the post-test, 46 attended the first follow-up, and of these, 29 attended the second. At the first follow-up the waiting list (WL) participants were offered the opportunity to take part in the same psychotherapy at the Health Centre as received by the CBT group.

In the course of the study the psychologist sent

periodical reports to the doctors about the evolution of their patients.

Design and data analysis

A quantitative analysis of the variables referring to the participants was carried out. It included the following calculations: (a) distributions of frequencies and descriptive statistics for the sample as a whole and divided by treatment groups; (b) intergroup comparison by means of ANOVA, Kruskal-Wallis and Chi² correlations of the control variables (COV); and (c) comparison intergroup and between the four measurement points by means of ANOVA, Kruskal-Wallis, Chi² correlations and T tests of the criterion variables (CRV). We used $p < 0.01$, .05 or .10, according to the case.

RESULTS

The sample characteristics (COV of the pretest) were quite heterogeneous, except with respect to gender, referring GP and physical health. Thus, the mean experimental participant is a woman aged 39.47 years, middle class, with secondary-school education and currently in work; she is married and lives with a mean of 2.27 people, and although she perceived her social support to be good, she has over the last 3 years experienced one or more painful life events related to the interpersonal and/or job context; she is in good physical health and has never previously presented psychological problems or received treatments of this type; in the pretest she presents diverse depressive symptoms, not mixed with other, non-depressive symptoms, and which she has been experiencing over the last 12.52 months; she obtains 23.81 points on the BDI, and this is why she consulted a professional, the GP, for the first time 7.93 months previously; since then the GP has been prescribing her benzodiazepines and antidepressants. Intergroup comparison of the COVs showed no significant difference, indicating a homogeneous distribution.

Box 2 shows the results of the intergroup comparison of the CRV measured in the post-test and in both follow-ups. Box 3 presents the statistical data for these results. In either box it can be seen that the waiting list (WL) group yields poorer results than the other three groups for the majority of the variables and points of measurement. Moreover, the social support (SS) group's results are comparable with those of the two psychotherapies in variables such as those of the BDI, the CCV or the ITC, but it offers poorer results than

these in variables such as perceived satisfaction, participation in sessions or practice of the strategies learned. The results of the SS group are better than those of the WL group, especially the later the measurement (6 or 12 months). These affirmations are not applicable in the cases of: (a) social skills (EES); (b) fulfilment of immediate objectives; and (c) participant's occupation, use of psychoactive drugs and increase in activity at any measurement point.

Box 4 shows the statistical data for the results of comparison of the CRVs measured in the four assessments for each group. As it can be seen, for the cognitive-behavioural therapy (CBT) group there were positive changes in practically all the variables (except social skills) in the post-test with respect to the pretest, changes which, moreover, were maintained, or even improved upon, in both follow-ups. The same can be said for the promotion of personal resources (PPR) group. For the SS group there were also positive changes in practically all the post-test variables with respect to the pretest, but the levels of both negative cognitions and

quality of life were not maintained in both follow-ups, returning instead to the pretest levels. Finally, for the WL group practically no positive changes were obtained over time in any of the variables.

DISCUSSION AND CONCLUSIONS

In accordance with the initial objective of analyzing the efficacy, effectiveness and efficiency of the three experimental interventions, the results permit us to state that the cognitive-behavioural therapy (CBT), promotion of personal resources (PPR) and social support (SS) are efficacious, effective and efficient in the majority of the criterion variables (CRV) of the post-test, but that only CBT and PPR (and not so much SS) are efficacious, effective and efficient in the CRVs in the follow-ups. That is, all three experimental groups obtain positive results in reduction of depressive symptoms and referral to mental health specialists and in increased quality of life, but only CBT and PPR succeed in maintaining these results at the 1-year follow-up.

