

# GROUP PSYCHOTHERAPY FOR MEN WITH CHRONIC MAJOR DEPRESSIVE DISORDER IN A COMMUNITY MENTAL HEALTH UNIT

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*Certain clinical features of depression in men led us to develop a specific group intervention: higher incidence of successful suicide, greater reluctance to seek professional treatment, tendency to isolate themselves and use of drugs to relieve the suffering. In this work we report the clinical improvement of six patients diagnosed with chronic major depression after two years of group psychotherapy. This treatment is based on Interpersonal Psychotherapy. The psychometric instruments used were: MADRS (assesses the intensity of depressive symptoms), SDI (perceived disability in different areas) and CGI-SI (clinical impression). The results show improvement in all areas. Our experience in this group psychotherapy programme highlights the relevance of specific and long-term treatment for the prevention of relapses.*

**Key words:** Chronic depression, Men, Interpersonal psychotherapy, Group psychotherapy.

*Ciertas características clínicas de la depresión masculina nos han orientado a definir una intervención grupal específica: su mayor tasa de suicidios consumados, la mayor resistencia a demandar ayuda, la tendencia al aislamiento y al consumo de tóxicos para apaciguar el sufrimiento. En este trabajo pretendemos dar cuenta de la mejoría clínica alcanzada por un grupo de 6 pacientes con diagnóstico de depresión mayor crónica, tras haber participado durante 2 años en terapia grupal. El tratamiento fue dirigido según las premisas de la Psicoterapia Interpersonal (PIP). Las pruebas psicométricas utilizadas fueron: MADRS (valora la intensidad de la sintomatología depresiva), SDI (discapacidad percibida por los pacientes en distintas áreas) y CGI-SI (impresión clínica). El grupo mostró una mejoría en todas las áreas. Pretendemos destacar, a partir de nuestra experiencia con este grupo de pacientes, la importancia de un tratamiento específico y prolongado con el objetivo de prevenir recaídas.*

**Palabras clave:** Depresión crónica, Hombres, Psicoterapia interpersonal, Psicoterapia de grupo.

Major depressive disorders, together with anxiety disorders, are the most common psychopathological diagnoses in the general population (European Commission 2005), and constitute one of the main reasons for primary health care consultations (Aragonés, Gutiérrez, Pino, Lucena, & Cervera, 2001). Nearly all epidemiological studies have found a higher incidence of such disorders in the female population, with a risk two to three times greater (Klerman & Weissman, 1989; Karasu, Docherty, Gellenberg, Kupfer, Merriam, & Shadoan, 1993). This higher incidence in women may be determined by genetic variables (greater frequency in first-degree relatives) or by chronic physical illness (Karasu et al., 1993), and especially by variables of a psychosocial nature (stressful life events,

such as conflict at work, unemployment, marital disputes, separation or death of loved ones) (Paykel & Cooper, 1992).

However, depression in men has some characteristics that make it worthy of special attention. One of the most alarming aspects is the high rate of suicide among depressed men by comparison with women, statistics showing that it is up to four times as high (Minino, Arias, Kochanek, Murphy, & Smith, 2002). The methods men use are more lethal, and they commonly fail to ask for help, so that the rate of successful suicides is also higher. The symptomatic profile in men is, in general, different, with a predominance of fatigue, insomnia, irritability and loss of interest in work or free time. Compared to women, depressed men express fewer feelings of sadness and are less prone to lack of self-esteem and excessive guilt feelings (Cochran & Rabinowitz, 2002).

For some authors, greater abuse of alcohol and drugs in men should be seen as a possible symptom of depression (Robins & Regier, 1991). Thus, instead of asking for

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help directly, so that their distress can be verbalized, they attempt to reduce their suffering through drug and alcohol abuse, especially for coping with feelings of irritability, frustration, sadness, and so on. Others tend to seek refuge in work, or engage in compulsive behaviours (Cochran & Rabinowitz, 2002), such as dangerous driving.

It should not be overlooked that certain cultural and social factors can exert pressure on men to present an image of strength, depression being considered as a sign of weakness or lack of self-control; this may lead to sadness feelings being channelled into hostile behaviours, as a more acceptable reaction from the perspective of the masculine stereotype. Moreover, it is observed that women respond better to pharmacological treatment with SSRIs (Kornstein, 1997) and to psychotherapy, while men show lower levels of adherence to therapeutic programmes.

