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Group Therapy for Patients with Adjustment Disorder in Primary Care

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Abstract. A high percentage of patients have a diagnosis of adjustment disorder (AD) when they arrive at primary care (PC) appointments. However, most of them do not receive adequate psychological treatment. The present study's aim is to determine the efficacy of a group psychological treatment program in patients with AD. The sample consisted of patients with AD from two PC units in Valencia, from which two groups were randomly generated: A treatment group (n = 31) and a waiting-list group (n = 20), homogeneous in terms of socio-demographic and psychometric variables prior to treatment. Treatment consisted of eight one-hour group sessions held on a weekly basis; taking a cognitive-behavioral approach, they addressed aspects like controlling anxiety, cognitive restructuring, and coping techniques. The variables analyzed were: Psychopathology (Revised Symptom Inventory, SCL–90–R), health-related quality of life (Health Questionnaire, SF–12), and risk of suicidal behavior (Suicide Risk Scale). Means comparisons, ANCOVAs, and tests of effect size were performed. Statistically significant differences were observed in the variables, such that after intervention, the experimental group exhibited less anxious (F = 4.11, p =.048, η^2 = .08) and depressive symptoms (F = 2.41, p =.029, η^2= .10) and higher quality of life related to physical (F = 7.17, p =.010, η^2 = .13) and emotional health (F = 10.31, p =.002, η^2 = .18). For the reasons above, we conclude that a comprehensive approach to emotional distress in PC, including group psychological interventions, is one solution for the demand for social services, and could provide savings on economic as well as human costs.

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Adjustment disorder (AD), a profile characterized by the development of emotional and/or behavioral symptoms in response to a stressful event, is among the most common diagnoses in clinical practice, in primary care (PC) settings as well as mental health units (MHUs) (American Psychological Association, 2014; Casey, 2009). However, we found highly variable prevalence rates, depending on the population and the methods utilized. The studies consulted assert that AD is the reason for 10% to 35% of first appointments at MHUs, and 11% to 18% of first appointments in PC settings (Casey, 2009).

The AD profile is considered residual and not very serious, but there is evidence that it lowers quality of life and poses socioeconomic costs in PC, sometimes more than physical illness (Casey, Dowrick, & Wilkinson, 2001; Fernández et al., 2010). One of the most dramatic outcomes of AD is suicidal behavior; studies have reported suicide rates 12 times higher than in other psychological disorders (Gradus et al., 2010).

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Likewise, there is an association between mood and behavioral disturbances observed in people with AD, and their influence on perceived health and quality of life. The relationship between mood and physical health may occur via direct or indirect pathways (Barra, 2003):

> Physiological functioning and the immune system may change as a function of negative life events.
> A person's appraisal of his or her health may vary according to their mood.
> Certain health-related behaviors (eating, drinking alcohol, smoking, or exercising) can be used as emotional regulation strategies.

When stress levels are high, people with low perceived social support are more predisposed to physical ailment than those with higher levels of social support.

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With regard to AD's public health impact, the prominent clinical guidelines advocate for stepped care (National Institute for Health and Care Excellence, 2011), that is, conducting initial group intervention at PC units, and then if that is not enough, patients proceed to the next level of treatment to receive more individualized, intensive treatment at a MHU (Cano, 2011).

The current scientific literature offers no empirically validated treatment to intervene in AD (Simón, Molés, & Quero, 2017), but there is evidence that psychotherapy is an adequate treatment option in various emotional disorders (Batterham et al., 2017; Kaplan & Sadock, 1998; Linde et al., 2015). Specifically, individual cognitive behavioral therapy (CBT) is recommended for anxiety and depression in PC (Butler, Chapman, Forman, & Beck, 2006; Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Cuijpers, Smit, & van Straten, 2007; Høifødt, Strøm, Kolstrup, Eisemann, & Waterloo, 2011; Ministerio de Sanidad y Consumo, 2008). It has also proven effective in a group format (Burgos, Ortiz, Muñoz, Vega, & Bordallo, 2006; Osma, Castellano, Crespo, & García-Palacios, 2015; Sundquist et al., 2015).

