Universitat Autònoma de Barcelona

Integrated Brief Systemic Therapy (IBST) in primary care
Exploration of its effectiveness with patients and General Practitioners

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1. MAIN ABBREVIATIONS

MTP Multimodal Training Programme

BSFT Brief Strategic Family Therapy

BST Brief Systemic Therapy

CBT Cognitive behavioural therapy

CCMs Collaborative Care models

DSM-IV-TR The text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders

ESTR Empirically Supported Therapeutic Relationships

ETSs Empirically supported treatments

FPS CPD Focussed Psychological Strategies Continuing Professional Development

FPS ST Focussed Psychological Strategies Skills Training

GPs General practitioners

IAPT Improving Access to Psychological Therapies

IBST Integrated Brief Systemic Therapy

PFBT Problem-Focused Brief Therapy

SCID-I Structured Clinical Interview for DSM-IV Axis I Disorders

SFBT Solution-Focused Brief Therapy

2. THESIS STRUCTURE

This document provides a report on original primary published research, and is structured according to the traditional reporting guidelines required by journals' editorial policies. The focus first revolves around making sense of IBST research across different therapeutic domains, with a special emphasis on primary care, and secondly looks into its feasibility and usefulness for clinical purposes.

Two main chapters are highlighted: *Introduction* and *General Discussion*: (a) the *Introduction* contains a first section devoted to the epistemological bases of *Integrated Brief Systemic Therapy* (IBST), the psychotherapeutic model that formed the essential base of all the publications. Later, in the second section, there is a general bibliographic review of IBST's research evidence and practice, with a final focus on IBST in primary care. (b) In *General Discussion*, the main second chapter, there is an explanation and discussion of the observations, criticism and considerations regarded as key aspects for the objectives of this thesis.

There is also a *Method* section and a *Results* section, where references are made to two scientific articles that constitute the compilation of the scholarly articles that justify and make up the core of this thesis Another article has been attached in the appendix to provide a better overview of the survey's development, as well as showing greater detail and how the thesis's objectives have been fulfilled. In order to avoid redundancy with already published articles, their methodology has been summarized, alongside an extensive disclosure of their justifications, results and limitations. The contents of this manuscript aim to show a clear and coherent general perspective of all the research conducted and its implications in practice.

Finally, the document includes a compilation of the scholarly articles that constitute the basis of this thesis.

3. COMPILATION OF SCHOLARLY ARTICLES REFERENCE LIST

Art-1:

Barcons C, Cunillera O, Miquel V, Ardèvol I, Beyebach M. Effectiveness of Brief Systemic Therapy versus Cognitive Behavioral Therapy in routine clinical practice. Psicothema. 2016;28:298–303. doi:10.7334/psicothema2015.309.

IF (Psychology, Multidisciplinary; 2016): 1.344; Position: 61/129, Quartile: Q2.

Art-2:

Barcons C, García B, Sarri C, Rodríguez E, Cunillera O, Parellada N, et al. Effectiveness of a multimodal training programme to improve general practitioners' burnout, job satisfaction and psychological well-being. BMC Fam Pract. 2019;20:155. doi:10.1186/s12875-019-1036-2

IF (Primary Health Care; 2018): 2.431; Position: 6/19, Quartile: Q2.

In order to easily identify which article is being referred to throughout the text, the article identifier will be provided in parentheses (*Art-1*, *Art-2*).

4. INTRODUCTION

Recent calls to action on global mental health were predicated on the high prevalence and disability of mental disorders [1]. These findings highlighted for the first time the central position that mental disorders take in population health. Hopefully, efforts like the *Comprehensive Mental Health Action Plan 2013–2021,* proposed by the World Health Assembly, will have great potential to change the direction of mental health in countries around the world [2, 3].

As the global burden of mental disorders continues to grow, health systems throughout the world are struggling to respond adequately [3]. In this context, primary care will surely exercise a key role. Primary healthcare is the access point to the mental health system for the vast majority of the population in Europe, and this is also the case in our clinical context [4, 5]. The number of patients could increase in the near future, taking into account the widespread benefits and acceptance of primary care-oriented health systems in terms of greater effectiveness, efficiency and equity [6]. Even though they remain under-detected, in 2016 1.4 million primary care patients sought assistance for a mental health problem in Catalonia (Spain), which represents 24% of total primary care visits [7]. In a cross-sectional study with a large representative sample of primary care patients and good external validity, Fernandez and colleagues found a 29.5% annual prevalence of mental disorders [8], in line to other related studies. In fact, compared with the pre-Spanish financial crisis period of 2006, a 2010 survey revealed substantial and significant increases in the proportion of patients with mood disorders (19.4% prevalence rate in major depression), anxiety (8.4% in generalized anxiety disorder), somatoform disorder (7.3%) and alcohol-related disorders (4.6% in alcohol dependence) among those visiting primary care centres [9]. So, given that roughly one in four primary care patients presented with multi-morbidity [10] and up to 30% met criteria for a psychiatric disorder [11], patient complexity in the primary care setting is high. As a result, the demand for changing mental healthcare systems towards a greater community focus and deinstitutionalisation may have caused a rise in the workload of general practitioners (GPs), increasing their mental health concerns and the need for solutions.

With regard to primary care, the assumption is that primary care physicians may provide a poorer quality of care for specific diseases than specialists, yet paradoxically, primary care is associated with higher value healthcare for the patient as a whole, as well as better health, greater equity, lower costs, and better quality of care when you look at the entire population [12]. In terms of mental health treatment, there is a need to surpass traditional approaches, based on assistance and recovering the functional capacities of the biomedical model, with others based on a biopsychosocial model that integrates the different levels in which disorders can present themselves (biological, personal and social), with a profound effect on societal inclusion and the right to equal opportunities [13]. The availability and integration of mental health services in communities can encourage the accessibility, acceptability, affordability and scalability of services, as well as promoting adherence to treatment and increasing the likelihood of positive clinical outcomes [14, 15]. From this perspective, in a clinical context, health services are also being rebalanced towards primary and community-based care; they seek people-centred health and integrated care models where decision-making is shared [7, 16]. To achieve these goals and make them feasible and adaptable throughout the territory, it is essential to define, implement and carry out a homogeneous evaluation of all the key care processes that are carried out in the vicinity, including mental health and drug addiction.

A good advance towards the aforementioned biopsychosocial approach paradigm occurs when psychologists and other behavioural health clinicians are incorporated as essential team members in these emerging models of primary care [17, 18]. The psychological interventions for mental health and health conditions will play a central role in our primary health model, as in other environments [19]. Nonetheless, as these psychological therapies are being more firmly established as bona fide interventions within mainstream mental health services, there is a greater case for evidence-based practice and scrutiny of public resources. In fact, patients' mental health can deteriorate if therapies are inappropriate or carried out incompetently [20]. So far, the evidence on the efficacy and cost effectiveness of many different psychotherapies is patchy [21]. With a range of evidence for each mental disorder in consideration, several psychotherapy models have gained support for their application; among others, a special mention goes to *Cognitive behaviour therapy, Family therapy, Interpersonal therapy, Assertive community treatment, psychoeducation; Short-term psychodynamic therapy; Eye movement*

desensitization and reprocessing, Dialectical behaviour therapy and Mindfulness [22–27]. It should be taken into account that these reviews do not usually contain a comprehensive critique of the research undertaken. In any case, Cognitive Behavioural Therapy (CBT) still has a prominent status among academic programs and practitioners, although it has been challenged as many of the studies are of low quality and/or the comparison conditions are weak (i.e., wait list rather than active interventions)[28]. In addition, many other psychological treatments still remain unevaluated in relation to many conditions [29].

Independently of the psychotherapeutic model in question, there are huge concerns about psychotherapy as a scientific discipline: first the limited reproducibility of psychological science [30]. Secondly, psychotherapy research must address critical methodological issues [31], for instance: high exclusion rates [32], and the significant proportion of patients who successfully respond to psychotherapy and who leave trials still with residual symptoms [33], or the dearth of long-term data [34]. Thirdly, meta-analytic studies support a more nuanced view of treatment efficacy than the one implied by a dichotomous classification of supported versus unsupported, suggesting a shift from validating treatment packages to testing intervention strategies and theories of change that clinicians can integrate into empirically-informed therapies [34, 35].

All the questions and mixed results related to the efficacy and cost-effectiveness of psychological interventions, as if they were not enough , are even more pronounced in primary care [36]. Among other reasons, it must be considered that, although most patients with mental disorders (for instance depressive disorders) are seen in primary care, most randomised controlled trials are carried out in more specialised settings [37]. Secondly, the meta-analysis of psychological interventions in primary care points out the absence of high-quality evidence from controlled trials [36]. For instance, there are no carefully-conducted evaluated studies of pragmatic trials conducted in usual practice conditions.

In spite of the aforementioned weaknesses and controversies surrounding psychotherapy, guidelines based on evidence-supported reviews are emerging that back up psychological therapies to treat a range of mental health conditions in primary care [38, 39]. In this context, research outcomes suggest first that clinical psychologists must provide evidence-based psychotherapies that are more suitable for the primary care environment

[40]; secondly, they have to be delivered within a framework of *Collaborative Care Models* (CCMs) in which the interaction between primary care and mental health providers is structured and multi-disciplinary [36, 41, 42].

4.1. Epistemological bases for *Integrated Brief Systemic Therapy* (IBST)

Several previous authors have managed to integrate different models from the *Brief Family Therapy* framework in their clinical practice [43–46]. In this dissertation, we have also tried to accommodate and evaluate two of these key approaches, based especially on Geyerhofer & Komori's empirical integration proposal, as well as Beyebach's proposition, among others [45, 47–50]:

(a) *Problem-Focused Brief Therapy* (PFBT) had its beginnings at the Mental Research Institute in Palo Alto [51–54]. PFBT is a goal-directed collaborative approach to psychotherapeutic change that is conducted through direct observation of client responses to a series of carefully constructed questions.

(b) *Solution-Focused Brief Therapy* (SFBT) was developed by Steve de Shazer, Insoo Kim Berg and their team at the Milwaukee Brief Family Therapy Center (BFTC) in Milwaukee [55–60]. It concentrates on finding solutions in the present and exploring one's hopes for the future to find quicker resolutions of one's problems. SFBT was later enriched through O'Hanlon and Weiner-Davis's developments of this approach [61], among others [62].

(c) *Narrative Therapy* introduces some narrative techniques and procedures [63–65], although this approach was not fully structurally incorporated in our IBST given the limitations to our psychologist's skills: for instance with regard to the *Reframing techniques*, *Externalisation* of problems and "*Deconstruction- and reconstruction questions*".

The aforementioned *Brief Family Therapy* models have been a modal form of treatment for some time [66, 67]. Nonetheless, there is a principally academic debate around the pros/cons of their integration, as well as on how to handle it.

On one hand we are aware that eclectic approaches in psychotherapy are and have been questioned [68]. On the other hand, however, a common method among clinical psychologists in our routine clinical praxis is to choose one theoretical model and apply it in a flexible and integrated way [69]. In fact, despite the availability of evidence-based clinical handbooks for psychological disorders, the choice of the most effective psychotherapy for each patient is complicated. As Krumboltz (1966) phrased it: "*What*

we need to know is which procedures and techniques, when used to accomplish what kinds of behaviour change, are most effective with what kind of client when applied by what kind of counsellor" . So, the balance between integration and purity should be seen as part of a developmental process that encompasses understanding, coherence, tolerance, flexibility and communication [70]. In this context, we have to distinguish *technical eclecticism,* in which a therapist chooses interventions because they work, from the *psychotherapy integration* approach, which looks at the relationship between theory and technique [71]. Since the 1990s, the integration approach has been gaining wider acceptance [67, 72]. In fact, a new research field is evolving towards the search for common goals, aiming at selecting theories and techniques among psychotherapy models and developing a new field in a collaborative and integrative manner [73].

From our understanding, the PFBT, SFBT and Narrative approaches are complementary because, first from a clinical perspective, they open up new possibilities for treatment and raise the option of meeting clients' needs and expectations. IBST decreases the risk of these models being applied in an excessively rigid manner when carried out individually; Geyerhofer & Komori (2004) consider that "*a purely problem focused course often runs danger to get stuck in the complaints and the stories around problems and symptoms. A pure focus on exceptions, resources and solutions often does not meet the clients' needs for complaining, their expectations to finally be able to tell the whole story of suffering to an expert, who hopefully will be able to understand it all*". Secondly, merging the approaches is theoretically feasible once the key domains of conceptualising and conducting the integration in psychotherapy have been analysed: *theoretical integration, technical eclecticism, assimilative integration and common factors theory* [72, 74–76]:

(1) ***The theoretical integration approach*** requires bringing together theoretical approaches from different psychotherapeutic models to develop a major unified theory. This new model has to reconcile different and sometimes contradictory assumptions. Our goal was not to produce a new psychotherapeutic model, but to bring about more supporting evidence that the PFBT, SFBT and Narrative alliance works theoretically and clinically, enhancing the range and impact of the *Brief Family Therapy* framework. From a clinically rooted need, we wanted to overcome the limitations and restraints of each model. We are aware that when therapists try to work across various perspectives, therapy

is too often provided in a disorganised "*eclectic"* way that is neither grounded nor structured. Nonetheless, despite the obstacles, we consider integrative practice and training to be crucial in the 21st century as the field embraces the growing diversity and complexity of families in different situations, which means we need a comprehensive and organised system of care that can effectively treat diverse and complex problems [77].

The IBST offers a flexible and broad framework in which the PFBT, SFBT and Narrative approaches can be brought together. At the same time, the IBST respects the fundamental premises of the models. We regard IBST as more suitable and fitting for *brief family therapies* than other proposals developed later, such as the *Integrative Systemic Therapy* formerly known as *Integrative Problem Centred Metaframeworks* [78, 79]. Instead, it is a theoretical integration proposition, offering *metaframeworks* or overarching constructs for multiple family therapy schools. Besides, contrary to IBST, this *Integrative Systemic Therapy* originally came out of Minuchin's traditional *Structural–strategic approach*. Nonetheless, both meta-theoretical clinical approaches offer guiding principles for working across theories that are both applicable to a wide variety of mental disorders and specific in providing key signposts for therapeutic decision-making.