Comparing the groups with one another, it can be

Box 1
Content of the experimental group sessions

Session	Cognitive-behavioural psychotherapy	Promotion of personal resources	Social support
1 ^a	Welcome. Presentations. Explanation of group norms. Sounding-out of expectations. Information on depression and existing treatments. Setting out of plan for the sessions. Homework tasks (CBT: self-record of activities; PPR: informal observation of activities). Questions and clarifications. Farewell		
2 ^a	Review. Homework tasks. Programming of reinforcement activities. Use of community resources. Homework tasks (practice, self-record of activities planned).	Review. Homework tasks. Selective attention to coping skills for occupation of time with activities. Homework tasks (practice, informal observation of how time is occupied).	Review. Discussion about how the week has gone. Debate about occupation of time with activities.
3 ^a	Review. Homework tasks. Training in cognitive modification. Homework tasks (practice, self-record of thoughts).	Review. Homework tasks. Selective attention to coping skills for negative thoughts. Homework tasks (practice, informal observation of thoughts).	Review. Discussion about how the week has gone. Debate about negative thoughts.
4 ^a	Review. Homework tasks. Training in social skills (assertiveness). Training in problem-solving. Homework tasks (practice, self-record of problems).	Review. Homework tasks. Selective attention to skills for coping with problems of interpersonal communication. Selective attention to skills for coping with decision-making problems. Homework tasks (practice, informal observation of problems).	Review. Discussion about how the week has gone. Debate about problems of interpersonal communication. Debate about decision-making problems.
5 ^a	Review. Homework tasks. Training in application of the above techniques to family problems. Training in application of the above techniques to relationship problems. Homework tasks (practice, self-record of family/relationship problems).	Review. Homework tasks. Selective attention to skills for coping with family problems. Selective attention to skills for coping with relationship problems. Homework tasks (practice, informal observation of family/relationship problems).	Review. Discussion about how the week has gone. Debate about family problems. Debate about relationship problems.
6 ^a	Global review. Homework tasks. Training for generalization and prevention of relapses. Farewell.	Global review. Homework tasks. Selective attention to skills for coping with maintenance and extension of their achievements and prevention of relapses. Farewell.	Global review. Discussion about how the week has gone. Debate about the maintenance and extension of their achievements and prevention of relapses. Farewell.

Box 2 Inter-group comparison of criterion variables	
Parametric quantitative CRVs	
Variables	Groups and direction of differences
<i>Variables indicating efficacy</i>	
BDI post-test *	CBT<WL, PPR<WL*, SS<WL*
BDI 1st follow-up*	CBT<WL*, PPR<WL*, SS<WL*
BDI 2nd follow-up*	CBT<WL*, PPR<WL*
CTI post-test*	CBT>WL, PPR>WL, SS>WL*
CTI 1st follow-up*	CBT>WL*, PPR>WL, SS>WL
CTI 2nd follow-up*	CBT>WL*, PPR>WL, SS>WL
Mood in AAE post-test*	CBT>WL*, PPR>WL*, SS>WL*
Idem 1st follow-up*	CBT>WL*, PPR>WL*, SS>WL
Idem 2nd follow-up	No differences
EES post-test	No differences
EES 1st follow-up	No differences
EES 2nd follow-up	No differences
<i>Variables indicating effectiveness</i>	
CCV post-test*	PPR>WL, SS>WL
CCV 1st follow-up	No differences
CCV 2nd follow-up*	CBT>WL*, SS>WL
Non-parametric quantitative and ordinal CRVs.	
Variables	Groups and direction of differences
<i>Variables indicating efficacy</i>	
Participation in sessions*	CBT>SS*, PPR>SS
Immediate fulfilment of objectives*	SS>CBT, SS>PPR*
Sustained fulfilment of objectives*	CBT>SS*
Practice of strategies (degree) at 1st follow-up*	CBT>SS*, PPR>SS*
Practice of strategies (number) at 1st follow-up*	CBT>SS*
<i>Variables indicating effectiveness</i>	
Perceived utility for participant for the problem at 1st follow-up.	No differences
Other perceived utilities of the intervention at 1st follow-up.	No differences
Perceived satisfaction at 1st follow-up*	PPR>SS*
Nominal CRVs	
Variables	Groups and direction of differences
<i>Variables indicating efficacy</i>	
Drop-out rate*	CBT = PPR < SS = WL*
Job at post-test and 1st and 2nd follow-up	No differences
Use of psychoactive drugs at post-test and 1st/2nd follow-up	No differences
Depressive symptoms reported by participant at post-test: sadness, cognitive problems, inhibition, anxiety, fragility, insomnia and suicidal thoughts *	WL > CBT = PPR = SS*
Sadness at 1st follow-up*	WL = SS > CBT = PPR*
Cognitive problems at 1st follow-up*	WL > CBT = PPR = SS*
Anxiety at 1st follow-up*	WL = SS > CBT = PPR*
Suicidal thoughts at 1st follow-up*	WL = SS > CBT = PPR*
Insomnia at 2nd follow-up*	WL = SS > CBT = PPR*
Suicidal thoughts at 2nd follow-up*	WL > CBT = PPR = SS*
Increase in AAE activ. at post-test and 1st/2nd follow-up	No differences
Degree of practice of behavioural strategies at 1st follow-up*	CBT = PPR > SS*
Degree of practice of cognitive strategies at 1st follow-up	CBT = PPR > SS
Degree of practice of problem-solving at 1st follow-up	CBT = PPR > SS
Degree of practice of social skills at 1st follow-up	CBT = PPR > SS
Degree of use of social support	CBT = PPR > SS
<i>Variables indicating effectiveness</i>	
Non-depressive symptoms reported by participant at post-test	WL > CBT = PPR = SS
Non-depressive symptoms reported by participant at 1st follow-up	WL = SS > CBT = PPR
Non-depressive symptoms reported by participant at 2nd follow-up	No differences
<i>Variables indicating efficiency</i>	
Attendance reported by participant at specialist	0 participants in CBT, PPR, SS
mental health services (public or private) at post-test*	7 participants in WL*
Idem at 1st follow-up*	0 participants in CBT and PPR
	3 participants in SS
	4 participants in WL*
Idem at 2nd follow-up*	0 participants in CBT and PPR
	1 participant in SS
	3 participants in WL*
* = difference statistically significant with p<0.10; (1) = difference in the direction that at some point there would be lower BDI or higher CCV, CTI and EES than previously; IV = independent variable; CRV = criterion variable(s); BDI = Beck Depression Inventory; CTI = Cognitive Triad Inventory; AAE = mean of mood on self-record of activities and mood; EES = Social Expression Scale - Motor Part; CCV = Quality of Life Questionnaire; CBT = Cognitive-Behavioural Therapy group; PPR = Promotion of Personal Resources group; SS = Social Support Group; WL = Waiting List group	