Focusing on AD treatment, we found that various studies in Spain successfully applied a CBT-based treatment protocol in patients with AD, even making use of new information and communication technologies (Egea, Trigo, & Bernal, 2014; Molés, Quero, Pérez, Nebot, & Botella, 2015; Sanz-Cruces et al., 2016). Around the world, CBT has yielded favorable results in studies of adolescents and adults with AD, improving psychosocial functioning and reducing anxious and depressive symptomatology (Pelkonen & Marttunen, 2005; van der Heiden & Melchior, 2012).

Yet currently, most patients with AD do not get access to adequate psychological treatment. We observed that only 31.8% in MHUs and 30.5% in PC do (Fernández et al., 2007); thus they are big psychopharmaceutical consumers (Carta, Balestrieri, Murru, & Hardoy, 2009). Moreover, psychological treatment can have a better cost-benefit ratio than psychopharmaceutical treatment (Hollinghurst, Kessler, Peters, & Gunnell, 2005; Pastor, 2008).

Patients who suffered a stressful event that overwhelms their ability to cope, and inflicts suffering and disorientation on their lives, are being treated in the public health system primarily with a pharmacological approach (Casey, 2009; Kovess-Masfety et al., 2007). That said, in recent years, researchers are actively investigating the adequacy of psychological treatment of AD, and results have been promising. With that in mind, our objective is to study the efficacy of a group CBT program for PC patients with an AD diagnosis. The present research hypothesis is that patients treated with group CBT will thereafter present lower psychopathology, lower suicide risk, and better perceived health-related quality of life than patients on a waiting list.

Method

Participants

This study was conducted in cooperation with primary care physicians (PCPs) at two health centers in Valencia. PCPs referred a total of 70 patients with Adjustment Disorder to the Mental Health Unit for assessment, and proposed group psychological treatment. Of the 70, 63 were accepted, having met the inclusion criteria (adult diagnosed with AD or exhibiting anxious and depressive symptomatology) and exclusion criteria (diagnosed with a Personality Disorder, or presenting antecedents of serious mental illness or substance dependence). Participants were randomly assigned to the waiting list group (n = 23) or experimental group (n = 40), and after attrition the final sample consisted of 51 patients (Figure 1).

Participants were 19 to 70 years old (M = 42.31, SD = 12.72) and 54.9% were women. 87.2% were taking psychopharmaceuticals, generally a combined treatment of anxiolytic and antidepressant (34%). Accordingly, 31.9% visited a psychiatrist (psychopharmaceuticals are controlled substances) at the Mental Health Unit during the course of the study, but none attended individual psychotherapy sessions. In 38.3% of cases, the stressor that triggered AD was occupational. For more detailed data analysis, see Tables 1 and 2.

Variables and Instruments

*Presence of psychopathology***.** Revised Symptom Check-List (SCL–90–R), Spanish adaptation by González de Rivera et al. (1989). This questionnaire assesses psychological distress using 90 Likert-type items, anchored at 0 and 4 and divisible into nine symptom dimensions: Somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Furthermore, it provides three global distress indices: Global Severity Index (GSI), Total Positive Symptoms (TPS), and Positive Symptoms Distress Index (PSDI). Its internal consistency is, on all dimensions, greater than or equal to .80, and its test-retest reliability is .70 (Derogatis & Savitz, 2000).

Health-related quality of life. SF–12 Health Survey, Spanish adaptation by Alonso, Prieto, and Antó (1995). This captures health-related quality of life profiles and is applicable to people with or without physical or psychological alteration. It assesses the respondents' mental and physical state, and higher scores indicate better perceived health. Similarly, items are scored, aggregated, and transformed on a 0–100 scale. With respect to its