Regarding the therapeutic *Change* process inside IBST, the model is committed to identifying and organising the influential and active ingredients of psychotherapy that play a key role in treatment outcome. In the case of IBST, they are to some extent originally grounded in co-constructivist approaches to communication and social interactional theories, along with post-structural thinking and its heavy emphasis on language such as Wittgenstein's [80–82]. From this historical perspective, we can see that, as in the 1970s, the understanding of *systems theory* was central to the *structural* (Minuchin) and *strategic* (Haley, Selvini Palazzoli) schools of family therapy which would later develop into *systemic therapy*; they endorsed a postmodern understanding of reality as socially and linguistically constructed. Despite the different therapeutic models developed within the *systemi*c framework, it is possible to infer fundamental proposals and subsequent principles from them (governing the action of systemic therapists) . In fact, some authors called this set of theoretical principle*s Integrated Brief Systemic Therapy (IBST)* [83]. In our case on the other hand (as with other authors supported prior to Hendrick), we apply this "*IBST"* concept to a concrete intervention model [48], instead

of an active attempt at synthesis and confrontation in the systemic field. Some of the key premises or basic assumptions about both the nature and resolution of human problems that guide our therapeutic work are as follows [83–87]:

- *Competence*: the client already has the resources, skills and self-healing capacities required to produce *change*.
- *The primacy of relation*s: the issues that people bring to therapists develop and are maintained in the context of human interaction. It is within the schemas of relationships that there lies both the keys to a problem and its solution.
- *Time-limited interventions*: the idea that therapy *change* takes place in a relatively short time, and in any case, one that is never undefined. The therapist integrates time into treatment planning.
- *Pragmatism*: these three models embrace (to a greater or lesser extent) integration in a natural way. They hold a balanced position between each model's assumptions and the *non-normativism* principle, which makes it easier for the therapist to bring together apparently contradictory procedures.
- The focus on (to a greater or lesser extent) *circularity*, *context*, and *pattern interruption;* these features imply a greater concern with how problems are maintained interpersonally, rather than how and why they originated.
  The resolution of problems is accomplished by getting the client to do something different.
- *Change*: it is assumed that it is achieved more easily when the treatment goal is small and clearly stated; otherwise, that change in one part of the interactional system will lead to a change in the system as a whole

So, we can see that there is a conceptual relationship and a developmental connection between these systemic models [88].

(2) The assimilative integration approach means that a solid grounding in one theoretical approach is accompanied by a willingness to incorporate techniques from other therapeutic approaches; it is important that this seamless quality be present so that the patient's experience is an easy flow of consistent treatment. *Assimilative integration* is useful because it provides integrative methods for tailoring therapy to individual clients

and their singular contexts [89]. The assumption is that there is not a one-size-fits-all therapy.

Along these lines, the IBST decision-making process framework is a versatile, continuously evaluated process. The therapist tries to maintain an open mind, not being too wedded to his or her own hypothesis. Depending on the clinical circumstances (type of mental disorder, level of family support and involvement, motivation to change, number of past psychological treatments, so on), PFBT or SFBT is chosen as the principal therapeutic approach to guide the procedure. They are "*closest cousin*" related approaches [43] that can complement one another if they are integrated diligently [87]. It should be kept in mind that the benefits that can be gained through IBST could go to waste if a premature integration of the models takes place, as it might detract from the process [90]. From this point onwards, we employ interventions that allow us to maintain a coherent position in therapy. It would not make sense, for instance, to start with SFBT (a non-normative model, where the therapist tries to adopt a non-expert position), move on to PFBT (a more directive model, with the therapist in the role of expert), and later use a Narrative format (again constructivist and non-normative). So, there are certain guidelines that inform our decision-making process; this way, in IBST the *assimilative integration* takes place by generating what Beyebach called a *sequential model*, because at different therapeutic stages we can introduce different procedures and techniques (each carry with them certain values, concepts, and premises) without coming into conflict with our initial basic therapeutic orientation (PFBT or SFBT) [47].

Remaining coherent with each PFBT, SFBT and Narrative approach decision-making programme, while at the same merging them in a complementary way, is not always easy. If we succeed, this integration could improve or broaden the spectrum of clinical situations it can be applied to, depending on two dimensions [48]:

1. "*problem" versus "solution":* PFBT By getting a concrete description of the problem behaviour -"*Who does what*?"- and the attempted solutions of everybody involved, PFBT therapists are lead towards a possible *180 degree intervention* which is utilised in sessions or given to clients as a homework task. On the other hand, SFBT therapists are less interested, or

not at all interested in a clear problem description, but from the very first session are looking for *exceptions* and *solutions*.

2. "*behaviour" versus "cognition*": PFBT and SFBT do not work exclusively, but mainly focus on the behaviour of the people involved in the problem interaction, whereas White and Epston are more interested in their cognition.

In conclusion, we see IBST represents a diligent platform to bring together these three therapeutic models not only as far as their premises is concerned, but also in terms of their procedures. Given the characteristics of IBST, a set of practical guidelines to help us to structure the variable process of treatment is provided [47, 48] instead of a formal, closed intervention protocol:

- First, the therapist tackles the problems practically rather than analytically, addressing current stagnant interaction patterns of behaviour between family members and their stories around the problem [81, 91, 92], rather than analysing the alleged causes of any given mental disorder (such as subconscious impulses or childhood trauma) or its biological bases. It is focused on the present and future, going back to the past only to the degree necessary for communicating empathy and accurate understanding of the client's concerns [93].
- It is encouraged to proceed as simply as possible in therapy. So, initially only techniques and procedures related to SFBT or PSFT framework are favoured; the option to resort to other therapeutic models should only be considered if it is believed that they cannot achieve the same positive effect.
- It is intended to fit the clients' characteristics (situation, language, or world views) as much as possible.
- Clients' competence and resources: it is intended to mobilise their resources and hand control back to them (for instance, reversing being more interested in getting advice than in listening to his/her own).
- *Change*: a key concept for these approaches, considered to be constant. Within a cooperative stance and by adaptating to the client's idiosyncratic use of language, the IBST therapist is aware of their changing goals during the therapy process, helping clients to construct a concrete vision of a preferred

future for themselves. The mental health professional continuously helps people identify small positive changes that are currently in process, because this is enough (as long as it is noticed) to foster sustained improvements.

- Use of language: a future-oriented language is adopted, offering new perspectives to client problems. The aim is to create a cooperative relationship, putting the client in control of the *change* process.
- Therapist stance: as explained earlier, we adopt the *assimilative integration* framework; nonetheless, depending on whether the PFBT or SFBT pathway is chosen as a mainstream therapist model, the therapist's stance will vary. In the case of SFBT, the clinical psychologist will attempt to stay "*behind"* the clients, taking a "*not-knowing stance*" [81], following the client's lead and avoiding the imposition of his or her own ideas on the client. The therapist does not lecture clients or tell them what to do, but tries to help them figure out which course of action to follow [84] on their own. In contrast, if PFBT is embraced, we get to know a problem through the solution implied by change. This involves working at a perceptive-emotive and behaviour level, with the final result that there will be a change in cognition, but it is assumed that this takes place only once the pathology has been unblocked.

  In certain therapy situations there is a risk of continually shifting positions from PFBT and SFBT, which can confuse, derail and compromise the therapy outcome. For instance, if we begin from a direct and expert position (using techniques such as *symptom prescription*, *externalize the problem*, and so on), then later we cannot rush to adopt a "*not-knowing stance*" (performing for example the "*miracle question"*, analysis of "*pre-treatment changes"* or *"exceptions"*, and so on). Whether SFT or PSFT is used for the case, it is important to proceed in line with the model, avoiding ready-made "recipes". So, our integration requires a great deal of procedural discipline. Although we can import other techniques, the therapist should return to the starting therapy model as soon as possible.
- *Interpretations*: PSBT, SFBT and Narrative therapists' deliberately refrain from making interpretations and rarely confront their clients; instead, they focus on identifying the client's goals, generating a detailed description of

what life will be like when the goal is accomplished and the problem is either gone or has been coped with satisfactorily [82].

(3) ***The technical eclecticism approach*** introduces different techniques, without a binding theoretical understanding. The therapist does not necessarily investigate why the positive change occurred in order to develop a generalizable model of treatment. In contrast, the *Integration approach* we encourage considers that the assembling process requires not only taking some techniques from different models and applying them as needed, but maintaining the link between theory, evidence, and technique [72]. While adopting the *Integration approach*, the therapist keeps in mind that importing certain therapeutic procedures might jeopardise the epistemological integrity of the base model, inadvertently leading to the adoption of different premises or to a different therapeutic position vis-à-vis the client [94]. The risk raises taking into account our pragmatic emphasis on using whatever might "work." When therapists try to work across numerous perspectives, therapy is too often performed in a disorganised 'eclectic' way that is neither grounded nor structured.

Along the same vein, IBST can be regarded as a kind of flexible umbrella under which different historically and conceptually linked practices within the *Brief Family Therapy* framework could find shelter. It includes basically all post-structuralist therapy models [45] and *Systemic Therapies* [86]. Sharing the aforementioned premises and procedures paves the way to introduce techniques that follow a coherent route-map and methodology [47, 87, 95]; Each technique is used according to the procedure and route-map of the ruling model that is initially embraced:

(a) In the SFBT route-map the process usually begins with finding times or attempts when the issue or problem cycle does not occur, called "*exceptions*". These are then they are amplified, showing how they might contribute towards the resolution to the client's problem, so the client attributes their control to themselves. In contrast with the PFBT model, SFBT spends considerably less, if any, time investigating the problem. In order to develop effective solutions, SFBT also introduces techniques such as *Miracle questions, coping questions, scaling questions, indirect (relationship) questions,* metaphors and short stories in therapy [96].

(b) The PFBT route-map attempts to identify the thoughts, attitudes, beliefs, and/or behaviours assumed to maintain the problem or problem cycle and then work within these thoughts, attitudes, beliefs, and/or behaviours to create small shifts that are then amplified to resolve the client's problem. PFBT is used to reframe some problematic behaviours [50, 97] through: *close-ended questions; to paraphrase; circular questioning*; *metaphors*; *aphorisms;* Milton H. Erickson's *symptom prescription*; and so on.

(c)The Narrative approach helps clients not only towards symptom reduction, but also to transform true stories of problems into true stories of adaptation and meaningfulness [98]. To achieve this goal, different techniques are used such as the *Reframing techniques*, the *Externalisation* of problems or "*Deconstruction- and reconstruction questions*" [63–65].

Links between the Narrative approach and SFBT have been made in particular, although M. White and S. de Shazer differ in terms of therapeutic intent (redefining persons vs redefining contexts), and stance towards the problem (against the problem approach vs utilisation approach). In any case, they are theoretically compatible, representing second cybernetic models that aim to empower clients [43].

(d) Other systemic techniques: some *Structural family therapy* [99, 100] tasks that aim to realign family alliances can be considered, along the use of *ordeals* or individual/family *rituals*.

(4) ***The common factors approach*** refers to aspects of psychotherapy that are present in most, if not all, approaches to therapy. Although there is no fixed established list of common factors (as e.g. *therapeutic alliance, client expectations, therapist empathy*), it is likely that they account for more outcome variance than the specific effects attributed to each psychotherapeutic approach (e.g., interpretations in dynamic therapies or cognitive restructuring in cognitive behavioural therapies) [101].

From one side, PFBT and SFBT hold and promote all the common factors that have been associated with positive outcomes and therapeutic changes that include: the ability of the therapist to inspire hope and to provide an alternative and more plausible view of the self and the world; the ability to give patients a corrective emotional experience that helps them remedy the traumatic influence of previous life experiences; the therapeutic alliance; positive change expectations; and beneficial therapist qualities, such as attention,

empathy and positive regard [35, 73, 102]. From another side, contrary to the *Common factors approach*, PFBT and SFBT do not downplay the importance of the specific techniques applied in psychotherapy, and they do not resort to working only with the common factors known to be related to positive outcomes [71].

In conclusion, given the aforementioned proposed key domains of integration, we consider that this IBST is not only feasible and useful, but also desirable. This convergence is aligned not only with systemic therapies' evolution from "pure" or singular approaches to more integrative ones [86], but also with all the supporting evidence for psychotherapy integration [71]. After 20 years of practice, from a researcher-academic perspective the integration of therapeutic models is still a problematic issue, while from the clinical perspective it is not only current clinical practice but also desirable situation [84].

Regarding the level at which integration works, in our case, integration (if needed) takes place mainly within an *assimilative integration* framework, generating a *sequential model*. We are not simply proposing putting together a set of unsupported, unconventional techniques. Of course, therapists are guided by consistent clinical theory throughout the sessions (whether the SFBT or PFBT pathway is chosen) and our treatment plan undergoes continuous revision.

4.2. Research evidence for *Integrated Brief Systemic Therapy* (IBST)

Before summarising IBST's research evidence, we would like to clarify:

1. First, we do not aim to undertake a systematic analysis of available research or develop clinical guidelines. Rather, our aim in this document is to report on the outcomes of research findings, giving information about the strengths, limitations, and quality of the research available in this field.

2. Secondly, we have ruled out research studies focused on analysing SFBT, SFBT and the Narrative approach separately. In this context, we just would like to point out that SFBT is probably the approach that has assembled the largest body of literature as an evidence-based intervention, given the results from systematic reviews and meta-analysis of randomised controlled trials [103, 104]. This has paved the way for SFBT being recommended by recent reviews of research literature that guide best practice in clinical application [27]. Moreover, beyond federal registries, two states in the United States have also included SFBT on their websites as evidence-based interventions [104]. In any case, a full discussion of the quality and distinguishing research features of the three systemic therapies evaluated separately is beyond the scope of this document. In contrast, we have focused only on the empirical studies in which all or part of these approaches were jointly applied.

3. In our review we have ruled out studies focused only on "*Brief"* psychotherapy. This broad concept brings together other different psychotherapy models [105] besides the *systemic* or (to be more precise) *Brief Family Therapies.*

4. We also discarded studies that target "*Systemic"* therapies, globally [86]. They offer a far too global perspective. For instance, in several research studies, *Brief Strategic Family Therapy* (BSFT) has proven to be effective for adolescent substance use and behavioural problems. The structural components of BSFT treatment draw on the work of Salvador Minuchin, and the strategic aspects are based on work by Haley and Madanes [106].

5. We are aware that the structure and procedure for IBST therapy sessions do not provide a detailed manual, or the standardised, clear-cut models traditionally required from fist-line journal articles. Although it could cause a problem for the biomedical research paradigm, we regard this circumstance as somewhat of an asset. In fact, some authors argue that principally adopting drug trial methodology in psychotherapy research has contributed, to some extent, to clinical psychology's lack of routine clinical practice innovations and poor mental health outcomes [107].