As far as the treatment of depression is concerned, recent decades have seen the emergence of various highly effective psychological treatments, such as Cognitive-Behavioural Therapy (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989; Thase, Greenhouse, Frank, Reynolds, Pilkonis, Hurley, Grochocinski, & Kupfer, 1997; NICE, 2004) or Interpersonal Psychotherapy (IPT). The latter of these was first developed in the 1970s, but its use has become diversified, and it is now applied in various formats and contexts, not only to affective problems but also to other psychopathological disorders. It has been adapted to brief treatment programmes for use in primary care, and to formats with couples and with groups (Schramm, 1998). This treatment has shown its efficacy by comparison with Cognitive-Behavioural Therapy or medication, even in cases of severe depression (Elkin et al., 1989; NICE, 2004).

However, despite the existence of highly effective treatments, a significant number of patients fail to improve, developing chronic depression (Elkin et al., 1989). This has led to the design of programmes for the treatment of resistant and chronic depression. Cognitive-behavioural approaches and IPT are being applied alone or in combination with medication for this type of depression (Arnow & Constantino, 2003). Special mention should be made of the Cognitive Behavioural Analysis System of Psychotherapy, the sole therapeutic model specifically designed for the treatment of chronic depression, and which incorporates components of cognitive, behavioural and interpersonal therapies in a

bio-psycho-social approach (McCullough, 2000). The published data are highly promising, showing a reduction of symptoms comparable to those achieved by medication, and even better when such therapy is applied in conjunction with drugs (Keller, McCullough, Klein, Arnow, Dunner, Gelenberg, Markowitz, Nemeroff, Russell, Thase, Trivedi, Zajecka, Blalock Borian, Fawcett, Hirschfeld, Jody, Keitner, Kocsis, Koran, Kornstein, Manber, Miller, Ninan, Rothbaum, Rush, Schatzberg, & Vivian, 2002). Data from the cited study suggest a combined treatment approach as the ideal option in chronic depressive disorders.

Moreover, the use of such empirically validated psychological treatments in group format constitutes an approach that is not only efficacious and effective, but also efficient – a far from irrelevant consideration in public health care settings (Romero & Salas, 2003).

The context described in this introduction aroused our interest in the situation of men with severe long-term depression attending our mental health unit, and in initiatives to relieve their suffering through interventions more appropriate to their characteristics.

We considered that a group intervention, exclusively targeting such patients, in which they can express themselves and feel understood by other men in the same situation, will permit them to verbalize more appropriately the interpersonal conflicts that give rise to, exacerbate and maintain their depressive conditions.

We continue by presenting the data from an application of Interpersonal Psychotherapy in group format to men affected by high-intensity long-term depression and attended at our Community Mental Health Unit.

## METHOD

### *Sample*

A total of 9 patients attended our Unit. Here we present the data for 6 patients who spent at least four months with the group, permitting adequate assessment of both the beginning and the end. Of these, two attended for four to six months. Of the remainder, three patients were in the group from the outset and one attended for 12 months.

All those attending the group reported medical pathologies that limited their functioning, such as cardiopathies, neurological, oncological and rheumatic pathologies, and so on. Chronic conflict situations in intimate partner and family relationships were common. None of the patients were currently in employment, due to their depression and associated illnesses.

The patients had a long history of treatment in our Unit,

with a mean of 44.2 months. Mean age of the patients on formation of the group was 55.3 years.

All met criteria of major depression with severe current episode, according to the ICD-10 (WHO, 1993). This, in conjunction with the fact that their depression was chronic, means that they also met previous criteria of dysthymic disorder, recurrent depressive disorder or chronic major depression according to the DSM-IVV (APA, 2000).

## INSTRUMENTS

The psychometric assessment carried out consisted in the application of the following instruments:

### *Montgomery-Asberg Depression Rating Scale (MADRS)*

This scale was designed to rate the intensity of the depressive symptomatology. It is an other-applied 10-item scale with a predominance of cognitive and mood-related symptoms. Intensity level can be indicated on a scale from 0 to 6 for each item. There are no cut-off points, but the generally accepted categorization of intensity on the basis of total score is as follows: normality (0-6), mild depression (7-19), moderate depression (20-34), severe depression (35-60). On taking less account of somatic symptoms than other scales (such as the Hamilton Depression Scale), it is especially useful in patients with comorbid medical pathology or severe depression and in elderly patients. Likewise, it is less contaminated by anxiety symptoms (Montgomery and Asberg, 1979).