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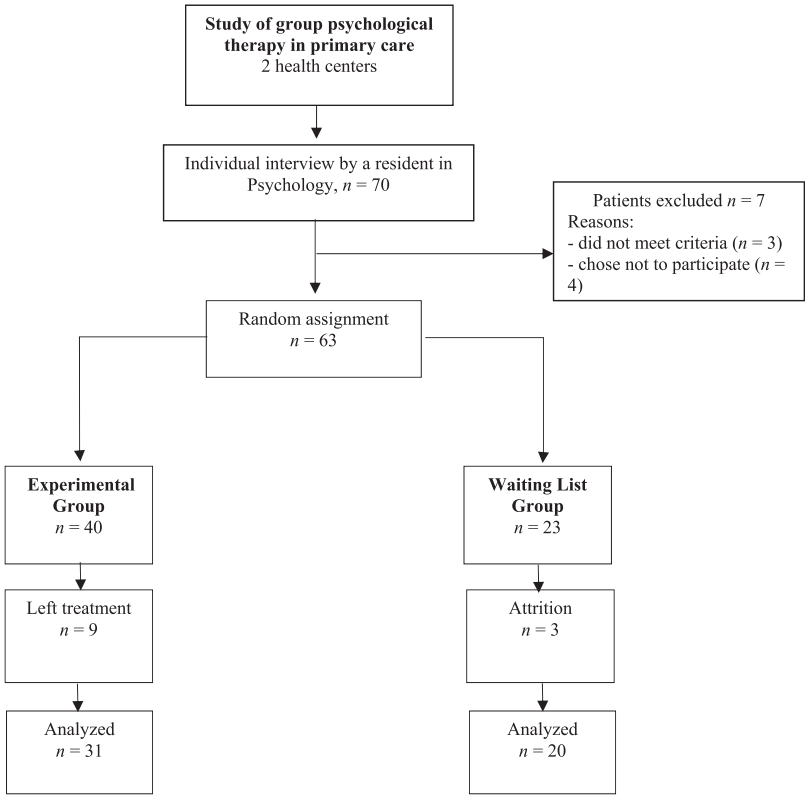

Figure 1. Sample Selection Process.

Table 1. *Descriptive Statistics and Means Differences on Sociodemographic Variables in the Experimental and Control Groups*

	Experimental group	Control group	Between groups differences	*p*
N	31	20	11	
Sex (% women)	54.8%	55.0%	0.2	.991
Age (± *SD*)	43.6 (11.8)	40.3 (14.1)	3.3	.384
Psychiatric care	35.7%	26.3%	0.09	.508
Psychopharmaceutical use	89.3%	84.2%	0.05	.618
Days between assessments (± *SD*)	84.68 (7.8)	83.79 (10.9)	0.89	.961

Table 2. *Descriptive Statistics Pertaining to Psychopharmaceutical Use and Type of Stressor in Experimental and Control Groups*

		Experimental group %	Control group %
Psychopharmaceutical use	Antidepressants	7.1	36.8
	Anxiolytic	21.4	21.1
	Antidepressant and anxiolytic	42.9	21.1
	Other	17.9	5.3
Type of stressor	Occupational	39.3	36.8
	Family-related	25	21.1
	Spouse-related	7.1	5.3
	Other	28.6	36.8

psychometric properties, Cronbach's alpha ranged from .71 to .94 (Alonso et al., 1995).

Risk of suicide. The Suicide Risk Scale (SRS; Rubio et al., 1998) is a 15-question self-report scale with response options yes (1) and no (0). Total scores are considered the sum of affirmative responses. The questions relate to past suicide attempts, the intensity of current suicidal ideation, feelings of depression and desperation,

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and other aspects associated with suicide attempts. On the Spanish validation, scores over 6 are considered at-risk, Cronbach's alpha is .90, and test-retest reliability Cronbach's alpha is .89 (Rubio et al., 1998).

Procedure

Following AD diagnosis and referral by a PCP, a third-year Resident in Psychology (RIP) conducted an initial diagnostic interview, gathering information on aspects of interest to the study. He or she meanwhile gauged the individual's acceptance or rejection of the referral for group psychological treatment. Following the inclusion and exclusion criteria, after collecting signed informed consent paperwork, we administered pre-treatment psychometric tests.

Patients were assigned to the waiting-list group if after assessment, group therapy could not begin due to lack of patients, or because holidays or vacation time would interrupt the course of treatment. When it became possible to start group treatment, subjects were contacted and the psychometric tests repeated, thus providing post-intervention data for the waiting-list group and pre-intervention data for the experimental group.

Five treatment groups were formed with 6–8 subjects each, and then eight weekly one-hour sessions were led by a fourth-year RIP. Patients attended an average of 5.75 sessions. Following treatment, we again evaluated all patients in the experimental group (Figure 1). The treatment's structure and contents are detailed in Table 3.