6. Finally, we consider that there is currently reasonable clinical experience and research knowledge about PFBT, SFBT and the Narrative approach (which is not to say that there is enough), in order to continue to foster and support them being merged. Some argue that integration might contribute to muddying the waters for outcome and effectiveness research even further. However, what we really want to assess are the challenges of delivering IBST in everyday circumstances, and its effects in ideal circumstances.

Although for some time now, research shows that practicing therapists pick and choose from a variety of approaches when conducting treatment, few attempts have been made to systematically integrate existing brief therapy models and methods [20]. In our case, perhaps the ongoing discussion around a theoretical integration of these three models of *Brief Family Therapy* does not help to build bridges. So, in this context it is unsurprising that the bulk of IBST research evidence emerges from analysing PFBT [108–110], SFBT [111–113] and Narrative approaches [114–116] separately.

When the PFBT, SFBT and the Narrative approach are considered together, we can mostly find essentially academic and theoretical studies about *Brief Family Therapy* integration (as a whole or in part) [43, 47, 48, 87, 95, 112, 117]. Focusing only on **empirical studies**, as far as we know, Jordan and Quinn's transversal observational study is one of the pioneers that evaluated whether there is a difference between PSBT and SFBT approaches [118] in terms of treatment impact in a single session process. The process of problem identification (starting with the formula of the first session task)

through the process of goal specification was evaluated using three self-reporting measures and one observational measure. Multivariate analysis of the variance in results indicated a significant difference between the two approaches when dealing with the client's perceived problem improvement, outcome expectancy, session depth, session smoothness, and session positivity. In general, both models achieved roughly similar outcomes, but authors suggested that when the unique features of each model were matched to particular client characteristics, the outcome might be enhanced.

From 1996 onwards, after preliminary evaluations (reported in conference presentations, book chapters, so on), Rodríguez-Arias and colleagues carried out a pre-post study without a control group, evaluating the results generated during the application of a *Brief Family Therapy model* (considering PFBT and SFBT) in a psychologist's office at the mental health unit of a rural hospital [119]. After a 20 month monitoring period assessing 785 patients, there were 19% relapses; while the problem had been solved for 66% of dropout cases and for 46% of failure cases. Later, in another pre-experimental study, this *Brief Family Therapy* model (considering PFBT and SFBT) was evaluated in a sample of 65 cases from a private clinic, applying Rodríguez-Arias and colleagues' methodology [120].

In early 2000 Geyerhofer & Komori conducted a non-experimental study (post-intervention assessments with no control group) to evaluate the effectiveness of IBST, combining PFBT, SFBT and the Narrative approach [48]. Using a similar methodology as the one used by contemporary related *Brief Family Therapy* studies [52, 91, 121, 122], they evaluated the treatment outcomes through clients' satisfaction with treatment outcomes, along with their own personal and subjective evaluation of the process. In this case, assessments took place 6 months after the last session, and they generally reported significant improvements. Despite the limitations in methodology, this was a naturalistic study carried out in a real clinical practice.

To sum up, we can observe that (so far) not all SFBT, PFBT and Narrative techniques are equally supported by research evidence when analysed separately. Moreover, when they are integrated into the IBST model, a serious lack of empirical data is observed, in terms

of both quantity and quality. Future clinical and empirical studies are needed to assess and guide this ongoing integration.

4.3. Primary care applications of *Integrative Brief Systemic Therapy* (IBST)

Worldwide, there is significant policy interest in improving the quality of care for patients with mental health disorders and who are under distress. Improving quality of care means addressing not only the effectiveness of interventions, but also the issue of limited access to care [123]. In fact, despite the availability of effective evidence-based treatments for depression and anxiety, many 'harder-to-reach' social and patient groups experience difficulties accessing treatment [124]. Primary care based psychosocial interventions have the potential to effectively alleviate mental disorders while simultaneously reducing barriers such as the stigma of using mental health services and the financial burden of commuting to mental health outpatient clinics.

In the vast majority of this primary care intervention research CBT is used, in up to 70% of studies. It is one of the most extensively utilised, examined and supported types of psychosocial interventions [125, 126] and it shows moderate treatment impacts [127]. Nonetheless, the findings related to the efficacy of primary care psychotherapy interventions should be understood under the light of biases [128]. This means the potential of other psychotherapies being used in primary care should be further evaluated.

Brief systemic interventions in primary care, such as IBST, could be a useful therapeutic alternative to CBT and other related behavioural models for several reasons: they are time-limited focused interventions, in the context of the ongoing relationship between patient and family; they can be implemented through a variety of primary care team members; they encourage the patient to be responsible for healthful living; and finally, evidence supports brief interventions in primary care [129], although their potential needs to be further evaluated.

In the case of IBST specifically, when first analysing the SFBT, PFBT and the Narrative approaches separately, there is again limited research evidence, as less attention has been paid to primary care compared to other mental health settings. Among these, SFBT is probably the approach that has a similarly growing body of literature demonstrating its effectiveness as an evidence-based therapy in primary care [128].

As far as we know, if we focus only on studies in which SFBT and the Narrative approach are partly or totally integrated, one of the first empirical studies is the one carried out by Real and colleagues in 1996. They applied *Brief Family Therapy* (considering PFBT and

SFBT) to treat 18 patients who had suffered somatoform disorder for at least a year [130]. In this pre-post study with no control group, a GP trained in *Brief Family Therapy* applied this treatment, with good results, under the supervision of a specially trained psychologist in scheduled primary care consultations. Moreover, in 2000, Real and colleagues again pointed out a cost reduction when applying *Brief Family Therapy* to somatoform pathology [131].

Later, Schade and colleagues (2009) showed symptomatology and patient autonomy improvements in a case study in which *Brief Family Therapy* (again, considering PFBT and SFBT) was delivered by a psychologist and a family doctor to a patient with somatisation disorder [132]. Afterwards, these authors evaluated the cost-efficiency of this *brief family intervention* for patients with somatoform disorder in a quasi-experimental study with 256 somatoform patients from Chile. The brief family intervention was compared with TAU (treatment as usual), offering a significant cost reduction both 6 months and 12 months after the intervention [133].

Beyond empirical support for IBST, considering the polyhedral and complex nature of mental health disorders, we would like to stress that it is unlikely that a single approach from any given discipline (such as clinical psychology, independently of its theoretical approach) will be enough to treat them. In this context, *Collaborative Care Models* (CCMs) could provide a framework in which related disciplines can be combined. CCMs are team-based, multicomponent interventions that have proven to be cost-efficient for improving mental and physical outcomes for a range of mental health conditions across diverse populations and a range of primary care settings [41].

5. RESEARCH JUSTIFICATION

IBST is a challenging, comprehensive, integrative, systemic, and research-informed approach that aggregates three post-structuralist *brief therapy* approaches [48] that are well-known separately from a clinical perspective. It is a versatile, pragmatic and empowering intervention with its emphasis on people's strength, competence and potential, helping people resolve problems quickly and efficiently. Nonetheless, it still lacks empirical evidence, both together and separately. Comparing IBST to other psychotherapy models, we consider that the use of such an integrated approach may be advantageous for clinicians by, first, helping them to embrace and better tailor the treatment to the specific patient's needs; and secondly, through its focus on the desired changes for the immediate future, which separates it from other approaches that seek for instance to identify and explain problems and their origins. It is a process that helps people change by constructing solutions rather than dwelling on problems, and finally, this type of therapy tends to promote more short-term changes than traditional psychotherapy.

Given the advantages of IBST assets and all the considerations previously covered in the *Introduction*, we considered it was worthy to examine the effectiveness of IBST in depth, evaluating its feasibility and usefulness for different clinical purposes. We expected to observe at least similar clinical outcomes when compared to *gold standard* therapies such as CBT. First of all, because there is no universally acceptable treatment for all kind of patients and situations. Secondly, because we know that there are certain groups of patients for whom CBT might not be the first choice treatment. It may not be suitable for people who have more complex mental health needs (a severe mental disorder such as schizophrenia) or learning difficulties (for instance, mental retardation) [134], although it can also be applied to IBST. Thirdly, given the structured nature of CBT, it might be less effective for those patients who are more prone to *over-intellectualising* problems as a psychological mechanism by which reasoning is used to avoid feelings associated with emotional stress. As already explain in *epistemological bases*, IBST does not focus on re-training maladaptive thoughts in order to make changes in how you feel. Finally, CBT might be less suitable for those patients where it is crucial to address current stagnant interaction patterns of behaviour between family members and their stories around the problem.

In this dissertation we focused on primary care settings because it is where the scarce research on IBST is particularly tangible. It is also, from our point of view, the platform in which this model has the greatest potential, given its credentials. This evaluation had to take place with high ecological validity standards, and the interventions had to be carried out within a *Collaborative Care Model* (CCM) framework.

Two main surveys were scheduled to evaluate the potential of IBST:

- The first one (*Art-1*) was devoted to analysing IBST's effectiveness in primary care with patients, comparing IBST and CBT in routine clinical practice.
- The other investigations concerned IBST's utility in primary care for GPs. We chose GPs (as well as patients) because both in coordination meetings and internal qualitative surveys of primary care centres, GPs reported worsening levels of burnout, job satisfaction and psychological well-being. In this context, they explained that dealing with musculoskeletal infections along with increasing mental disorders were the factors that most contributed to this situation. Given these circumstances, an initial transversal observational study with 38 GPs was carried out (Appendix I).

  We would like to mention that this research does not properly constitute the compilation of scholarly articles that justify and conform the core of this thesis. It has been attached as an appendix to provide a better long-term development perspective and goals, and a justification for the IBST's effectiveness in a survey in with GPs in primary care. This study was aimed at determining the following in a sample of GPs from our adult ambulatory mental-health sector: (a) their current level of burnout, professional satisfaction, psychological well-being and attitudes towards mental health; (b) the influence of burnout, professional satisfaction and certain socio-demographic variables on their level of psychological well-being. Given the aforementioned warning indicators of GPs' work-related health and psychological, we felt compelled to conduct this initial transversal observational study. Results showed that burnout (median= 38, IQR = 29, 54) and job satisfaction levels (median = 75.5, IQR = 73, 79) were moderate. Only 5.26% of GPs reported high burnout levels. Anxiety, depression and somatic concerns were the predominant psychiatric symptoms. 55.26% presented

(moderate - extremely severe) symptoms for at least one psychiatric symptom. Regression models reflected that burnout played a key role on psychiatric symptoms. So, GPs presented heterogeneous (generally moderate) levels across the different work-related health parameters analysed, as well as high levels of psychiatric symptoms.

Given the importance of work-related health and the mixed results detected in our sample, later, in a second survey, we tested the effectiveness of a multimodal training program (MTP) with an IBST approach for GPs (*Art-2*).

6. OBJECTIVES AND HYPOTHESES

The **overall aim** of this dissertation is to examine the effectiveness of *Integrated Brief Systemic Therapy* (IBST) for both patients and GPs in primary care settings. Through this dissertation, we have attempted to undertake a rigorous theoretical reflection, and have evaluated a promising therapy programme. Our research was carried out in primary care centres, through clinical rooted interventions and within a *Collaborative Care Model* (CCM) framework.

Two studies were organised to achieve the above mentioned general objective. **The first *(Art-1)*** was aimed at testing the potential of IBST as an effective and efficient treatment in a public mental health setting, by comparing it to Cognitive-Behavioural Therapy (CBT) in routine clinical outpatient practice. In a pre-post study we followed up a sample between one and three years later.

Taking into account the *noninferiority trial designs*[135], we hypothesised that patients would not show worse outcomes when treated with IBST than when treated with CBT, in terms of:

(a) percentages of therapeutic discharges, dropouts, relapses, and use of other mental health services during the follow-up period.

(b) length of psychotherapy treatment.

The objective of our **second study *(Art-2)*** was to investigate the effectiveness of a multimodal training programme (MTP) with an IBST approach for GPs, given the burnout problems, low job satisfaction and low psychological well-being detected in primary care settings in a previous study. The aim of this second study was twofold: a) to determine the effectiveness of an intensive multimodal training program for GPs designed to improve their management of mental-health patients; and b) to ascertain whether the programme could be also useful to improve how the GPs managed their own burnout, job satisfaction and psychological well-being.

We hypothesised better outcomes in the experimental group that underwent the clinical routine programme for primary care plus the *ad-hoc* MTP, when compared to the control group (which was only applied to the first one), in terms of:

(a) Management of indicators for mental health patients:

- Administrative and healthcare indicators: (1) *Total annual visits for all pathologies;* (2) *Rate (percentage) of annual visits linked to Mental Health*; (3) *Rate of Accessibility*.
- Opinions about Mental Illness

(b) Burnout, job satisfaction and psychological well-being indicators:

- Job satisfaction
- Burnout
- Psychological well-being
- Psychopharmacology use

7. METHOD SUMMARY

In our **first study (*Art-1*)** we conducted a quasi-experimental, pre-post study with two non-randomised groups. Participants were 419 patients referred by GPs from six primary care units. 212 participants were allocated to a routine cognitive-behavioural therapy programme and 207 to a new IBST programme. Patients were followed between one and three years. The main outcome measures used were therapeutic discharges, dropouts, relapses and the use of other mental health services during the follow-up period. A detailed description of the programme is provided in the article.

Similarly, the **second study (*Art-2*)** carried out was also a quasi-experimental research with two non-randomised groups. In this case, 18 GPs made up a control group that underwent the routine clinical mental health support programme for primary care. A treatment group (N=20) additionally received a Multimodal Training Programme (MTP) with an IBST approach. Through questionnaires and a clinical interview, level of burnout, professional satisfaction, psychopathological state and various indicators of the quality of administrative and healthcare management were analysed at baseline and then ten months after the programme, between January 2016 and February 2017. Again, an exhaustive explanation of the programme is provided in the article.