Box 3 Inter-group comparison of criterion variables (statistical data)						
Parametric quantitative CRVs – One-factor ANOVA						
Criterion variables		Sum of squares	df	Quadratic Mean	F	Sig.
AAE POST	Inter-groups	78.373	3		26.124	8.311 .000
	Intra-groups	169.736	54		3.143	
	Total	248.109	57			
AAE 1st follow-up	Inter-groups	52.526	3		17.509	4.141 .012
	Intra-groups	177.586 42	4,228			
	Total	230.112	45			
AAE 2nd follow-up	Inter-groups	19.959	3		6.653	1.750 .183
	Intra-groups	95.069	25		3.803	
	Total	115.028 2	8			
BDI POST	Inter-groups	1761.093	3		587.031	5.739 .002
	Intra-groups	5524.010	54		102.296	
	Total	7285.103	57			
CCV POST	Inter-groups	4358.692	3		1452.897	2.333 .084
	Intra-groups	33629.877	54		622.775	
	Total	37988.569	57			
CTI POST	Inter-groups	10494.353	3		3498.118	3.053 .036
	Intra-groups	61880.544	54		1145.936	
	Total	72374.897	57			
EES POST	Inter-groups	2963.329	3		987.776	1.091 .361
	Intra-groups	48887.774	54		905.329	
	Total	51851.103	57			
BDI 1st follow-up	Inter-groups	2432.375	3		810.792	4.873 .005
	Intra-groups	6988.582	42		166.395	
	Total	9420.957	45			
CCV 1st follow-up	Inter-groups	3348.353 3	1116.118		1.598	.204
	Intra-groups	29340.951	42		698.594	
	Total	32689.304	45			
CTI 1st follow-up	Inter-groups	14348.626	3		4782.875	3.817 .017
	Intra-groups	52622.178	42		1252.909	
	Total	66970.804	45			
EES 1st follow-up	Inter-groups	1948.800	3		649.600	.738 .535
	Intra-groups	36944.939	42		879.641	
	Total	38893.739	45			
BDI 2nd follow-up	Inter-groups	1927.970	3		642.657	3.782 .023
	Intra-groups	4248.582	25		169.943	
	Total	6176.552	28			
CCV 2nd follow-up	Inter-groups	6636.770	3		2212.257	2.637 .072
	Intra-groups	20975.782	25		839.031	
	Total	27612.552	28			
CTI 2nd follow-up	Inter-groups	14002.450	3		4667.483	3.265 .038
	Intra-groups	35736.309	25		1429.452	
	Total	49738.759	28			
EES 2nd follow-up	Inter-groups	1348.242	3		449.414	.748 .534
	Intra-groups	15023.895	25		600.956	
	Total	16372.138	28			
Non-parametric quantitative and ordinal CRVs.						
Kruskal-Wallis test						
Criterion variables		Chi-squared	df		Asymptotic sig.	
Participation in sessions		11.877	2		.003	
Immediate objectives		7.898	2		.019	
Maintained objectives		7.584	2		.023	
Practice of strategies (degree)		9.598	2		.008	
Practice of strategies (number)		7.067	2		.029	
Perceived utility for problem		3.327	2		.189	
Other perceived utilities		.051	2		.975	
Perceived satisfaction		8.935	3		.030	
Nominal CRVs - Chi-squared correlation with treatment						
Criterion variables		Asymptotic sig. of Pearson Chi-squared				
Drop-outs		.010				
Job post-test		.424				
Job 1st follow-up		.752				
Job 2nd follow-up		.317				
Specialist post-test		.078				
Specialist 1st follow-up		.080				
Specialist 2nd follow-up		.007				
Drugs post-test		.583				
Drugs 1st follow-up		.640				
Drugs 2nd follow-up		.451				
Non-depr. symptoms post-test		.130				
Non-depr. symptoms 1st follow-up		.200				
Non-depr. symptoms 2nd follow-up		.273				
Depr. symptoms post-test		.000/070				
Depr. symptoms 1st follow-up		.024/569				
Depr. symptoms 2nd follow-up		.002/366				
Increased activ. Post-test		.724				
Increased activ. 1st follow-up		.462				
Increased activ. 2nd follow-up		.451				
Practice behav. skills		.063				
Practice cogn. skills		.489				
Practice prob.-solving		.641				
Practice social skills		.233				
Use of social support		.630				
* = difference statistically significant with p<0.10; (1) = difference in the direction that at some point there would be lower BDI or higher CCV, CTI and EES than previously; IV = independent variable; CRV = criterion variable(s); BDI = Beck Depression Inventory; CTI = Cognitive Triad Inventory; AAE = mean of mood on self-record of activities and mood; EES = Social Expression Scale - Motor Part; CCV = Quality of Life Questionnaire; CBT = Cognitive-Behavioural Therapy group; PPR = Promotion of Personal Resources group; SS = Social Support Group; WL = Waiting List group						