Data Analysis

This study's data were analyzed in the program SPSS, version 22.0. Patients' data was only included if they attended five or more therapy sessions. We calculated descriptive statistics; carried out Shapiro-Wilk tests of normality; ran t tests for independent samples to analyze basic between-groups differences when the assumption of homogeneity of variance was met; and used Cohen's d to calculate effect size (ES). Additionally, the Mann-Whitney U test and Rosenthal r were used when the assumption of homogeneity of variance did not apply. According to Cohen (1988), values ≈ .20 indicate small ES, medium ≈ .50, and high ≈ .80.

A simple between-groups ANCOVA was done, with two treatment conditions – experimental group and control group – to observe if there was an effect on emotional symptomatology. The covariable was pre-intervention score, having verified that all the pertinent assumptions were met. Partial eta squared was used to measure effect size, recognizing that values ≈ .02 indicate a small ES, ≈ .15 medium, and ≈ .30 large.

Results

Pre-treatment results broadly suggested a high presence of psychopathology – particularly depressive, anxious, somatic, and obsessive-compulsive symptomatology – indicated by high global severity indexes in both groups. This was accompanied by a noticeable decline in quality of life related to physical and mental health, and by worrisome scores on risk of suicide. Prior to intervention, no statistically significant differences were observed between groups (control and experimental) on any of the aspects evaluated; small effect size was observed on all parameters. Therefore the two groups were considered similar prior to their respective experimental conditions (Table 4).

We tested the assumptions that have to be met in order to conduct ANCOVA. The covariable had a statistically significant effect on post-treatment scores,

Table 3. *Treatment Sessions Plan*

Session	Content
1. **Introduction**	Energetic introduction. Explain expectations about treatment and intended solutions.
2. **Psychoeducation**	Introduce techniques to control arousal: diaphragmatic breathing.
3. **Techniques to control arousal**	Progressive muscle relaxation.
4. **Cognitive restructuring I**	Come up with practical examples to learn to identify: A (situations), B (thoughts), and C (behaviors and emotional states). Turn in self-registry.
5. **Cognitive restructuring II**	Discuss negative thoughts and substituting them for more positive ones. Registry of new behaviors and resulting feelings.
6. **Exposure to feared situations**	Imagined exposure. Exposure homework.
7. **Problem solving**	Differentiate between worries and problems. Do practical exercises with examples proposed by participants.
8. **Preventing relapse**	Review earlier content. Goodbye.

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Table 4. *Analysis of Differences between the Experimental and Control Groups Pre-treatment*

		Experimental group *M(SD)*	Control group *M(SD)*	*T*	*U*	*p*	*d/r*
SCL–90–R							
	Somatization	1.5 (0.9)	1.8 (0.9)	–1.16	/	.253	.33
	Obsessive-compulsive	1.8 (0.8)	1.9 (1.0)	–0.42	/	.677	.11
	Interpersonal sensitivity	1.4 (0.8)	1.3 (1.0)	/	269	.428	.11
	Depression	2.0 (0.8)	2.1 (1.0)	–0.36	/	.718	.11
	Anxiety	1.6 (0.9)	1.7 (0.9)	/	285	.629	.08
	Hostility	1.1 (0.8)	1.5 (1.1)	/	257.5	.309	.04
	Phobic anxiety	1.0 (1.0)	0.8 (1.0)	/	288	.669	.09
	Paranoid ideation	1.4 (1.0)	1.3 (1.0)	/	280.5	.568	.08
	Psychoticism	0.9 (0.7)	0.9 (0.8)	–0.14	/	.886	0
	Global severity index	1.5 (0.8)	1.6 (0.7)	0.40	/	.692	.13
SF–12							
	Mental state	39.2 (24.4)	44.6 (23.8)	/	273.5	.480	.07
	Physical state	32.1 (20.3)	31.8 (26.5)	–0.78	/	.971	.01
Plutchik's Scale							
	Suicide risk	6.6 (3.2)	6.2 (3.4)	/	286	.641	.09

Note: Effect size (Cohen's *d* and Rosenthal's *r*) = small ≈.20; medium ≈ .50; large ≈ .80.

whereas no statistically significant effect occurred between the covariable and the independent treatment variable. We also tested for homogeneity of regression slopes and confirmed there was no statistically significant interaction between the covariable and the treatment variable. Moreover, we observed that patients who had attended group therapy scored lower on depressive and anxious symptomatology, and showed improved quality of life related to physical and mental health compared to patients who did not receive treatment. The difference was statistically significant, and the effect size small or medium in all cases (Table 5).