### *Sheehan Disability Inventory (SDI)*

Aimed at evaluating the disability perceived by patients due to their psychopathological disorder, this instrument rates its interference in three areas (work, social and family), each on a scale of 0 to 10. Together with these three measures, perceived stress level is rated on a 10-point scale and perceived social support on a scale of 0 to 100 points. There are no cut-off points, and the higher the score, the greater the perceived disability. Given its simplicity, the inventory can be used in severely affected patients (Sheehan, Hamett-Sheehan, & Raj, 1996).

### *Clinical Global Impression (CGI)*

This is one of the scales most widely used for assessing severity and improvement of the clinical condition. It has two sub-scales: CGI-SI, for the rating of illness severity, on an 8-point scale, from 0 (unrated) to 7 (the most extreme cases); and CGI-I, for rating level of improvement with respect to baseline, on another 8-

point scale, from 0 (unrated) to 7 (much worse) (Guy, 1976). In the present work we present the data for the severity subscale, CGI-SI.

## PROCEDURE

Total duration of the intervention was two years. It was originally scheduled to last one year (from September to July), but on observing the improvement obtained it was decided to keep the group together for another year so as to increase the symptomatic stability and allow further therapeutic work on other sources of interpersonal conflict. Thus, the treatment not only covered the acute stage of depression but also continued for the prevention of relapse.

Sessions, which lasted 90 minutes, were weekly throughout the first year, becoming fortnightly and later, gradually during the second year, monthly. Given the severity of many patients, size of the groups was limited to between 4 and 6. The idea was that the group would provide an opportunity for interpersonal encounters, a secure base for exploring new alternatives at the cognitive, behavioural and affective levels, and a space for mutual understanding.

The therapy group was of an open character. Opening of the group to new members took place after a period of stabilization of the group dynamics following the admission of the previous members, and after a process of interviews for assessment and information about the group: characteristics, rules, role of the patient, etc. The therapists took advantage of this phase to assess the patient's symptoms and the interpersonal factors related to his depression, and to carry out the requisite psychometric evaluation. This assessment, through the interviews, helped to gain time so that at the point of joining the group the patient was sufficiently familiar with its functioning and characteristics, and for the establishment of an adequate alliance with the group therapist; this helped avoid certain apprehension in the patient that could lead to his dropping out of the treatment programme early.

Below we discuss briefly the content and structure of Interpersonal Psychotherapy. However, for further information we recommend the excellent original manual by Klerman, Weissman, Rounsaville and Chevron (1984), or its Spanish version in Schramm (1998).

### *Interpersonal Psychotherapy*

IPT is a specific brief therapy for depressive conditions. It focuses on the interpersonal problems presented by

patients and their connection with current affective distress. Although it does not originate from other approaches, such as Cognitive Therapy or Psychoanalysis, it allows for the occasional use of elements or techniques from other methods as long as they help to increase patients' coping skills and resources. IPT gives more importance to the present than the past, and concentrates on the social roles patients play in their life today. The goal is not only to alleviate patients' symptoms, but also to help them develop more appropriate strategies for coping with the conflict situations in which they are currently involved. It does not seek to modify the personality, though it does acknowledge its clinical relevance.

IPT is implemented in three phases: A) initial or diagnostic phase, B) intermediate or focused phase, and C) final or termination phase. One of the features of the IPT approach is the flexibility it encourages in the therapist, so that the indicated number of sessions is also only a guide.

A) In the *first phase* the aim is to give the patient hope and encouragement, and explain the nature of his current disorder and how we intend to help him. For the assessment, we choose the instruments considered most appropriate, such as semi-structured interviews, scales or inventories. This is an eminently psychoeducational phase, involving explanation of the patient's symptoms, diagnosis, prognosis and proposed treatment. The therapist weighs up at this time whether or not to add pharmacological treatment, taking into account the severity of the condition and the patient's own opinion about it. Another distinctive element in this phase of the therapy is that of conferring the *patient role*, which permits him, during a given period, to remove certain obligations he is experiencing as burdensome at present, allowing the formation of a better therapeutic relationship, but with the aim of his gradually taking more responsibility for his treatment. This acts as a kind of "rest stop" for recovering energy and starting out again refreshed.