8. RESULTS: ORIGINAL RESEARCH

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Effectiveness of Brief Systemic Therapy versus Cognitive Behavioral Therapy in routine clinical practice

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Abstract

Background: Combining strategies and techniques from different therapeutic approaches is a common procedure in routine mental health practice. It has been claimed that the integration of systemic brief therapies offers useful psychotherapeutic alternatives, especially in our overloaded public mental health services. However, this claim has rarely been put to the test, and comparison with well-established empirically-based treatments has been scarce. **Method:** Of 419 patients referred to an Adult Ambulatory Mental Health Service, 212 were allocated to Cognitive-Behavioral Therapy (CBT), and 207 to an integrative Brief Systemic Therapy (BST). Follow-up assessments of patients' status took place between one and three years later. **Results:** Both therapy models were found to be equivalent in their percentage of therapeutic discharges, drop-outs, relapses and in the use of other mental health services during the follow-up period. Although both treatments were cost-efficient, BST was not briefer than CBT. The between-group equivalence was also confirmed, analyzing the data by psychiatric diagnosis. **Conclusions:** This study provides some preliminary data that suggest that BST might be an effective and efficient treatment in public mental health practice, comparable to well-established treatments like CBT.

Keywords: Brief systemic therapy, cognitive behavior therapy, effectiveness, efficiency.

Resumen

Efectividad de la Terapia Sistémica Breve versus la Terapia Cognitivo-Conductual en la práctica clínica rutinaria. **Antecedentes:** la combinación de estrategias y técnicas de diferentes modelos psicoterapéuticos es un procedimiento común en la práctica habitual en salud mental. Se ha propuesto que la integración de terapias sistémicas breves ofrece alternativas psicoterapéuticas útiles, especialmente en nuestros sobrecargados servicios públicos de salud mental. Sin embargo, esta afirmación apenas ha sido investigada y la comparación con tratamientos empíricamente validados ha sido escasa. **Método:** de 419 pacientes adultos remitidos a un Servicio Ambulatorio de Salud Mental, 212 fueron asignados a Terapia Cognitivo-Conductual (TCC) y 207 a una Terapia Sistémica Breve integrativa (TSB). Las evaluaciones del estado de los pacientes tuvieron lugar entre uno y tres años más tarde. **Resultados:** ambos modelos terapéuticos resultaron equivalentes en términos de sus porcentajes de altas terapéuticas, abandonos, recaídas y uso de otros servicios de salud mental durante el tiempo de seguimiento. Aunque ambos tratamientos fueron coste-eficientes, la TSB no fue más breve que la TCC. La equivalencia entre grupos fue también confirmada analizando los datos según los diagnósticos psiquiátricos. **Conclusiones:** este estudio aporta datos preliminares que sugieren que la TSB podría ser un tratamiento efectivo y eficiente en servicios públicos de salud mental, comparables con otros tratamientos bien establecidos como la TCC.

Palabras clave: terapia sistémica breve, terapia cognitivo-conductual, efectividad, eficiencia.

Brief Systemic Therapy (BST) (Beyebach, 2009; García, 2013; Quick, 2008; Selekman & Beyebach, 2013) is the integration of Problem Focused Brief Therapy (PFBT) (Weakland & Fisch, 1992) and Solution Focused Brief Therapy (SFBT) (de Shazer, Dolan, Korman, Trepper, McCollum, & Berg, 2007). These two brief therapy approaches are relational and interpersonal in nature, sharing their basic assumptions about therapeutic change. However, they adopt complementary therapeutic strategies: while PFBT focuses on interrupting the problematic "ironic processes" (Rohrbaugh & Shoham, 2001) that maintain problems, SFBT emphasizes exceptions to the problem patterns, the resources that clients possess and how they can be applied to reach their goals (de Shazer et al., 2007). Separately, both therapies have provided empirical evidence of their effectiveness (Franklin, Trepper, Gingerich, & McCollum, 2011; Gingerich & Peterson, 2013; Kim, 2008; Rohrbaugh & Shoham, 2001), demonstrating they can be used successfully in the treatment of a variety of behavioral and psychological problems. They have also been compared with other well-established therapies in a small number of randomized controlled trials (Boyer, Geurts, Prins, & Van der Oord, 2014; Castelnuovo, Manzoni, Villa, Cesa, & Molinari, 2011; Cohen, O'Leary, & Foran, 2010; Knekt et al., 2008). However, the integration of SFBT and PFBT (Geyerhofer & Komori, 2004;

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Quick, 2008; Saggese & Foley, 2000), with its promise to increase the clinical range of PFBT and SFBT applied separately, has so far only produced limited research evidence (Beyebach et al., 2000; Carrera et al., in press; López & Muñiz, 2014; Rodríguez-Arias, Otero, Venero, Ciordia, & Vázquez, 2004) and has yet to be compared with well-established alternative treatments.

Cognitive Behavioral Therapy (CBT) is one of the therapeutic approaches of choice for the treatment of most of the mental disorders usually referred to Clinical Psychology from Primary Care services, such as anxiety disorders (Otte, 2011), depression (Driessen & Hollon, 2010) or personality disorders (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010). Therefore, it can be considered a golden standard with which to compare BST.

The aim of this study was to test the potential of BST as an effective and efficient treatment in a public mental health setting by comparing it to CBT in routine clinical ambulatory practice. To this end, a controlled, non-randomized design was used on a well-defined participant sample. The primary goal of the study was to compare the outcomes of these two treatments in terms of their percentages of therapeutic discharges, dropouts, relapses, and use of other mental health services during the follow-up period. A secondary aim of the study was to determine whether BST was briefer than CBT in this sample.

Method

Participants

The sample of this naturalistic study consisted of 422 adult patients who were referred to the *Mental Health Support Program to Primary Care* by the General Practitioners (GP) of six Primary Care units in Catalonia, Spain, that cover a population of approximately 125.000 inhabitants. The only exclusion criteria were a diagnosis of moderate or severe mental retardation or of a substance dependence disorder. Sample homogeneity was demonstrated in a previous study (Barcons et al., 2014).

The average age of the sample was 38 years, with a majority of women (73%). Concerning marital status, 47% of the patients were married, 12% divorced and 30% single. Regarding education, 42% of the patients had completed at least secondary school. 28 % were unemployed, 10% on sick leave and 7% retired. From a clinical point of view, 65% of the patients had a history of psychiatric disorders and 7% also a history of suicide attempts, and 87% of the sample had been prescribed psychiatric medication by their GP or by other mental health professionals.

From the mental health point of view, 37% of the sample received a DSM-IV-TR adaptive disorder diagnosis, and 29% of the sample an anxiety disorder diagnosis; 14% were diagnosed with depressive disorder, and 8% personality disorders. Less frequent (less than 10 cases per diagnostic category) were somatoform disorders, psychotic disorders, impulse-control disorders, sexual disorders, eating disorders, and attention-deficit disorders.

Instruments

Recruitment of patients took place from 06/2011 to 06/2013. Data collection complied with data protection required by the Spanish Ministry of Health especially in terms of confidentiality and consent. In the first session, the therapists established a mental health diagnosis according to DSM-IV-TR criteria.

The follow-up assessment of patients' status took place between August and September 2014; therefore, patients' follow-up period was variable, with a minimum of one year. Clinical administrative data were registered as outcome measures: case situation at follow-up (discharge, in treatment, dropout), number of relapses (number of new therapeutic processes initiated by discharged patients), number of admissions to Acute Psychiatric Units, number of referrals to Drug Abuse Treatment Units, and number of referrals to a Day Psychiatric Hospital unit.

Procedure

After being admitted to the *Mental Health Support Program to Primary Care,* 212 patients were allocated to CBT and 207 to BST. Three patients were dismissed from the sample because they received both CBT and BST. The allocation to treatments was not random, being determined according to the geographical location of the patient's Primary Care unit of reference.

CBT as applied in this study focused on modifying patients´ dysfunctional emotions, maladaptive behaviors and dysfunctional cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. Homework assignments were used in most cases. Although the treatment was not applied according to a closed manual, it followed the guidelines proposed for CBT for different disorders (Labrador, Cruzado, & Muñoz, 2001; NICE, 2007, 2011; Williams, 2009). The CBT therapists were two female clinical psychologists with ten and twelve years of experience in using CBT.

BST was applied in a goal-directed and collaborative way, following the general guidelines for the integration of PFBT and SFBT (Beyebach, 2009; Geyerhofer & Komori, 2004; Selekman & Beyebach, 2013). General problem-focused interventions included: defining the complaint in specific behavioral terms; investigating unsuccessful attempted solutions to the problem; and using client position to interdict problem-maintaining solutions (Weakland & Fisch, 1992). The solution-focused component included: negotiating specific and positive goals; identifying exceptions to the problem sequences; discussing possible pretreatment improvements; using scaling questions to encourage small next steps; and giving clients credit for their improvements (de Shazer et al., 2007). All clients received compliments at the end of each session and homework assignments based on what had been discussed during the session. No closed treatment manual was used, but the decision process was based on the available treatment manuals (Beyebach, 2009; Quick, 2008). The therapist was a male clinical psychologist with three years of experience using BST.

In both treatment conditions, the first session focused on diagnosis and case planning; with a maximum of one hour for the first and 30 minutes for the follow-up sessions. Time between sessions varied from 2 weeks to 2 months. Therapeutic discharges were decided by the therapists when symptom remission and a functional improvement of the patients were reported. Patients who unilaterally abandoned therapy and did not return for more than 6 months were considered dropouts.

Data analysis

Sample characteristics were described calculating medians and inter-quartile ranges (IQR) for numerical variables and absolute and relative frequencies (%) for binary and categorical variables.

Differences between intervention groups were tested with the Wilcoxon rank sum tests for numerical variables and Fisher's exact test for categorical variables.

In order to estimate the differential effect of BST *versus* CBT treatment on the main outcome variables adjusting for other confounding variables, multivariate regression models were used. To assess the effect of treatment type on the number of psychotherapy sessions, a negative binomial regression model was adjusted; a logistic model was regressed to estimate the effect of therapy on relapse rates. These effects were adjusted taking into account the following variables: personal history of psychiatric disorders, family history of psychiatric disorders, personal history of suicidal attempts, anxiety disorder, depressive disorder, adjustment disorder, personality disorder, receiving psychiatric treatment, and not taking psychiatric medication. Final models were obtained by consecutively introducing significant two-way interactions and removing non-significant terms according to the Akaike Information Criterion.

All statistical tests were conducted using the R Development Core Team software (2011). Standard significance level of 5% was interpreted as statistically significant.

Given that first sessions were primarily focused on case assessment and planning, re-analyses of only of those patients who had received more than one psychotherapeutic visit was conducted. Patients with only one visit tended to be wrong referrals, as their clinical and functional deficits were insufficient to require therapy proper.

Results

Pretest data

Both treatment groups were homogeneous in terms of patients age (p = .687) and sex (p = .441). There were also no statistically significant differences between therapy groups in participants civil status (p = .540) and labor status (p = .096). A statistically significant difference was observed in the level of schooling (p<.001), although the high number of missing data in this last variable in the CBT group (32%) makes this difference difficult to interpret.

In relation to DSM-IV-TR diagnoses, significant differences between CBT and the BST groups were found. The percentage of anxiety disorders was higher in the BST group (CBT = 24%; BST = 35%; p = .014), adaptive disorders were more frequent among the CBT patients (CBT = 48; BST = 24%; p = .001), and personality disorders were more frequent among the BST patients (CBT = 4%; BST = 13%; p = .002).

At pretest, the percentage of patients with a personal history of psychiatric disorders was significantly higher in the BST than in the CBT group (CBT = 51%; BST = 79%; p<.001), and also the percentage of patients with a family history of psychiatric disorders was higher for the BST condition (CBT = 35; BST = 77%; p<.001). No statistically significant differences among groups were found with respect to the number of other medical diseases that the patients presented (current comorbidity with other medical diseases p = .401), the history of suicidal attempts (p = .051), or the type of mental health setting attended by those patients with a history of personal psychiatric disorders (p = .262).

As displayed in Table 2, some statistically significant inter-group differences in medication prescription were also found. More patients in the BST group were taking benzodiazepines than patients in the CBT group (CBT = 34%; BST = 48%; p = .004). Regarding non-psychiatric medication, BST patients were also taking more medications (p<.001).

Results at follow-up

As shown in Table 3, at follow-up, 8% of the patients in our sample were still in treatment, 52% had been therapeutically discharged, 38% had dropped out, and 2% had been referred to other services. Comparing patients treated with BST with those treated with CBT, no statistically significant inter-group differences were found in the case situation at follow-up (p = .90), with a similar percentage of therapeutic discharges (CBT = 52%; BST = 52%) and dropouts (CBT = 37%; BST = 39%). There were

Table 1
Clinical variables at baseline (N = 419)

Clinical variables	Global	CBT	BST	P[a]
1. P.H.[b] of suicidal attempts	28 (6.68%)	9 (4.25%)	19 (9.18%)	.051
2. P.H. of Psychiatric Disorders				***
No	147 (35.08%)	103 (48.58%)	44 (21.26%)	
Yes	271 (64.68%)	108 (50.94%)	163 (78.74%)	
Unknown	1 (0.24%)	1 (0.47%)	0 (0.00%)	
3. Type of Mental Health Professional				***
Psychologist	71 (16.95%)	34 (16.04%)	37 (17.87%)	
Psychiatrist	86 (20.53%)	42 (19.81%)	44 (21.26%)	
Not specified	1 (0.24%)	1 (0.47%)	0 (0.00%)	
Primary care physician	92 (21.96%)	66 (31.13%)	26 (12.56%)	
Psychologist and psychiatrist	67 (15.99%)	11 (5.19%)	56 (27.05%)	
Unknown	2 (0.48%)	2 (0.94%)	0 (0.00%)	
4. Family History of Psychiatric Disorders				***
No	136 (32.46%)	98 (46.23%)	38 (18.36%)	
Yes	235 (56.09%)	75 (35.38%)	160 (77.29%)	
Unknown	19 (4.53%)	11 (5.19%)	8 (3.86%)	

Note: Median and 1st and 3rt IQR are reported for numerical continuous variables and absolute and relative frequencies are presented for categorical variables
[a] p-values corresponding to Wilcoxon Test for numerical variables and Fisher's exact tests for categorical variables
[b] Personal History
* p<.05; ** p<.01; *** p<.001

Table 2
Use of medication at baseline (N = 419)

Use of medication	Global	CBT	BST	P[a]
Receiving Psychiatric treatment	141 (33.65%)	81 (38.21%)	60 (28.99%)	.050
Prescribed Antidepressants (SSRIs)	192 (45.82%)	87 (41.04%)	105 (50.72%)	.050
Prescribed Benzodiazepines (BZDs)	173 (41.29%)	73 (34.43%)	100 (48.31%)	.004
Other medication (not Psychiatric)				***
No	270 (64.44%)	158 (74.53%)	112 (54.11%)	***
Between 1 and 3	103 (24.58%)	36 (16.98%)	67 (32.37%)	***
Between 4 and 6	28 (6.68%)	11 (5.19%)	17 (8.21%)	
More than 6	18 (4.30%)	7 (3.30%)	11 (5.31%)	

[a] p-values corresponding to Fisher's exact test
* p<.05; ** p<.01; *** p<.001

also no statistically significant differences in the percentage of relapses (CBT = 9%; BST = 11; p = .639), or in the percentage of patients with Emergency Psychiatric Units admissions (CBT = 0.94; BST = 0.97; p = .983), Psychiatric Day Hospital Unit admissions (CBT = 1.42; BST = 0.48; p = .328) or Drug Abuse Treatment Unit admissions (CBT = 0.94; BST = 1.45; p = .632).