Discussion

Although the tenets of PC consider actions from a biopsychosocial view, and even though a high percentage of PC visits cannot be treated from a purely biomedical perspective, the reality is that few patients actually receive comprehensive care on demand (Pastor, 2008). In our study examined two groups – experimental and control – that were statistically similar on demographic variables, the time interval between pre- and post-treatment assessments, and the variables examined.

In terms of our objective, results were consistent with expectations. However, the hypothesis we proposed was only partially confirmed in that patients who attended group therapy showed reduced emotional symptomatology and improved quality of life, but did not reduce their risk of suicide.

With respect to the SCL–90–R questionnaire, we observed the biggest changes on the dimensions targeted by treatment: *Depression* and *anxiety*. These results are consistent with past research as well as systematic reviews of the effectiveness and efficiency of group CBT versus individual intervention for this type of issue (Huntley, Araya, & Salisbury, 2012; Segarra, Farriols, & Palma, 2011; van der Heiden & Melchior, 2012).

We believe it was important to improve depression and anxiety indexes given that patients scored most severely on those items. Nonetheless, other items tapping anxious symptomatology – like phobic anxiety and somatization – did not show a significant reduction in severity. This finding leads us to consider how we might potentiate strategies to reduce anxious symptomatology, including third-generation techniques like mindfulness, which has proven effective in other group interventions (Sanz-Cruces et al., 2016).

The present study also evaluated the impact of psychological treatment on physical distress, using items on the SF–12 to assess physical state, and items on the SCL–90–R to detect somatizations. On the first aspect, subjects reported better perceived health, yet they showed no significant improvement on the second. Sánchez-García (2014) reported the same apparent contradiction; in their case, 65.38% of participants reduced their physical distress while somatization did not change. That said, we believe the two instruments evaluate non-equivalent constructs such that the SF–12 detects health-related quality of life profiles, while the SCL–90–R's somatization index determines if specific somatic symptoms are present. Ergo, patients may improve their mood and feel better physically, but continue to present somatic symptoms that are harder to eradicate through psychological treatment.

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Table 5. *Analysis of Pre- and Post-treatment Differences between the Experimental and Control Groups*

		Experimental group *M(SD)*	Control group *M(SD)*	*F*	*p*	η^2
SCL–90–R						
	Somatization	1.17 (0.91)	1.75 (1.04)	3.76	.058	.07
	Obsessive-compulsive	1.47 (0.75)	1.71 (1.10)	0.73	.398	.02
	Interpersonal sensitivity	1.16 (0.81)	1.25 (0.97)	.88	.354	.02
	Depression	1.57 (0.93)	2.08 (0.96)	2.41	.029	.10
	Anxiety	1.25 (0.8)	1.66 (0.94)	4.11	.048	.08
	Hostility	0.96 (063)	1.34 (1.08)	.796	.377	.02
	Phobic anxiety	0.7 (0.85)	0.98 (1.14)	.796	.377	.02
	Paranoid ideation	1.28 (0.88)	1.13 (1.02)	.064	.802	.00
	Psychoticism	0.81 (0.64)	0.92 (0.82)	.491	.487	.01
	Global severity index	1.20 (0.73)	1.52 (0.87)	3.57	.065	.07
SF–12						
	Mental state	51.18 (24.68)	32.20 (25.53)	10.31	.002	.18
	Physical state	58.20 (28.80)	45.21 (29.13)	7.17	.010	.13
Plutchik's Scale						
	Suicide risk	4.93 (3.15)	5.75 (3.24)	3.41	.071	.07

Note: Effect size (η^2) = small ≈ .02; medium ≈ .15; large ≈ .30.

In relation to suicide risk, please note that the sample's pre-treatment index was worrisome. We realize suicide risk is an issue of keen interest when it comes to this diagnostic category (Gradus et al., 2010). With that in mind, we propose that future interventions expand the program to teach participants, through CBT, to manage and curb suicidal ideation and suicide attempts.

Notwithstanding the contributions discussed above, these results can only be considered preliminary given the present study's limitations.