In this phase, recent changes in the patient's personal relationships are explored, and their relevance to the current depressive condition is considered. The goal is to identify the areas of conflict that will be worked upon in the second phase. The areas of work can be grouped as follows: mourning (abnormal reaction in view of its intensity or duration), interpersonal role disputes (e.g., conflict with intimate partner, with co-workers or with

superiors), role transitions (enforced retirement, unemployment, etc.) and interpersonal deficits (lack of social skills). Naturally, the longer the duration of the therapy, the greater the possibility of working on different conflict areas.

This first phase covered the first 8 to 10 sessions.

- b) In the *second phase*, after focusing on the areas of conflict, different strategies for coping with and resolving problems are considered, as well as alternative options or plans for behaviour. The relief of symptoms obtained in the initial sessions permits the gradual withdrawal of the *patient role*, so that they can begin assuming responsibility and recovering their previous functioning. This phase took up most of the first and second years.
- c) The final phase involves preparing the patient for leaving the treatment programme, and this can lead to the development of behaviours related to fear or dependence, or even a slight worsening of the patient's condition. There is a summing up of the therapeutic process, the progress made and what the patient has learned. The therapist should help put into practice what has been achieved to consolidate the improvement obtained through the treatment. The goal is the prevention of relapses. This phase accounted for the final sessions of the programme.

Finally, it should be stressed that what is important in IPT are the strategies and goals, more than the techniques, which are chosen and used as required, depending on the goals set. In the group therapy reported here we used various techniques, including problem-solving, social skills training, relaxation training, planning of gratifying activities and cognitive restructuring. The manual is extremely helpful and offers highly specific guidelines, so that a psychotherapist with expertise in other approaches can master IPT without too much difficulty. As far as the therapist's role is concerned, it should be that of an ally, working actively to encourage the participation of all group members, transmitting hope and showing empathy.

## RESULTS

### *Data from the instruments applied*

Given the small number of patients in the sample, for the statistical analysis of the data we used a non-parametric instrument, the Wilcoxon signed-rank test.

The data indicate a significant and sustained improvement in the depressive symptoms. More specifically, all the patients showed a reduction in their

symptomatology of over 45% with respect to baseline, and in four cases the reduction was over 50%. Thus, we can confirm that there was a good response to the treatment; in two patients, indeed, the data indicate clinical remission.

There was a highly significant improvement in level of disability in both the family and social areas, insofar as extreme levels of incapacity at baseline were converted into moderate or even mild levels after the group therapy. As far as disability in the work context was concerned, the data were not significant, though this result was to be expected given the employment incapacity of the group (early retired, permanent disability, etc.).

As regards reported stress level, it was generally rated as extreme at baseline, but as moderate and more manageable after the therapy.

The clinical global impression obtained through the CGI-SI confirms these improvements. As a group, the patients' score improved from one indicative of "severely ill" to one of "mildly ill".

#### **Global clinical impression from the referring doctors**

Below we offer brief summaries of the general impression expressed by the doctors who referred each case.

##### *Case 1*

Patient aged 56, contacts the District Mental Health Team for the first time in 2002, with a condition involving anxiety, irritability and episodes of impulsiveness, which alternated at the time with moderate depressive episodes. He also showed obsessive personality features: excessively neat, meticulous, exacting with himself, and with a tendency to blame himself for professional and marital frustrations. The only apparent trigger was a high level of work stress. Anxiety symptoms and depressive episodes responded only partially to the psychological treatment and medication (antidepressants and anxiolytics) employed, and the improvements in periods when he was off work (and after his permanent invalidity) were also only partial. After a serious accident (a fall into a gully, which he claimed was not self-harm behaviour), we decided, together with his clinical psychologist, to include him in the therapy group.

His adaptation to the group was adequate, and within the space of a few sessions he had become an important figure for the rest of the group members. During the individual interviews he expressed his affection for the

other members of the group, as well as his satisfaction at being able to talk with them about his everyday conflicts. He began to feel altruistic sentiments that would lead him to his current occupation as a volunteer in an NGO.