Table 3
Treatment outcome measures at follow-up (N = 419)

Follow-up Measure	Global	CBT	BST	P[a]
Case situation at follow-up				.900
Engaged only with Psychotherapy	10 (2.39%)	4 (1.89%)	6 (2.90%)	
Engaged only with Psychiatry	8 (1.91%)	5 (2.36%)	3 (1.45%)	
Engaged with both Psychotherapy and Psychiatry	16 (3.82%)	10 (4.72%)	6 (2.90%)	
Therapeutic discharge	218 (52.03%)	111 (52.36%)	107 (51.69%)	
Dropout	158 (37.71%)	78 (36.79%)	80 (38.65%)	
Engaged with Drug Abuse Treatment Unit	3 (0.72%)	1 (0.47%)	2 (0.97%)	
Engaged with Elderly Psychiatric Units	1 (0.24%)	0 (0.00%)	1 (0.48%)	
Engaged with Psychiatric Day Hospital	1 (0.24%)	1 (0.47%)	0 (0.00%)	
Discharge for transfer	4 (0.95%)	2 (0.94%)	2 (0.97%)	
Relapses	41 (9.79%)	19 (8.96%)	22 (10.63%)	.639
Individuals with Emergency Psychiatric Units admissions	4 (0.95%)	2 (0.94%)	2 (0.97%)	.983
Individuals with Psychiatric Day Hospital Unit admissions	4 (0.95%)	3 (1.42%)	1 (0.48%)	.328
Individuals with Drug Abuse Treatment Unit admissions	5 (1.19%)	2 (0.94%)	3 (1.45%)	.632

[a] p-values corresponding to Fisher's exact test
*p <.05; ** p <.01; *** p <.001

As shown in Table 4, initially a small but significant difference favoring CBT was found between treatments, both in the number of therapy sessions for the whole sample (CBT = 3.71; BS = 3.80; p = .005) and in the number of therapy sessions for those patients receiving therapeutic discharges (CBT = 3.47; BST = 4.16; p = .001). However, reanalyzing data to include only those patients who had more than one session, these differences disappeared both overall (CBT = 5.25; BST = 4.58; p = .788) and for the cases with therapeutic discharge (CBT = 5.22; BST = 4.45; p = .540).

Differences between the CBT and BST groups were also analyzed within the most frequent psychiatric disorders in our samples (adaptive disorder, anxiety disorder, depression). No significant differences were found in the percentage of therapeutic discharges, the percentage of dropouts, the percentage of relapses, or the number of therapy sessions within any of these diagnostic categories.

Regression analyses

The negative binomial regression model (Table 5) revealed that for those patients with neither family nor personal history of psychiatric disorders, successful BST involved more sessions than CBT. However, this effect inverted among those patients with both a family and a personal history of psychiatric disorders, for which BST was shorter than CBT. The rest of the variables present in the model, although influencing the number of sessions, had no differential effect for CBT versus BST.

The final logistic regression model found no significant differential effects of treatment on the percentage of relapses. Presenting an anxiety disorder was associated with a lower propensity to relapse in comparison to other diagnoses, but this was the case for both for CBT and for BST patients: COEF = 3.73 (-6.81, -1.71); OR = 0.02 (0.00, 0.18); p = .002). Although not statistically significant, patients with a family history of

Table 4
Number of sessions according to type of treatment

Variable	Min	1st Q	Median	Mean	Sd	3st Q	Max	Total	W[a]
Nº Therapy Sessions (overall)									
Global	1	1	3	3,75	3,71	5	25	1573	.005
CBT	1	1	2	3,71	4,15	4	25	786	
BST	1	2	3	3,80	3,20	5	22	787	
Overall, excluding those patients with only 1 session									
Global	2	2	3	4.89	3.87	6	25	1451	.788
CBT	2	2	3	5.25	4.53	7	25	709	
BST	2	3	3	4.58	3.21	5	22	742	
Overall for discharged patients									
Global	1	1.25	3	3.81	3.58	5	25	830	***
CBT	1	1	2	3.47	4.12	4	25	385	
BST	1	2	3	4.16	2.88	5	14	445	
Overall for discharged patients, excluding those with only 1session									
Global	2	2	3	4.76	3,68	6	25	775	.740
CBT	2	2	3	5.22	4.67	7	25	339	
BST	2	3	3	4.45	2.83	5	14	436	

[a] p-values corresponding to Wilcoxon Test
* p<.05; ** p<.01; *** p<.001

psychiatric disorder also tended to relapse more, both in the CBT and in the BST conditions.

Discussion

Our findings show that, in our sample, patients treated with BST reached the same outcomes as patients treated with CBT. Therapeutic outcomes for CBT and BST were equivalent in terms of percentage of therapeutic discharges, percentage of dropouts, and percentage of relapses. The equivalence between the CBT and the BST treatments was also confirmed analyzing the data by clinical diagnosis, where no differential effectiveness was found.

Before discussing these findings further, we need to acknowledge a number of important limitations of our study. Given that it is a naturalistic comparison study, patients were not randomly assigned to treatments and in fact the two groups showed some demographic and clinical differences at pretest. As a result, BST patients were initially more disturbed than CBT patients: they were taking more medication and presented a higher percentage of cases with a personal history of psychiatric disorders and with a family history of psychiatric disorders. Multivariate regression models were adjusted in order to control for the differential effect of these possible confounding factors.

Another important limitation is that only three therapists participated in the study, in the double role of both diagnosing patients at onset and conducting the CBT and BST therapies. Finally, the outcome measures, of a clinical-administrative nature (therapeutic discharges, dropout, relapses and number of sessions), are very relevant from a public mental health perspective, but only provide limited clinical information and do not allow to compare the degree of improvement of the patients in the two therapy conditions.

As strengths of our study, we would like to emphasize its external validity. The study was conducted with broad patient inclusion criteria in a real public outpatient mental health unit, with all its accompanying constraints: high service demand, work overload, restrictions to the frequency of follow-up meetings, and so on. The fact that the BST and CBT treatments were not conducted in a manualized way and without measuring treatment integrity is an obvious limitation, but can also be seen as an asset, given that a flexible delivery of treatments is in fact typical of how psychotherapeutic treatments are actually practiced. This is especially the case in public mental health contexts, where case management with other professionals takes place, pharmacological treatments are often used concurrently, and comorbidity is frequent.

Within the context of these limitations and strengths, our data suggest that in our sample, BST was as effective and as cost-efficient as the comparison CBT treatment. In both conditions, the percentage of dropouts was slightly above one third of the sample, but over 50% of the cases were successful therapeutic discharges. For both therapies, this outcome was achieved after a rather low number of sessions, with an average of around 5 sessions. The percentage of relapses was below 10% in both treatment conditions, and the number of cases that had to be referred to more intense care (Day Hospital, Emergency Psychiatric Units or Drug Abuse units) was negligible, below 3% for both conditions.

In our view, these findings are especially relevant from the point of view of BST, given that in our study it successfully withstood the comparison with a "golden standard" therapy like CBT in routine clinical practice. Both therapies tended to be brief, with a median of 3 and an average below 5 sessions for successfully treated cases, and the percentage of relapses and of referrals to more specialized units was very low. In our view, these data suggest that CBT and

Table 5
Negative binomial regression on the number of Psychotherapy Sessions

Variable	Coef.[a]	Exp. Coef.[b]	*P*
Intercept	1.91 (1.19, 2.69)	6.74 (3.28, 14.67)	***
BST Therapy	1.25 (0.06, 2.52)	3.50 (1.06, 12.44)	*
Personal History of Psychiatric Disorders	-0.16 (-0.95, 0.64)	0.85 (0.39, 1.90)	.684
Family History of Psychiatric Disorders	-0.79 (-1.66, 0.10)	0.46 (0.19, 1.10)	.061
Personal History of Suicidal Attempts	-1.08 (-2.12, -0.02)	0.34 (0.12, 0.98)	*
Anxiety Disorder	-0.66 (-1.32, -0.03)	0.52 (0.27, 0.97)	*
Depressive Disorder	-0.54 (-1.26, 0.16)	0.58 (0.28, 1.18)	.122
Adjustment Disorder	-0.49 (-1.15, 0.14)	0.61 (0.32, 1.15)	.128
Not taking psychiatric medication	-1.42 (-2.35, -0.53)	0.24 (0.10, 0.59)	***
(Inter)[c] Family history of Psychiatric Disorders with Not taking psychiatric medication	1.50 (0.47, 2.58)	4.50 (1.59, 13.20)	*
(Inter) BST with Family history of Psychiatric Disorders	-1.26 (-2.37, -0.21)	0.28 (0.09, 0.81)	*
(Inter) Personal History of Psychiatric Disorders with Familiar history of Psychiatric Disorders	1.26 (0.23, 2.33)	3.53 (1.25, 10.24)	*
(Inter) BST with Personal history of Psychiatric Disorders	-0.85 (-1.88, 0.16)	0.43 (0.15, 1.17)	.078

[a] Coefficients and 95% confidence intervals of a Negative Binomial regression model predicting the number of Psychotherapy Sessions
[b] Regression adjusted on the logarithm of the number of sessions minus two, so that Exp. Coef. is interpreted as the multiplicative effect on the number of sessions of the reference group
[c] Indicates that the coefficient is an interaction between two variables (variables that, when presented simultaneously, they do have a different effect than the sum of their separate effects)
* $p<.05$; ** $p<.01$; *** $p<.001$

BST, as applied in our study, were both effective and cost-efficient, fulfilling their role in the context of the needs and constraints of a public mental health service. It should be noted, however, that in our study, a solution-focused treatment like BST had, in fact, no fewer sessions than CBT, in spite of the claims made about solution-focused therapy as probably being briefer than other treatments (Franklin et al., 2011; Gingerich & Peterson, 2012).

Our findings can also be taken to provide some provisional support to the feasibility of integrating different brief solution-focused and systemic therapies, as proposed by the clinical literature (Chang & Phillips, 1993; Quick, 2008; Selekman & Beyebach, 2013). The findings of this study provide some evidence that integrative brief systemic therapy approaches can be effective and efficient in routine clinical practice, as recent research on integrative solution-focused group therapy also suggests (Carreras et al., in press). We expect that future and better controlled studies will allow more robust claims to be made as to the effectiveness of BST for different disorders and settings. In this way, the repertoire of available evidence-based therapeutic tools for therapists would be enlarged, contributing to help patients who might not profit from the most commonly used therapeutic approaches (Hays & Iwamasa, 2006; Roth & Fonagy, 2005).

References

Barcons, C., Sarri, C., Miquel, V., Argila, A., Saló, L., Fàbregas, M., & Sasiaín, P. (2014). Estudio epidemiológico: pacientes atendidos por psicología clínica en el marco de aplicación del programa de soporte de salud mental en atención primaria (PSP) [Epidemiological study: Clinical psychology patients treated in the context of a primary care mental health support program]. *Informaciones Psiquiátricas*, *218*(4), 39-52.

Beyebach, M. (2009). Integrative brief solution-focused family therapy: A provisional roadmap. *Journal of Systemic Therapies*, *28*(3), 18-35.

Beyebach, M., Arribas, F., Rodríguez, M., Hernández, C., Herrero de Vega, M., & Rodríguez Morejón, A. (2000). Outcome of solution-focused therapy at a university family therapy center. *Journal of Systemic Therapies, 19*(1), 116-128.

Boyer, B. E., Geurts, H. M., Prins, P. J. M., & Van der Oord, S. (2014). Two novel CBTs for adolescents with ADHD: The value of planning skills. *European Child and Adolescent Psychiatry*, *24*, 1075-1090.

Carrera, M., Cabero, A., González, S., Rodríguez, N., García, C., Hernández, L., & Manjón, J. (in press). Solution-focused group therapy for common mental health problems: Outcome assessment in routine clinical practice. *Psychology and Psychotherapy: Theory, Research and Practice*.

Castelnuovo, G., Manzoni, G. M., Villa, V., Cesa, G. L., & Molinari, E. (2011). Brief strategic therapy vs cognitive behavioral therapy for the inpatient and telephone-based outpatient treatment of binge eating disorder: The STRATOB randomized controlled clinical trial. *Clinical Practice and Epidemiology* in *Mental Health, 7*, 29-37.

Cohen, S., O'Leary, K. D., & Foran, H. (2010). A randomized clinical trial of a brief, problem-focused couple therapy for depression. *Behavior Therapy*, *41*, 433-446.

Chang, J., & Phillips, M. (1993). Michael White and Steve de Shazer: New directions in family therapy. In S. G. Gilligan & R. Price (Eds.*), Therapeutic conversations* (pp. 95-111). New York, NY: Norton.

de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg I.K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Routledge.

Driessen, E., & Hollon, S. D. (2010). Cognitive behavioral therapy for mood disorders: Efficacy, moderators and mediators. *Psychiatric Clinics of North America, 33*, 537-555.

Franklin, C., Trepper, T., Gingerich, W., & McCollum, E. (2011). *Solution-focused brief therapy. A handbook of evidence-based practice*. New York, NY: Oxford University Press.

García, F. (2013). *Terapia Sistémica Breve. Fundamentos y aplicaciones* [Brief Systemic Therapy. Foundations and applications]. Santiago de Chile, Chile: RIL

Geyerhofer, S., & Komori, Y. (2004). Integrating poststructuralist models of brief therapy. *European Review of Brief Strategic and Systemic Therapy, 1*, 46-64.

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, *23*, 266-283.

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive–behavioral therapy: Assessment, practice and supervision*. Washington, DC: American Psychological Association.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18*, 107-116.

Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., & Laaksonen, M. A. (2008). Randomized trial on the effectiveness of long-term and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3 -year follow-up. *Psychological Medicine*, *38*, 689-703.