concluded that CBT and PPR do not show significant differences from one another, but that they are more efficacious, effective and efficient than SS in the majority of the CRVs, and that SS, in turn, yields better results than those found for the waiting list (WL) group.

It is important to point out that given that after the pretest, many more participants from SS (4 people) and WL (all except one) were referred to mental health specialists than from CBT and PPR (from which none were referred), the positive results of these two groups could be due, in part, to such referral.

There are, however, some exceptions to these general conclusions. First of all, the differences reported were not found in social skills, which were either not trained sufficiently in CBT or were not measured adequately with the EES (or indeed, their variation depends on factors unrelated to the intervention). Secondly, the fact that in SS the participants achieved more immediate objectives than those in CBT and PPR may be explained by the fact that the SS objectives (participants were only required to participate spontaneously in the discussions in each session) were less demanding than those of the CBT and PPR (in which participants had to practise the

skills acquired or promoted in the week following each session). Thirdly, participant's occupation (active, off sick, unemployed, etc.) in the post-test and follow-ups did not differ as a function of group, perhaps because it was influenced by other factors unrelated to the psychopathology (socioeconomic class, job satisfaction and conditions, physical health, etc.). Fourthly, consumption of psychoactive drugs in the post-test and the follow-ups did not differ as a function of group either, and this finding should be attributed to the primary care protocol that involved the invariable prescription of these drugs for a given period, and to patients' typical resistance to give up treatment that has coincided with an improvement in their condition. And finally, fifthly, the experimental groups did not succeed in increasing participants' activity level more than WL, a finding that can be explained by the personal needs and circumstances that modulate the number of behaviours they carry out daily.