The characteristics of this sample, and the type of sampling utilized, complicate the generalizability of results to the general population. Convenience sampling was used, which can affect the validity of results since they may be due to uncontrolled variables, like patients' motivation or availability to receive treatment, among other considerations. The therapists conducting diagnostic interviews or treatment were not blind, whereas patients were. Furthermore, there was no long-term follow-up to confirm the intervention's effects were stable over time. Future research should increase the sample size and use structured diagnostic interviews, plus self-report measures that enable clinical diagnosis, to increase the study's validity. That being said, this study was conducted in a real-life clinical environment in a place patients were familiar with, which reduces reactivity bias in the assessment context, and thus enhances validity.

In light of these results, we conclude that the data show that multi-component, short-term, cognitive-behavioral intervention is a useful tool to reduce anxious and depressive symptomatology in the context of adjustment disorder. Furthermore, it improved patients' health-related quality of life.

By way of conclusion, there is a high demand in current PC to treat emotional distress in response to stressful life events, such as losing a job or significant other. These adaptive profiles with symptoms of anxiety, depression, and physical distress cannot be referred to specialized units, so they end up being treated with pharamaceuticals, or by PCP's who lack the space and the tools necessary to treat such cases. Group therapy by a clinical psychologist offers an ideal space to foster health, through therapeutic aspects like developing social skills, learning coping skills, and feeling solidarity in pain.

The healthcare system faces numerous challenges to instituting this type of intervention, because while there are spaces and appropriately trained professionals, the figure of the clinical psychologist does not currently exist in PC. For implementation to happen, further studies on the efficiency and effectiveness of psychological treatment are needed, along with awareness raising – for politicians, healthcare workers, and patients alike – about the importance of comprehensive healthcare that attends to patients' needs on a biopsychosocial level.

References

Alonso J., Prieto L., & Antó J. M. (1995). La versión española del SF–36 Health Survey (Cuestionario de salud SF–36): Un instrumento para la medida de los resultados clínicos [The Spanish version of the SF–36 Health Survey: An instrument for measuring clinical outcomes]. *Medicina Clínica*, *104*, 771–776.

https://doi.org/10.1017/sjp.2018.51 Published online by Cambridge University Press

American Psychological Association (2014). *Manual diagnóstico y estadístico de los trastornos mentales* [Diagnostic and statistical manual of mental disorders] (5th Ed.). Madrid, Spain: Panamericana.

Barra E. (2003). Influencia del estado emocional en la salud física [Influence of emotional state on physical health]. *Terapia Psicológica*, *21*, 55–60.

Batterham P. J., Christensen H., Mackinnon A. J., Gosling J. A., Thorndike F. P., Ritterband L. M., … Griffiths K. M. (2017). Trajectories of change and long-term outcomes in a randomised controlled trial of internet-based insomnia treatment to prevent depression. *BJ Psych Open*, *3*(5), 228–235. https://doi.org/10.1192/bjpo.bp.117.005231

Burgos M. L., Ortiz M. D., Muñoz F., Vega P., & Bordallo R. (2006). Intervención grupal en los trastornos de ansiedad en atención primaria: Técnicas de relajación y cognitivo conductuales [Group intervention in anxiety disorders in primary care: Relaxation and cognitive behavioral techniques]. *SEMERGEN - Medicina de Familia*, *32*, 205–210. https://doi.org/10.1016/S1138-3593(06)73258-0

Butler A. C., Chapman J. E., Forman E. M., & Beck A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*, 17–31. https://doi.org/10.1016/j.cpr.2005.07.003

Cano A. (2011). Bases teóricas y apoyo empírico de la intervención psicológica sobre los desórdenes emocionales en atención primaria. Una actualización [Theoretical bases and empirical support for psychological intervention in emotional disorders in primary care. An update]. *Ansiedad y Estrés*, *17*, 157–184.