He himself requested and tolerated reductions in his medication, but this did not prevent his maintaining a strong improvement in areas such as impulsiveness and irritability, anxiety, loss of interest and capacity for enjoyment.

##### *Case 2*

Patient aged 65, makes contact for the first time in 2004, complaining of severe depressive symptoms: anhedonia, withdrawal, sadness, insomnia, anxiety, despair and suicidal ideation. Triggers identified were the loss of the family business and his wife's filing for divorce. His response to pharmacological treatment was satisfactory until 2006 when, coinciding with the diagnosis of a tumour in the bladder, and despite maintenance medication with antidepressants, the melancholic symptoms intensified. We decided at that time to refer him to psychological support and include him in the therapy group.

In the individual interviews the patient repeatedly expressed high levels of satisfaction with the group sessions and reported that his mood had improved in general, noting early on that he had "more energy for doing things around the house." Over the first year of the group therapy the depression symptoms showed a marked and sustained improvement, in spite of the setbacks that occurred during this period (reappearance of the bladder tumour). Ten months after joining the group, he said "I'm a lot better now than before... I no longer feel that apathy or anxiety, or that pain in my chest." The medication was reduced (withdrawal of anxiolytics) during this time without causing relapse.

**Table 1**  
Pre-treatment/Post-treatment comparison of the general results of the sample for the instruments applied

INSTRUMENTS	PRE-TREATMENT	POST-TREATMENT
MADRS	45.33	17.33*
SDI-job	9.33	8.33 n.s.
SDI-social life	9.5	5.5*
SDI-family life	8.58	5.83*
SDI-perceived stress	95%	50.83%*
SDI- perceived social support	20%	60%*
CGI-SI	6.33	2.83*

\* significant difference  $p < 0.05$   
n.s.: non-significant difference

Both Patient 1 and Patient 2 maintained contact with other members of the therapy group outside of the official sessions, permitting an ongoing improvement in their personal and social functioning.

#### *Case 3*

Patient aged 65, consults the District Mental Health Team in 2006 after having experienced the following symptoms for one year: sadness, weeping, anxiety, despondency, and lack of energy/activity, as well as intrusive thoughts about the apparent trigger, the deaths of his brother-in-law (“like a second father to me”) and a sister. He also reports considerable problems in the relationship with his wife (he refers to her as “domineering”), who insults and belittles him, so that the patient has adopted an attitude of withdrawal and submission (he has lost contact with his children and friends). Six months after beginning treatment he attempts to self-harm, so that it is decided to admit him to hospital. On his discharge from hospital we decide, in consultation with his clinical psychologist, to incorporate him into the therapy group; we also make arrangements for him to live with one of his sisters for a month, given the high levels of hostility and criticism he suffers at home.

The adaptation of this patient was gradual, and he missed many interviews at first. During the individual interviews he expressed from the outset how distressing he found it to have to listen to “other people’s problems.” Having got over this initial period, in which he showed a marked tendency for mood swings and withdrawal, the patient noted that on “opening up his problems” to the group he had received a satisfactory response, and felt supported. The clinical improvement in this patient was less evident than in the previous cases, though he did show a reduction in social and family isolation (he re-established contact with his friends at the Civic Centre and with his children and sister), a higher level of activity and less sadness (“I have more good days than bad days”). He remained in the group for four months.

#### *Case 4*

Patient aged 49, begins receiving psychiatric treatment in 1996, after a diagnosis of fibromyalgia. The patient’s complaints from that time on revolve around an incapacity “to do anything at all”, a lack of “energy or excitement about things” and a constant state of anxiety, which improves only partially with the treatment applied (antidepressants, anxiolytics, and individual and group

relaxation therapy). In view of the lack of clinical improvement and his general deterioration (activity, relationships, work, leisure), we decided to include this patient in the therapy group. After several months of treatment he begins to express his interest in taking up activities he had given up years before (he starts working at a football club training children), and his apathy and lack of interest decrease. He maintains the improvement over the last year with the group, increasing his social life and satisfaction with his intimate partner relationship.