Labrador, F., Cruzado, J., & Muñoz, M. (Eds.) (2001). *Manual de técnicas de modificación y terapia de conducta* [Behavior modification techniques manual]. Madrid: Ediciones Pirámide.

López, I., & Muñiz, J. A. (2014). Estudio de los resultados obtenidos con terapia familiar breve en un centro clínico privado [Analysis of the outcomes of brief family fherapy in a private clinical center]. *MOSAICO*, *59*, 26-35.

Matusiewicz, A. K., Hopwood, C. J., Banducci, A. N., & Lejuez, C. W. (2010). The effectiveness of cognitive behavioral therapy for personality disorders. *Psychiatric Clinics of North America*, *33*, 657-685.

National Institute for Health and Clinical Excellence (2007). *Anxiety (amended): Management of anxiety in adults in primary, secondary and community care. NICE guidelines CG22*. London, UK.

Otte, C. (2011). Cognitive behavioral therapy in anxiety disorders: Current state of the evidence. *Dialogues in Clinical Neuroscience*, *13*, 413-421.

Quick, E. (2008). *Doing what works in brief therapy. A strategic solution focused ap-proach (2nd edition)*. London, UK: Academic Press.

Rodríguez-Arias, J. L., Otero, M., Venero, M., Ciordia, N., & Vázquez, P. (2004). Estudio de evaluación de resultados en terapia familiar breve [Outcomes of brief family therapy]. *Papeles del Psicólogo, 25,* 20-28.

Rohrbaugh, M. J., & Shoham, V. (2001). Brief Therapy Based on interrupting ironic processes: The Palo Alto model. *Clinical Psychology Review, 8*, 66-81.

Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York, NY: Guilford.

Saggese, M., & Foley, F. (2000). From problems or solutions to problems and solutions: Integrating the MRI and solution-focused models of brief therapy. *Journal of Systemic Therapies*, *19*, 59-73.

Selekman, M. D., & Beyebach, M. (2013). *Changing self-destructive habits: Pathways to solutions with couples and families*. New York, NY: Routledge.

Weakland, J., & Fisch, R. (1992). Brief therapy-MRI style. In S. Budman, M. Hoyt & S. Friedman (Eds.), *The first session in brief therapy* (pp. 306-323). New York, NY: Guilford Press.

Williams, C. (Ed.) (2009). *Overcoming depression and low mood: A five areas approach*. London, UK*:* Hodder Arnold.

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Effectiveness of a multimodal training programme to improve general practitioners' burnout, job satisfaction and psychological well-being

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Abstract

Background: The changes in the models of care for mental disorders towards a community focus and deinstitutionalisation might have risen General practitioners' (GPs) workload, increasing their mental health concerns and the need for solutions. Pragmatic research into improving GPs' work-related health and psychological well-being is limited by focusing mainly on stressors and through not providing systematic attention to the development of positive mental health via interventions that develop psychological resources and capacities. The aim of this study was twofold: a) to determine the effectiveness of an intensive multimodal training programme for GPs designed to improve their management of mental-health patients; and b) to ascertain if the program could be also useful to improve the GPs management of their own burnout, job satisfaction and psychological well-being.

Method: Eighteen GPs constituted a control group that underwent the routine clinical *Mental health support programme for primary care*. An experimental group ($N = 20$) additionally received a Multimodal training programme (MTP) with an Integrated Brief Systemic Therapy (IBST) approach. Through questionnaires and a clinical interview, level of burnout, professional satisfaction, psychopathological state and various indicators of the quality of administrative and healthcare management were analysed at baseline and 10 months after the programme.

Results: In relation to government of mental-health patients indicators, on the one hand MTP group showed statistically significant improvements in certain administrative health parameters, but on the other it did not improve opinions and attitudes towards mental illness. Regarding GPs management of their own burnout, job satisfaction and psychological well-being assessments, the MTP presented better scores on global psychopathological state and better evolution of satisfaction at work; psychopharmacology use dropped in both groups; in contrast, the MTP did not improve burnout levels.

Conclusions: Findings of this preliminary study are promising for the MTP (with an IBST approach) practice in primary care. More research evidence is required from larger samples and randomized controlled trials to support both the hypothetical adoption of MTP (with an IBST approach) as a part of a continuing professional-training programme for GPs' management of mental-health patients and its positive effects on work-related health factors.

Keywords: Brief systemic therapy, Burnout, General practitioners, Job satisfaction, Primary care, Psychological well-being

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Background

Burnout, job satisfaction and a psychological well-being construct are key work-related health factors that need to be assessed and controlled in any work environment, and hence also in primary-care services. Their correct management could improve the quality of healthcare offered, promoting greater patient satisfaction and better treatment compliance, improving morbidity and mortality, as well as reducing the likelihood of hospitalization [1, 2].

Despite variabilities in defining these constructs, links between burnout, job satisfaction and psychological well-being have been established [3–5]. Recent research shows that GPs have a higher prevalence of mental health problems, such as symptoms of burnout, and are less satisfied with their work-life balance than is the case with the general population [6]. Taking into account the discrepancies in results between the longitudinal and cross-sectional surveys, we observe, first, that given the high levels of burnout and frequency and patient safety incidents within primary care, research on this issue is essential. Nonetheless, burnout prevalence fluctuates over time and countries, observing some studies reporting high rates in their samples [7], whereas others describing lower rates [8]; one survey conducted in 13 European countries found a 12% of GPs scoring *high* for all burnout dimensions [9]. Regrettably, according to longitudinal studies, GPs' burnout prevalence tends to remain relatively stable [10]. Second, despite the contextual differences between longitudinal surveys of GPs' job satisfaction, available evidence does not confirm a declining degree over recent years despite the aforementioned high rates of burnout and poor mental wellbeing [11–13]. Third, so far less attention has been given to GPs' psychological well-being, although certain risk factors in GPs' mental health are indicated by the bibliography, such as lack of reward by patients [14].

Even given the associations found between these three factors, to date there is no sound theory that connects them. Perhaps the strongest proposal would be the *Job demands control model*, since, according to the greater part of occupational stress and health research, most studies of psychosocial factors as antecedents of impaired well-being and work-life imbalance have been based on this model [15].

Attending to the rise in the number of visits, the increasing complexity of clinical work and the scarcity of resources [16], previous levels of burnout, job satisfaction and psychological well-being might change, with a concomitant need for GPs to be better skilled at coping with this increased burden at less personal cost. In this context, a number of limited controlled psychological interventions have already shown certain benefits associated with the improvement of GP burnout, job satisfaction and—especially—psychological well-being. Mindfulness-based programmes may perhaps obtain a prominent status in such contexts, showing short-term benefits in burnout, stress and anxiety levels [17, 18]. Likewise, cognitive-behavioral-based interventions have also displayed short-term improvements in stress outcomes [19, 20]. Recently, a modified mindfulness-based cognitive therapy course also demonstrated the potential to reduce stress and burnout [21]. Furthermore, in a controlled trial evaluating a simple letter, giving feedback and interpreting psychological scores together with a self-help sheet, contributed to a reduction in psychological distress after 3 months [22]. Related systematic reviews and meta-analyses have recommended implementation of the aforementioned approaches, among others [23, 24], but such reviews also questioned the alleged good outcomes due to a detection of various shortcomings. For example, Murray and colleagues conducted a systematic review of 5392 studies related to interventions aimed at improving GPs' psychological well-being, and detected distinct shortcomings and risks of bias such as insufficient information on the temporal stability of the improvements sought; use of self-administered questionnaires as primary outcome measures; and long-term follow-up of mental illness not being reported, among others [25]. Given these circumstances, it is difficult to ascertain which elements of these therapies are really of use for improving doctors' work-related health and psychological well-being. Beyond the debate asking which of the array of therapeutic targets are eligible and what their real impacts are, it would seem to be more effective and appropriate to shift from the deficient approach underpinning stress-response improvement towards a more proactive approach for fostering mental health that empowers and enhances work and personal resources [26].

Considering its multiple and complex nature, it is unlikely that a single approach from a given discipline (such as psychology) could be sufficient to effectively address these work-related factors and the psychological well-being of GPs. In this context, *Collaborative Care Models* (CCMs) offers a framework in which related disciplines can be combined, consequently allowing for an evaluation of their respective interventions. CCMs are team-based, multicomponent interventions that have been shown to be cost-efficient in improving mental and physical outcomes for a range of mental-health conditions across diverse populations and primary-care settings [27, 28]. To our knowledge, CCM methodology has never been tested on the burnout, job satisfaction and psychological well-being of GPs rather than that of patients. One possibility to put this bio-psychosocial programme into practice would be to promote GPs' patient-management strategies and competences for distinct pathologies, most especially for mental disorders. In fact, GP-patient encounters focussing on mental-health concerns represent a large proportion of GPs' patient lists and workload. In our context, even though this remain under-detected, 1.4 million primary-care patients sought assistance for

some type of mental-health problem in Catalonia in 2016, which represented 24% of total primary-care visits [29]. As a comparison, this exceeds the estimated 12.7% of such visits for Australia in 2014–15 [30], for example. To understand this figure, we need to take into account the fact that primary health care is the access to the mental health system for the vast majority of the population in Europe [31]. These numbers may well increase in the near future given the widespread benefits and acceptance of the importance of primary-care-oriented health systems in terms of greater effectiveness, efficiency and equity [32]. It is therefore not surprising that, in light of the high prevalence and disability of mental disorders, recent calls to action for global mental health have been made [33]. GPs will have a key role in this mental-health assistance.

Taking into account the research considerations indicated above, by means of empowering activities and instructions, GPs could enhance their individual and group-management strategies and the competences applicable to mental-health patients in primary care. We should also note that GPs mainly tend to work alone, and also that passive dissemination of guidelines to improve the recognition and management of mental disorders have generally and to date been found to have minimal positive outcomes [34]. In our routine clinical *Mental-health support programme for primary care*, these abilities were taught in an intermittent and unstructured manner, in accordance with both down-top (primary-care-centre coordinators) and top-down demands (GPs' comments in internal qualitative surveys). Our team was therefore requested to devise strategies for delivering better integrated mental health with less personal cost. As a result, the aim of this study was binary: a) to determine, for the first time, the effectiveness of an intensive multimodal training programme (MTP) with an Integrated Brief Systemic Therapy (IBST) approach for GPs designed to improve their management of mental-health patients; and b) to ascertain if the program could be also useful to improve the GPs management of their own burnout, job satisfaction and psychological well-being. In order to assess the first objective, quality-of-healthcare-management indicators were analysed along with GPs' opinions about mental illness; to evaluate the second one, in addition to questionnaires, the use of a clinical interview and psychopharmaceutical indicators were also deemed necessary.

Method

We conducted a quasi-experimental study with two non-randomised groups. Pre and post-intervention measurements were registered among GPs working in the public-health system between January 2016 and February 2017.

Inclusion criteria

Subjects had to be GPs working in public primary-care units. These units also had to belong to the assistance sector of our ambulatory mental-health service. GPs needed to be willing to attend at least 80% of the training programme and to fulfil the psychometric measures.

Participants and recruitment strategy

Our public ambulatory mental-health service provided assistance to all four primary-care units in Sant Boi (Barcelona) throughout the routine clinical *Mental-health support programme for primary care.* All GPs involved were invited to participate. In this programme, in order to strengthen cooperation, a mental-health team regularly visited each primary-care unit to conduct assistance, coordination and training tasks. These primary-care units covered a population of 95,313 inhabitants in 2016; such a territorial representation provides patients from urban and semi-urban areas.

After a presentation on the management of psychiatric patients, GPs from all primary care centres were invited to participate in the study. Those who agreed to participate were given the baseline assessment questionnaires. In addition, an interview with an independent rater (Psychiatry Medical Residency Training programme) was scheduled for each participant. During this interview, besides delivering questionnaires, the *Brief Psychiatric Rating Scale* (BPRS) was applied to assess participants' psychiatric symptoms. BPRS was not used to allocate participants to intervention groups. The rater was trained by a senior specialist in administering BPRS. All interviews were carried out within a maximum period of 15 days from sign-on. The rater was blind to the study's objectives.

Subsequently, GPs were allocated to the experimental group (EG) or control group (CG). Allocation was not random; instead, it corresponded to the primary-care unit for which the participant was working for. Each group was composed of GPs from 2 primary care services, respectively.

Intervention design

The CG underwent our clinical routine programme for primary care, titled *Mental-health support programme for primary care*. It was aimed at treating mild mental disorders in primary-care units from a normalizing and preventive perspective. To accomplish these goals, a team of mental-health specialists visited each primary-care setting to provide frequent and direct assistance. These included a psychiatrist regularly performing weekly clinical and advisory functions; a clinical psychologist also performing clinical and advisory tasks (fortnightly); and a nurse providing monthly advisory and training tasks.

In the EG, within the aforementioned programme framework, we added and carried out a multimodal training programme (MTP). The intervention was structured as a continuing-education course with group psychoeducational activities. It was coordinated by the clinical psychologist guided by the psychotherapy model and the CCMs. Course duration was 9 hours in total and consisted of nine weekly sessions. MTP comprised different clinical group sessions (1 h/session), each conducted by the same professional, in this order:

1. *Clinical Psychology*: a senior clinical psychologist carried out six sessions of integrated brief systemic therapy (IBST), which essentially integrates solution-focused and problem-focused models. Training was conducted according to guidelines [35–37]. In the initial session, participants' attitudes in the management of dysfunctional cases were discussed (for example, paternalistic behavior; difficulties establishing limitations for patients' requests, etc.). Here, as at the end of each session, the aim was to reach group consensus regarding the given topic, which could then be useful for participants' work environment. In the remaining sessions, distinct techniques were taught such as defining complaints in specific behavioural terms; investigating unsuccessful attempted solutions to a problem; using the patients' position to negate problem-maintaining solutions; negotiating specific and positive goals; discussing patients' ambivalence and resistance management; identifying exceptions to problem sequences; discussing possible pre-treatment improvement; using scaling questions to encourage series of small steps; giving patients credit for their improvements; verbal and non-verbal language techniques.

Real-patient videos were presented, and practical exercises were carried out during the sessions. GPs were also encouraged to bring their own cases of patients who might be experiencing difficulties.

2. *Psychiatry*: a senior psychiatrist carried out two sessions designed to provide instruction on how to correctly conduct a psychopathological examination, while also detailing the areas that need to be examined and the correct terminology to use. The intention was not for GPs to establish a thorough diagnosis but rather for their examinations to be more productive and more accurate. This makes coordination meetings with mental-health services more constructive and is of use for therapeutic planning.
3. *Social work*: a senior social worker carried out one session reporting on social and community services that might be suitable for distinct patients, but most especially for those suffering mental disorders. These services included non-governmental organization, family-patient associations, social clubs, etc.