Carta M. G., Balestrieri M., Murru A., & Hardoy M. C. (2009). Adjustment disorder: Epidemiology, diagnosis and treatment. *Clinical Practice and Epidemiology in Mental Health*, *5*(15). https://doi.org/10.1186/1745-0179-5-15

Casey P. (2009). Adjustment disorder. *CNS Drugs*, *23*, 927–938. https://doi.org/10.2165/11311000-000000000-00000

Casey P., Dowrick C., & Wilkinson G. (2001). Adjustment disorders. Fault line in the psychiatry glossary. *The British Journal of Psychiatry*, *179*, 479–481. https://doi.org/10.1192/bjp.179.6.479

Cape J., Whittington C., Buszewicz M., Wallace P., & Underwood L. (2010). Brief psychological therapies for anxiety and depression in primary care: Meta-analysis and meta-regression. *BMC Medicine*, *8*, 38. https://doi.org/10.1186/1741-7015-8-38

Cohen J. (1988). *Statistical power analysis for the behavioral sciences* (2nd Ed.). Hillsdale, NJ: Erlbaum.

Cuijpers P., Smit F., & van Straten A. (2007). Psychological treatments of subthreshold depression: A meta-analytic review. *Acta Psychiatrica Scandinavica*, *115*, 434–441. https://doi.org/10.1111/j.1600-0447.2007.00998.x

Derogatis L. R., & Savitz K. L. (2000). The SCL–90–R and brief symptom inventory (BSI) in primary care. In M. E. Maruish (Ed.), *Handbook of psychological assessment in primary care settings* (pp. 297–334). Mahwah, NJ: Lawrence Erlbaum Associates.

Egea E., Trigo A., & Bernal M. T. (2014, February). Experiencia de grupo terapéutico para trastornos adaptativos [Experience of group therapy for adaptive disorders]. *Paper presented at Interpsiquis 2014, the 15th virtual meeting of Psiquiatría.com*. Retrieved from https://psiquiatria.com/atencion-primaria/experiencia-de-grupo-terapeutico-para-trastornos-adaptativos/

Fernández A., Haro J. M., Martinez-Alonso M., Demyttenaere K., Brugha T. S., Autonell J., … Alonso J. (2007). Treatment adequacy for anxiety and depressive disorders in six European countries. *The British Journal of Psychiatry*, *190*, 172–173. https://doi.org/10.1192/bjp.bp.106.023507

Fernández A., Saameño J. A., Pinto-Meza A., Luciano J. V., Autonell J., Palao D., … Serrano A. (2010). Burden of chronic physical conditions and mental disorders in primary care. *The British Journal of Psychiatry*, *196*, 302–309. https://doi.org/10.1192/bjp.bp.109.074211

González de Rivera J. L., Derogatis L. R., de las Cuevas C., Gracia R., Rodríguez F., Henry-Benítez M., & Monterrey A. L. (1989). *The Spanish version of the SCL– 90–R. Normative data in the general population*. Towson, MD: Clinical Psychometric Research.

Gradus J. L., Qin P., Lincoln A. K., Miller M., Lawler E., & Lash T. L. (2010). The association between adjustment disorder diagnosed at psychiatric treatment facilities and completed suicide. *Clinical Epidemiology*, *2*, 23–28. https://doi.org/10.1192/bjpo.bp.117.005231

Høifødt R. S., Strøm C., Kolstrup N., Eisemann M., & Waterloo K. (2011). Effectiveness of cognitive behavioral therapy in primary health care: A review. *Family Practice*, *28*, 489–504. https://doi.org/10.1093/fampra/cmr017

Hollinghurst S., Kessler D., Peters T. J., & Gunnell D. (2005). Opportunity cost of antidepressant prescribing in England: Analysis of routine data. *British Medical Journal*, *330*, 999. https://doi.org/10.1136/bmj.38377.715799.F7

Huntley A. L., Araya R., & Salisbury C. (2012). Group psychological therapies for depression in the community: Systematic review and meta-analysis. *The British Journal of Psychiatry*, *200*, 184–190. https://doi.org/10.1192/bjp.bp.111.092049

Kaplan H. I., & Sadock B. J. (1998). *Synopsis of psychiatry*. Baltimore, MD: Williams & Wilkins.