In addition to all the above, participants in the CBT and PPR, compared to the SS and WL, participated in more sessions, more successfully maintained the therapeutic objectives, were less likely to drop out of the study and,

Box 4
Comparison between different measurement points of the criterion variables
divided by treatment groups (statistical data)

Bilateral signif. of t tests of related samples							
Group	Variables	Pre/post-test difference ⁽¹⁾	Post-test/1 st follow-up difference ⁽¹⁾	Pre-test/1 st follow-up difference ⁽¹⁾	1 st follow-up/2 nd follow-up difference ⁽¹⁾	Post-test/2 nd follow-up difference ⁽¹⁾	Pre-test/2 nd follow-up difference ⁽¹⁾
CBT	BDI	.011*	.107	.001*	.804	.204	.000*
	CTI	.010*	.054*	.003*	.946	.234	.019*
	AAE	.000*	.935	.000*	.281	.815	.001*
	EES	.562	.001*	.002*	.118	.020*	.029*
	CCV	.052*	.008*	.000*	.061	.703	.070*
PPR	BDI	.000*	.175	.000*	.502	.403	.003*
	CTI	.005*	.746	.065*	.817	.928	.117
	AAE	.000*	.275	.001*	.448	.210	.002*
	EES	.017*	.562	.097*	.411	.361	.076*
	CCV	.000*	.238	.002*	.001	.390	.184
SS	BDI	.001*	.768	.004*	.576	1.000	.010*
	CTI	.000*	.332	.172	.634	.757	.198
	AAE	.003*	.878	.006*	.920	.477	.003*
	EES	.102	.653	.124	.172	.182	.011*
	CCV	.013*	.789	.195	.777	.540	.132
WL	BDI	.298	.420	.882	.353	.176	.407
	CTI	.402	.313	.218	.261	.287	.172
	AAE	.772	.339	.476	.518	.504	.988
	EES	.118	.952	.558	.656	.503	.871
	CCV	.957	.051*	.086*	.227	.870	.395

*= difference statistically significant with $p < 0.10$; (1) = difference in the direction that at some point there would be lower BDI or higher CCV, CTI and EES than previously; IV= independent variable; CRV= criterion variable(s); BDI= Beck Depression Inventory; CTI= Cognitive Triad Inventory; AAE= mean of mood on self-record of activities and mood; EES= Social Expression Scale - Motor Part; CCV= Quality of Life Questionnaire; CBT= Cognitive-Behavioural Therapy group; PPR= Promotion of Personal Resources group; SS= Social Support Group; WL= Waiting List group

6 months after the intervention, were more likely to practice the skills learned or promoted (behavioural, cognitive, etc.) and to seek social support.

In sum, it would appear justified to use therapeutic groups in primary care for the secondary prevention of depression, that is, to prevent, in people with moderate depressive symptoms, the worsening of those symptoms, the emergence of a psychopathology on the depressive spectrum or of another type, a deterioration in perceived quality of life and satisfaction and the need to seek specialist mental health attention. Such justification becomes even stronger, moreover, if we bear in mind the reduction in health costs involved. As regards the procedures, it would also seem justified to employ both CBT and intervention aimed at promoting the participant's own competencies. These conclusions lend support to the hypothesis on the basis of these interventions were designed, and which is that the principal active component of CBT in depression is its capacity for promoting in the participant the use of coping strategies already incorporated into his or her basic repertoire of behaviour. That is, people will benefit from a therapeutic procedure in which they are stimulated to bring into play strategies already acquired but little or poorly used, in which they are taught to use them in a more adaptive way in the appropriate contexts, in which they will be maximally generalized and taken advantage of. On the other hand, training in new skills for the participant may not turn out to be so effective insofar as sessions in a clinical context do not work sufficiently well as a substitute for the real context in which such skills must emerge as functional. In any case, this only serves to heighten the need to continue research in this line and study more in depth which elements promote change in therapies, as well as which participant characteristics make them most suitable for this type of intervention.

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