Finally, regarding non-psychiatric medical conditions, GPs were encouraged to reach a consensus on *what not to do* as a team (as opposed *what to do*, which is already well-established in clinical guidelines), given its low efficacy or efficiency.

All participants in the study were offered the course free of charge.

At the end of the study, the EG went back to monitor only the *Mental health support programme for primary care*. Nonetheless, within the ordinary coordinating meetings with GPs, mental-health specialists continued referring to the programme's concepts and procedures, and team agreements were made (for example, if the case was already being treated by our mental-health service, assistance was not duplicated in primary care when the reason for consultation was the same). At all events, no formal mandatory supplementary work was issued during or after the training.

The MTP was therefore an ad-hoc clinically rooted training programme for GPs' management of mental-health patients, although to some extent its psychological dimension could be applicable to all types of cases. It seeks to improve all weaknesses and defects detected by the *Mental-health support programme for primary care* that we were already carrying out. For example, detection of mental disorders, which are often unobserved and/or unrecognised by GPs; shortage of communication and management skills; scarcity of teams' collaborative strategies, etc. These shortcomings were factors affecting GP burnout, job satisfaction and well-being, which were the ultimate targets that we intended to address.

Outcome measures

Outcome measures are shown in Table 1.

We administered validated versions of these instruments for both EG and CG to each participant, selecting those that were most used in the related Spanish bibliography in order to facilitate any comparison:

1. Self-reported psychometric measures:
   (a). Socio-demographic questionnaire designed ad hoc for this study. This included 8 items related to personal, social and work information
   (b). Psychopharmacology use: Within the clinical interview, GPs were asked about the current use of psychiatric medication.

Table 1 List of Outcome measures

Outcomes	Instruments
Management of mental-health patients indicators	
Administrative and healthcare indicators	(a) *Total annual visits for all pathologies;* (b) *Rate (percentage) of annual visits linked to Mental Health;* (c) *Rate of Accessibility*
Opinions about Mental Illness	*Struening and Cohen's Opinion about Mental Illness questionnaire* (OMI) (38)
Burnout, job satisfaction and psychological well-being indicators	
Job Satisfaction	*Font-Roja Job Satisfaction Questionnaire* (FR) (39)
Burnout	*Maslach Burnout Inventory* (MBI) (40)
Psychological well-being	*Brief Psychiatric Rating Scale* (BPRS) (41)
Psychopharmacology use	Current use of psychiatric medication; asked within the clinical interview

(c). *Struening and Cohen's Opinion about Mental Illness questionnaire* (OMI) [38]. The Spanish adaptation has shown satisfactory global reliability (*Cronbach's alpha* = .81). It has 63 items, yielding five standardized opinion-attitude factor scores: *Negativism* (α = .81); *Social/interpersonal* (α = .70); *etiology* (α = .71); *Authoritarianism* (α = .79); *Restrictiveness* (α = .68); *Prejudice (α = .69).*

(d). *Font-Roja Job Satisfaction Questionnaire* (FR) [39]. The *extended version* presents adequate psychometric properties (*Cronbach's alpha* = .79). It has 26 [1–5] Likert-type items. It contains 9 job satisfaction dimensions: *Satisfaction at work; Work tension; Professional competence; Work pressure; Professional promotion; Interpersonal relationship with superiors; Interpersonal relationships with peers; Extrinsic characteristics of status; Labor monotony.*

(e). *Maslach Burnout Inventory* (MBI) [40]. The Spanish version corresponds to the later renamed *MBI-Human Service Survey* (MBI-HSS). It has shown adequate psychometric properties within its three dimensions of burnout: *Emotional exhaustion* (EE) (*Cronbach's alpha* = .89), *Depersonalization* (DP) (α = .57); and *Personal accomplishment* (PA) (α = .72). *Total MBI score* is obtained as: EE + DP + LPA. LPA (*lack of personal accomplishment*) is calculated as: [LPA = 48 - PA]. The cut-off points for MBI that we used were those proposed by Doulougeri and colleges in 2016: EE scores ≥27 are considered as *high*, 19–26 as *average*, ≤ 18 as *low;* DP scores ≥10 as *high,* 6–9 as *average*, ≤ 5 as *low*; PA scores ≥40 as *high*, 34–39 as *average*, ≤ 33 as *low*; Total MBI scores percentile > 76 as *high*, 25–75 as *average*, < 25 as *low*.

2. Hetero-applied psychometric measures:

(a). *Brief Psychiatric Rating Scale* (BPRS) [41]. This semi-structured interview is one of the oldest and most widely used scales by clinicians and researchers to measure psychiatric symptoms. It presents adequate psychometric properties (*Cronbach's alpha* for *Positive scale* α = .73; *Negative scale* α = .83; *Global psychopathology* α = .87). We used the 18-item version. Single items are rated on a Likert-type scale (1, *not present*; 2, *very mild*; 3, *mild*; 4, *moderate*; 5, *moderately severe*; 6, *severe*; 7, *extremely severe*). The range of possible BPRS total scores is [18–126], where a higher score indicates more psychiatric symptoms.

As regards administrative and healthcare indicators, these were provided by the regional health authority. For the baseline data, these indicators were registered in 2015 and 2016 (and extracted in 2016 and 2017, respectively, for the current study). For the post-intervention data, we used the following as indicators of the objective work burden for each GP: (a) *total annual visits for all pathologies*; (b) *rate (percentage) of annual visits linked to mental health*; (c) *rate of accessibility*: annual percentage of patients' attempted requests for visits for the following 48 h and that were successfully scheduled for each professional. In all three cases, data on patients enrolled for home-care programmes, chronically complex patients and patients with chronic advanced diseases were rejected.

Follow-up assessments of GP status took place 10 months after finishing the programme. This post-programme assessment timing was average or higher than that observed in other related research [17, 18].

Sample size

No sample-size calculation was formally determined. Given our GP population ($N = 45$), we attempted to recruit as many participants as possible. From initial estimations with 45 GPs, we were aware that we would be able to detect a 0.856 effect size in a t-test; we therefore only had the power to detect large effect sizes and through a single bivariate contrast. Our team nevertheless deemed

this worthwhile in order not to achieve robust data which reinforce strong claims, but rather to serve as a pilot study for evaluating MTP potential.

Considering the observed data as the real latent distribution and rectifying threshold levels of significance from 0.05 to 0.0026 through Bonferroni's adjustment for multiple comparisons, in *Results* we indicate the power to detect as significant for the intervention effect in the observed pre-post change for the primary outcome measures in linear mixed-effects models (LMMs).

Data analysis

Sample characteristics were described by calculating medians and inter-quartile ranges (IQR) for numerical variables, and absolute and relative frequencies (%) for binary and categorical variables. Baseline group differences were evaluated using the Wilcoxon Test for numerical variables and Fisher's exact test for binary and categorical variables.

Paired Wilcoxon Signed Rank Tests were performed to compare repeated intra-group measurements. To check for differences between groups in progression, we fitted unadjusted linear mixed-effects models (LMMs)—as a longitudinal proxy to bivariate analysis—to account for the longitudinal data assessments and the complexity of inter-group interactions, regressing the different outcomes for treatment group, follow-up, and their interaction. The results are shown in terms of *p*-values of the marginal effects, representing the significance of baseline differences between treatment groups, overall change over time in the overall sample, and differences in evolution over time between treatment groups, respectively. In the tables, in addition to the p-value and where this is significant (*P*-value of ≤0.05 was used as the cut-off point), association direction is also shown. For *Inter-group differences*, a + sign indicates a higher score or a higher evolution in the EG; in the global change analysis, this sign indicates a higher score in the follow-up assessments.

The main outcome measures included in the analysis were all the administrative and healthcare indicators, as well as the overall job satisfaction, burnout and well-being. They are key work-related health factors that need to be assessed and controlled, according to related surveys.

All statistical analyses were conducted using the R software package (v. 3.2.2; R Development Core Team, 2015).

Results

Participants

Thirty-eight out of forty five GPs agreed to participate in the study (four GPs were dismissed because they were the authors of this study and the rest declined to collaborate). Finally, 18 GPS were allocated to CG, and 20 to EG. All 38 GPs completed follow-up measures after two GPs were rejected (one from each group) due to retiring from their jobs during this period.

Baseline patient-demographic values

Groups were homogeneous in terms of age ($p = 0.177$), years of professional experience (17[12.25, 28]; $p = 0.349$) and sex ($p = 0.045$), where men were slightly more numerous in EG. Likewise, no statistically significant differences were detected between proportions of indefinite contracts ($p > 0.999$), mixed shifts ($p = 0.291$) and hours of mental-health training during the last year ($p = 0.129$), variables that were respectively predominant in both groups. No statistically significant differences between groups were observed for length of time on current contract ($p = 0.037$), this being higher in CG.

Changes in outcome measures within and between groups

The average attendance at the nine sessions was 75% (70%, clinical psychology; 90%, psychiatry; 65% for the social work). Attendance rates at coordinating meetings or other activities that constitute the *Mental-health support program for primary care* were not registered for either group.

In relation to government of mental-health patients indicators, as regards administrative data (Fig. 1), first, no statistically significant differences between groups were detected for the percentage of *annual visits by each GP linked to mental health*, either in *overall pre-post change* ($p = 0.360$) or in inter-group evolution differences ($p = 0.544$). Second, we did observe a lower rate of *total annual visits by each GP for all pathologies* in the CG when examining the *overall pre-post change* ($p < 0.003$), although this result was not regarded as significant after Bonferroni's adjustment; besides, it was identified a greater inter-group evolution differences in the EG ($p < 0.001$). Finally, rate of *accessibility* decreased in the CG when observing *overall pre-post change* ($p < 0.001$), which was exactly the opposite to the evolution of the EG, thus contributing to the significance of the inter-group evolution differences in *accessibility* ($p < 0.001$). No significant baseline inter-group differences were detected in any of the previously commented variables, except for *total annual visits by each GP linked to Mental Health*, this being higher in the EG ($p = 0.040$).

As regards opinions and attitudes towards mental illness reported in the *Struening and Cohen's Opinion about Mental Illness questionnaire* (OMI), a worsening of all five dimensions was observed in *overall pre-post change* for both groups (Table 2), the EG presenting only a different evolution in prejudice, namely a higher increase ($p = 0.004+$).

Regarding GPs management of their own burnout, job satisfaction and psychological well-being indicators, with respect to the responses from the *Font-Roja Job-Satisfaction Questionnaire* (FR), no significant differences

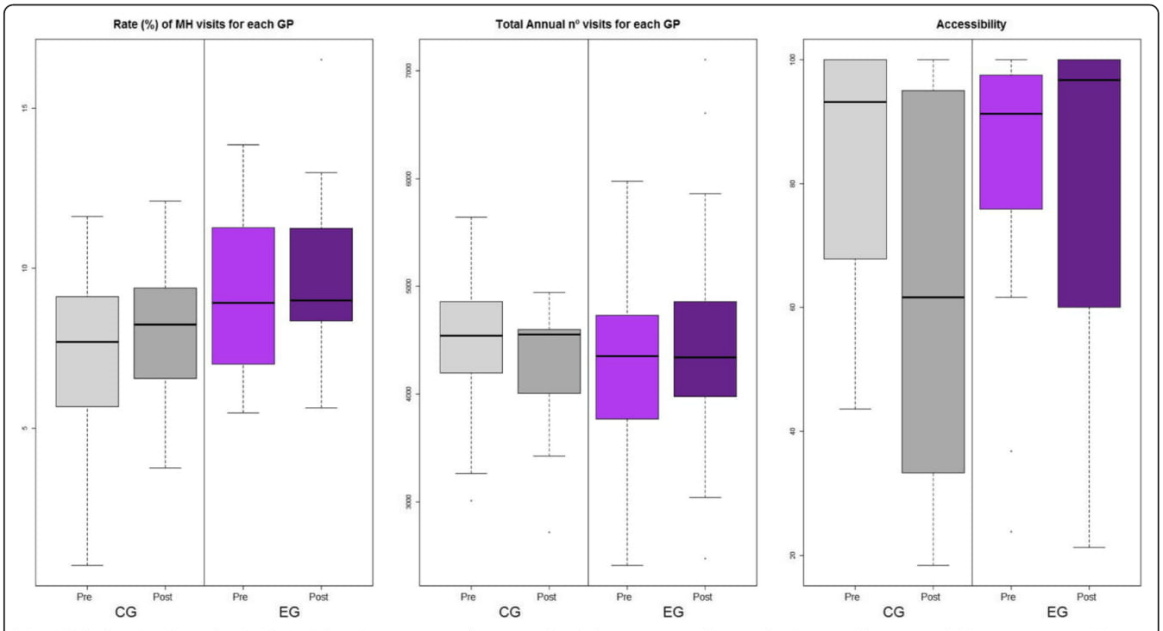

Fig. 1 Distribution (box-plots) of administrative parameters' reported by 38 general practitioners, by intervention group (CG, control group; EG, experimental group), and before and after intervention (Pre, pretreatment; Post, Post-treatment)

were detected between groups in terms of overall job satisfaction (Table 3). However, we did observe a decrease in *satisfaction at work* in the CG, reflected both in *overall pre-post change* ($p = 0.009$), although again this result was not regarded as significant after Bonferroni's adjustment; besides, it was identified a greater inter-group evolution differences in the EG ($p = 0.002$). Likewise, a decrease in *interpersonal relationship with peers'* scores was observed in CG ($p = 0.011$), but it did not reach statistical significance.

No significant statistical differences were observed in either the *Total burnout* or in any of the three *Maslach Burnout Inventory* (MBI) parameters (Table 4).

As for well-being, we observed statistically significant reductions in *Total Brief Psychiatric Rating Scale* (BPRS) in the EG (baseline: 23.50 [22, 24.25]; post-treatment: 20.50 [19, 22]; $p = 0.001$), while this was not observed in CG (baseline: 24.50 [23.25, 27.75]; post-treatment: 23.50 [21, 26]; $p = 0.122$) (Fig. 2). Nonetheless, in LMMs, no *overall pre-post change* ($p = 0.100$) or *inter-group evolution differences* ($p = 0.147$) were detected.

Focusing only on both single BPRS item scores or on differences in intervention within the subgroup of *worrying cases* (defined as GPs suffering ≥1 from *moderate* to *extremely severe* symptoms), no statistical differences were observed between groups.