Kovess-Masfety V., Alonso J., Brugha T. S., Angermeyer M. C., Haro J. M., & Sevilla-Dedieu C. (2007). Differences in lifetime use of services for mental health problems in six European countries. *Psychiatric Services*, *58*, 213–220. https://doi.org/10.1176/ps.2007.58.2.213

Linde K., Sigterman K., Kriston L., Rücker G., Jamil S., Meissner K., & Schneider A. (2015). Effectiveness of psychological treatments for depressive disorders in primary care: Systematic review and meta-analysis. *Annals of Family Medicine*, *13*, 56–68. https://doi.org/10.1370/afm.1719

Ministerio de Sanidad y Consumo (2008). *Guía de práctica clínica para el manejo de pacientes con trastornos de ansiedad en atención primaria* [Clinical practice guidelines for managing patients with anxiety disorders in primary care]. Madrid, Spain: Unidad de Evaluación de Tecnologías Sanitarias.

Molés M., Quero S., Pérez M. A., Nebot S., & Botella C. (2015). Eficacia diferencial de dos formas de aplicar las tareas para casa en el tratamiento de los trastornos adaptativos. Terapia emocional on line vs. formato tradicional [Differential efficacy of two ways to apply

homework in the treatment of adaptive disorders. Emotional therapy online vs. traditional format]. *Àgora de Salut*, *1*, 245–257. https://doi.org/10.6035/AgoraSalut.2015.1.19

National Institute for Health and Care Excellence (2011). *Common mental health disorders. Identification and pathways to care* (NICE clinical guidelines CG123). Retrieved from NICE website https://www.nice.org.uk/guidance/cg123

Osma J., Castellano C., Crespo E., & García-Palacios A. (2015). El protocolo unificado para el tratamiento transdiagnóstico de los trastornos emocionales en formato grupal en el ámbito de la salud mental pública española [The unified protocol for cross-diagnostic treatment of emotional disorders in a group format in the context of public mental health in Spain]. *Behavioral Psychology/ Psicología Conductual*, *23*, 447–466.

Pastor J. (2008). El psicólogo en atención primaria: Un debate necesario en el sistema nacional de salud [The psychologist in primary care: A necessary debate in the national health system]. *Papeles del Psicólogo*, *29*, 271–290.

Pelkonen M., & Marttunen M. (2005). Adolescent outpatients with depressive disorders: Clinical characteristics and treatment received. *Nordic Journal of Psychiatry*, *59*, 127–133. https://doi.org/10.1080/08039480510022981

Rubio G., Montero I., Jáuregui J., Villanueva R., Casado M. A., Marín J. J., & Santo-Domingo J. (1998). Validación de la escala de riesgo suicida de Plutchik en población española [Validation of the Plutchik Suicide Risk Scale in a Spanish population]. *Archivos de Neurobiología*, *61*, 143–152.

Sánchez-García M. (2014). Análisis de la eficacia de un tratamiento grupal cognitivo-conductual en sujetos con somatizaciones [Analysis of the efficacy of a cognitive-behavioral group treatment in subjects with somatizations]. *Anales de Psicología*, *30*, 412–421. https://doi.org/10.6018/analesps.30.2.170271

Sanz-Cruces J. M., García-Cuenca I. M., Cuquerella-Adell M. A., Cano-Navarro I., Jordá-Carreres E., Blasco-Gallego J., & Carbajo-Álvarez E. (2016). Intervención grupal en trastorno adaptativo [Group intervention in adaptive disorder]. *Behavioral Psychology*, *24*, 389–403.

Segarra G., Farriols N., & Palma C. (2011). Prevalencia, impacto y tratamiento psicológico grupal de los trastornos de ansiedad: Una revisión en el ámbito de la atención primaria [Prevalence, impact and group psychological treatment of anxiety disorders: A review in the primary care context]. *Aloma Revista de Psicologia, Ciències de l'Educació i de l'Esport*, *28*, 209–224.

Simón N., Molés M., & Quero S. (2017). Tratamientos psicológicos para los trastornos adaptativos: Una revisión [Psychological treatments for adjustment disorders: A review]. *Àgora de Salut VI*, *4*(39), 377–386.

Sundquist J., Lilja Å., Palmér K., Memon A. A., Wang X., Johansson L. M., & Sundquist K. (2015). Mindfulness group therapy in primary care patients with depression, anxiety and stress and adjustment disorders: Randomized controlled trial. *The British Journal of Psychiatry*, *206*, 128–135. https://doi.org/10.1192/bjp.bp.114.150243

van der Heiden C., & Melchior K. (2012). Cognitive-behavioral therapy for adjustment disorder: A preliminary study. *The Behavior Therapist*, *35*, 57–60.