#### *Case 5*

Patient aged 56, whose first consultation was in 2005, for anxiety-depression symptoms that had lasted for several months as a consequence of problems at work (greater pressure to achieve goals and disagreements with his superior), and which had caused severe high blood pressure and heart problems. Despite his medication, he began to develop a depressive condition with melancholic features, with a predominance of anhedonia, psychomotor inhibition and extreme social isolation. In view of this it was proposed to include him in the therapy group. After joining the group he showed a gradual improvement, increasing his social activity and stating in the individual interviews that the group had given him “the will to live.” The improvement in his mood had brought about an improvement in his cardiovascular pathology, according to his cardiologist. His feelings of despair and apathy improved considerably, resulting in better global functioning. Despite the detection of cerebral atrophy in the last year, he maintained the progress made.

#### *Case 6*

Patient aged 58 with antecedents of alcoholism and dysthymia. On arrival at our mental health unit he presented severe depression, with high levels of despair, irritability and self-harm ideation, and poor response to the medication received. Stressful factors such as lack of work, rheumatoid arthritis and, especially, being a carer for his mentally ill wife and son for many years, were at the basis of his distress at the time of his referral to group psychotherapy. Given his previous experience of group therapy at Alcoholics Anonymous, he had expressed a desire for such an approach from the outset. Moreover, he was quite afraid of relapsing into his alcohol addiction, losing control over his impulses and behaving aggressively toward his son. He remained on the programme only six months, but in that time he

showed a clear improvement in the most extreme symptoms, increasing his coping ability and his capacity for seeking solutions to his problems. He was also able to increase his level of trust in relations with his family. Finally, as one of the solutions that had been considered, a group of his relatives requested his admission to another care unit where he would receive psychoeducation on his son's mental illness. He reported that the group helped him to cope with a difficult stage of his life and come out the other side.

## DISCUSSION

We consider the results obtained to be of clinical interest. However, we are aware of the methodological limitations of this study, such as the lack of a control group, the small number of participants or the fact that their selection was not random, and with such limitations in mind we acknowledge the need for caution with regard to any conclusions drawn. The shortcomings of this study should be addressed in future research, with a view to obtaining conclusions as valid as possible and helping to improve public services in this area.

The group was designed to attend to severely depressed patients, and preferentially those with a limited or non-existent social network, without incentives in life, who were focused on their own distress and without external references to give them support and help them cope with their suffering. The psychosocial functioning of such patients would also often be severely affected, and they would be largely unresponsive to the individual treatment provided at the Community Mental Health Unit.

The initial assessment through the individual interviews, with adequate analysis of patients' needs and expectations, facilitated better treatment compliance, removing the preconceived ideas and fears that might lead to premature dropout.

The intervention involved work in the acute phase, in order to reduce the severity of the depression, and in the continuing treatment phase, with the eventual goals of improving on the initial achievements, preventing relapses and improving the patients' quality of life. These objectives were largely attained, as can be seen from the results presented. All group members reported having experienced improvement to a level they had not attained for many years. Moreover, our clinical impression suggests that the longer and the more involved they are in the group, the greater the improvement.

Attendance at the group therapy enabled the patients to recover social contacts, serving as a "trampoline" to get in touch with old friends, for example. This, in turn, led to an increase in their social support to levels they had not experienced for years. In general, it helped them live a fuller life.

Gender-related issues emerged spontaneously during the sessions. Patients shared their fears over the shame involved in acknowledging their suffering, a taboo for them as males. They reported being more prepared after the therapy to express their feelings without this affecting their self-concept.

Modifications to medication, where they took place, involved reductions in dosage of antidepressants or withdrawal of anxiolytics. This occurred in four patients. Therefore, the improvements found cannot be attributed to increases in medication.

In any case, we should not overlook the relevance of the curative factors present in effective group therapy, as widely studied by Irving D. Yalom (1986). We were alert to the spontaneous comments of the patients during the sessions about which aspects present in the group were the most relevant to their improvement, finding that those most widely referred to were therapeutic factors such as universality, exchange of information, altruism, understanding of oneself and interpersonal learning. These findings are in the same line as those from previous research (Colli & Zaldivar, 2002).

All of this gives us encouragement to continuing working in this direction, refining the current therapeutic programme so as to offer better care for men with chronic major depression, and attempting to extend the treatment to as many patients as possible. Good collaborative work between the different professionals, combined with clear and specific treatment goals (with a bio-psycho-social perspective from which to observe our patients' problems without prejudice) and sound motivation, are basic elements if patients are to benefit from the best possible care. This represents quite a challenge, but given the results obtained so far, it is worth the effort.

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