Table 2 Non-adjusted evolution analysis of Struening and Cohen's Opinion about Mental Illness questionnaire's punctuations of 38 GPs depending on intervention group (2016–2017)

	Control Group Evolution *N = 18*			Experimental Group Evolution *N = 20*			LMMs *p*-values[a]		
	Pre	Post	*W*	Pre	Post	*W*	Baseline[b]	Change[c]	Evol.[d]
F1	59 [57.25, 60.75]	73 [71.25, 78]	0[e]	58 [53.75, 61.25]	72 [68, 77.50]	0[e]	0.633	<0.001 + [e]	0.889
F2	44 [40, 49]	53.50 [50.25, 57]	0[e]	42.50 [33.75, 48]	58 [50, 62]	0[e]	0.311	<0.001+ [e]	0.163
F3	9 [8, 11]	18.50 [17.25, 21.50]	0[e]	10 [7.75, 12.25]	18 [17, 21]	0[e]	0.983	<0.001+ [e]	0.867
F4	8.50 [6.25, 10]	11.50 [11, 14]	0[e]	7 [6, 9]	11 [10, 13]	0[e]	0.555	<0.001+ [e]	0.303
F5	7.50 [6, 9]	10.50 [9, 12]	0[e]	6.50 [5, 8]	12 [9.50, 13]	0[e]	0.337	<0.001+ [e]	0.004

Abbreviations: *Pre* Pretreatment, *Post* Post-treatment, *W* Wilcoxon Signed Rank Tests
Struening and Cohen's Opinion about Mental Illness questionnaire's factors: F1: Negativism; F2: Social/interpersonal etiology; F3: Authoritarianism; F4: Restrictiveness; F5: Prejudice
[a]linear mixed-effects models; [b]Inter-group baseline differences; [c]Pre-post Overall Change; [d]Inter-group Evolution differences
[e]$p < 0.0026$ (intervention group versus control group)

Table 3 Non-adjusted evolution analysis of *Font-Roja Questionnaire*'s punctuations of 38 GPs depending on intervention group (2016–2017)

	Control Group Evolution *N = 18*			Experimental Group Evolution *N = 20*			LMMs *p*-values[a]		
	Pre	Post	*W*	Pre	Post	*W*	Baseline[b]	Change[c]	Evol.[d]
F1	14 [10.50,16]	12 [9, 6]	0.031[e]	15 [13, 16.25]	16 [15, 17]	0.065	0.304	0.009	0.002+ [e]
F2	13.50 [12.25, 16.75]	15 [1, 16]	0.773	12 [11, 14]	13 [11, 16]	0.418	0.188	0.876	0.587
F3	4.50 [3, 6]	5 [4, 6]	0.404	5 [4, 6]	5 [4.50, 6]	0.689	0.386	0.130	0.512
F4	12 [12, 13]	11 [11, 12]	0.499	12 [10, 12.25]	12 [10,12.50]	0.904	0.543	0.618	0.728
F5	11 [10, 13.75]	12 [11, 15]	0.303	12 [9, 13]	12 [10, 13]	0.631	0.736	0.099	0.336
F6	6 [4, 6.75]	6 [4, 8]	0.510	4 [4, 6.50]	4 [4, 6.50]	0.753	0.156	0.567	0.934
F7	5 [5, 6]	6 [5, 7.]	0.095	6 [5.75, 7]	5 [5, 6]	0.057	0.032	0.122	0.011
F8	5 [5, 6]	6 [4, 6]	0.525	5.50 [4, 6]	5 [5, 6.50]	0.104	0.864	0.502	0.577
F9	5 [4, 5.75]	4 [3, 5]	0.050	4.50 [4, 6]	5 [4, 5]	0.968	0.665	0.069	0.186
Total	76 [73, 80.50]	77 [75, 78]	0.726	75 [72, 77.50]	76 [73, 83]	0.485	0.818	0.796	0.515

Abbreviations*: Pre* Pre-treatment, *Post* Post-treatment, *W* Wilcoxon Signed Rank Tests
Font-Roja Questionnaire's dimensions: F1: satisfaction at work; F2: work tension; F3: Professional competence; F4: work pressure; F5: professional promotion; F6: interpersonal relationship with superiors; F7: interpersonal relationships with peers; F8: extrinsic characteristics of status; F9: labor monotony
[a]linear mixed-effects models; [b]Inter-group baseline differences; [c]Pre-post Overall Change; [d]Inter-group Evolution differences
[e]$p < 0.0026$ (intervention group versus control group)

Psychopharmacology use dropped in both groups when observing *overall pre-post change* ($p = 0.014$), falling from 6 to 2 GPs using psychopharmaceuticals in the CG, and from 3 to 2 in the EG. Regarding type of psychopharmaceuticals, this decrease was especially noticeable in the case of benzodiazepine consumption ($p = 0.037$).

Finally, the statistical *power* analysis to detect the intervention effect as significant in the observed pre-post change for the primary outcome measures in LMMs was as follows: *power* = 0.006 for overall job satisfaction; *power* = 0.006 for *Total burnout; power* = 0.013 for *Total Brief Psychiatric Rating Scale.*

Discussion

Our findings, although insufficient, highlight the potential of MTP (from an IBST approach) to be hypothetically integrated as part of a continuing training programme for GPs' individual and group-management competences for mental-health patients, which may ultimately enhance GPs' work-related health and psychological well-being to a certain extent. On the one hand, we observed improvements in the EG for the global psychopathology state, certain administrative parameters and psychopharmacology use, along with better evolution of *satisfaction at work*; on the other hand, MTP did not alleviate *burnout* level or enhance *opinions and attitudes towards mental illness (prejudice)*, which deteriorated in both groups.

Comparison with existing literature

As with other programmes aimed at engaging GPs in the management of psychiatric patients based on a long-term and sustainable partnership, MTP advances have not so far led to the programme being adopted by the regional Institute of Mental Health [42].

Table 4 Non-adjusted evolution analysis of *Maslach Burnout Inventory's* punctuations of 38 GPs depending on intervention group (2016–2017)

	Control Group Evolution *N = 18*			Experimental Group Evolution *N = 20*			LMMs *p*-values[a]		
	Pre	Post	*W*	Pre	Post	*W*	Baseline[b]	Change[c]	Evol.[d]
EE	24.50 [14, 41.25]	25.50 [18, 34.25]	0.756	19.50 [13.75, 23.25]	21.50 [15.50, 28.25]	0.089	0.038	0.881	0.263
DP	7 [5.25, 13.75]	9 [7.25, 11]	0.835	6 [4, 8.50]	7 [3.75, 12.25]	0.317	0.425	0.535	0.807
PA	38 [33.25, 45.25]	38 [32.25, 43.75]	0.297	38 [34, 42.50]	37.50 [29.75, 43]	0.420	0.559	0.410	0.550
Burn	46.50 [24.50, 62.25]	46 [30, 57.25]	0.727	37 [29, 49.25]	40 [33, 52]	0.331	0.243	0.600	0.637

Abbreviations*: Pre* Pretreatment, *Post* Post-treatment, *W* Wilcoxon Signed Rank Tests
Maslach Burnout Inventory's subscales: EE: *Emotional exhaustion*; DP: *Depersonalization*; PA: *Reduced personal accomplishment*
Global Scales: Burn: *Burnout*
[a]linear mixed-effects models; [b]Inter-group baseline differences; [c]Pre-post Overall Change; [d]Inter-group Evolution differences
[e]$p < 0.0026$ (intervention group versus control group)

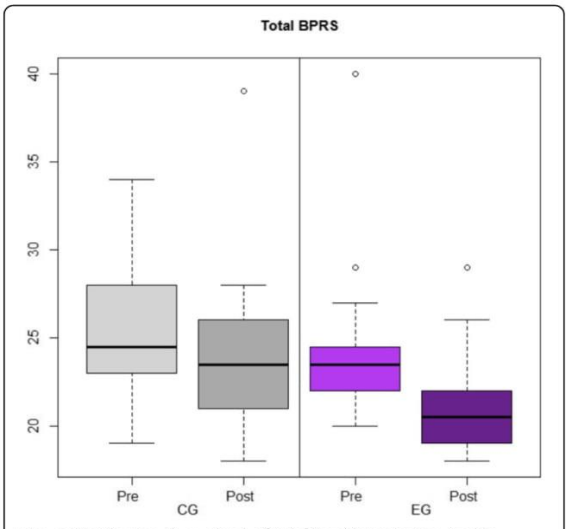

Fig. 2 Distribution (box-plots) of *Brief Psychiatric Rating Scale*'s punctuations reported by 38 general practitioners, by intervention group (CG, control group; EG, experimental group), and before and after intervention (Pre, pretreatment; Post, Post-treatment)

In relation to government of mental-health patients indicators, first, analysing the indicated improvements on our administrative health data offered by the MTP, it is difficult to draw clear conclusions when comparing our results with related surveys, given the disparity of samples, health-system structures, etc. [27]. The achievements shown by the EG in *accessibility* and in *total annual visits by each GP for all pathologies* (inter-group evolution differences) might be interpreted as case-management improvements, although our study design did not allow us to draw strong conclusions or to elucidate alternative explanations. Additionally, the results related to the *rate of annual visits by each GP linked to Mental Health* were inconclusive, which was probably because GPs did not always codify mental-health visits as such.

Two components that could compromise both the work-related health factors and the GPs' role in diagnosing mental disorders and arranging treatment are (first) the stigmatising attitudes held by GPs towards mental illness, and (second) their reluctance to become involved in shared-care practice [43]. Contrary to other similar studies, MTP did not improve opinions and attitudes towards mental illness [44], although our baseline OMI scores didn't reflect a high prejudice towards mental disorders but they did show a lack of sufficient dealings in psychopathology which is congruent with previous studies [45]. Although it was not a direct target of our programme, we did expect positive changes as a desirable side effect. Given both the negative evolution of all OMI scores registered in both groups and the positive outcomes of EG on other work-related health parameters, this leads us to question whether opinions and attitudes towards mental illness are a somewhat independent factor. In other words, feeling more capable to cope with mental- health patients may be distinct from our personal thoughts about and interests in this subject. Given our results, more in-depth, longer-lasting and distinct goal-oriented interventions might be needed to reverse these negative attitudes. Following this line of argument, key elements here are the addressing of both level of work pressure and of the low level of training and awareness in relation to mental disorders [46].

Regarding GPs management of their own burnout, job satisfaction and psychological well-being indicators, first, in contrast to other surveys, the MTP did not show better results in overall job satisfaction, nor did it achieve a reduction in GPs' intention to change their location [20]. We were unable to carry out further analyses with closely related research aimed at enhancing GPs' mental-health case management within a CCMs because such research failed to assess this issue [42]. Although not globally, EG did present improvements in some of the *Font-Roja* dimensions, reaching statistical significance in *satisfaction at work* (inter-group evolution differences). Clearly, effective inter-professional management of individual patients depends on confidence in one's colleagues' skills and good communication, which are issues that are also treated by the MTP. Broader and far more complex interventions are needed in order to address job satisfaction, which in turn is regarded as a key element for resolving the GP recruitment crisis [47].

Contrary to other interventions [17], MTP did not improve burnout levels in our study. Nonetheless, at baseline the median level of burnout (total MBI scores) was 38 (IQR = 29, 54), being this moderate level observed according with previous research [48, 49]; only 2 (5.26%) GPs reported a total MBI scores percentile > 75 (as *high*), figure less prevalent than in other studies [9]. In any case, we consider tackling GPs' burnout an important issue that should be addressed in future interventions because GPs have high rates of burnout and poor mental wellbeing compared with the general population and other healthcare professionals [49, 50]. Besides, amongst other negative effects, GPs perceive that burnout and poor wellbeing negatively impacts their ability to deliver safe care [51]. We posit that additional resources should be assigned to this subject in order to mitigate our result.

In line with related studies, our results reflected a high proportion of GPs presenting psychiatric symptoms [52]; taking into account only the cases where mental health

support could be somewhat recommended, at baseline 21 (55.26%) GPs suffered from *moderate* to *extremely severe* symptoms. Regarding the type of psychiatric symptoms observed, as signaled by the literature, anxiety, depression and somatic concerns were predominant [53]. The MTP improved GPs' global psychological well-being, but contrary to other studies [17], no *inter-group change* or *evolution differences* were detected. Possible interference may have been given rise to by psychological state being evaluated by a psychiatric interview rather than being self-administered. Furthermore, although score differences for single BPRS items were not statistically significant, a tendency towards greater reductions was detected in the EG.

Finally, so far, we have not found related psychological interventions with which to compare our results in psychopharmacology use. This dropped in both groups, but our study's limitations again impeded us from making any strong claims with regard to this positive outcome.

Study strengths and limitations

As limitations of our study, first there is the modest sample size that influences statistical significance and *power*, since statistically significant differences are more difficult to identify in smaller samples. Nonetheless, the study does comprise an important proportion of the total amount of GPs in our health sector. Second, although the administration of our clinical interview (BPRS) could be somewhat controversial in non-clinical samples, it is not limited to indicating only the participants' own perceptions, as is the case with questionnaires. Response bias (for instance the social-desirability bias) is a widely discussed phenomenon in behavioural and healthcare research where self-reported data are used [54]. Regarding administrative data, although relatively good results were reported for the EG, it is difficult to compare our data externally with other health centres, due to disparity in terms of organization and characteristics. Additionally, indicators themselves are not exempt from criticism. Finally, treatment integrity and fidelity were not assessed or supervised.

As strengths of our study, we would like to emphasise, first, that it was conducted in real clinical practice with all its accompanying constraints: high service demand, work overload, restrictions on the frequency of follow-up meetings, etc. Thus, the duration of our MTP was far from the 50 h or more invested in some other programmes [55]. Second, we evaluated the sustainability of improvements (over nearly 10 months) rather than immediate post-intervention effects, which differs from other studies [17, 22]. Third, GPs were encouraged to introduce suggested MTP procedures into ordinary clinical practice, but in order to avoid selection bias toward only highly motivated professionals no complementary work commitments were set within the inclusion criteria, unlike other studies [17].

Implication for practice

Finally, it is clear that GP burnout, job satisfaction and psychological well-being require broader and more in-depth approaches than that offered by single disciplines (such as psychology) if we are to improve their institutional and work conditions.

Although further research with methodological improvements and prolonged instruction periods is required, our preliminary findings suggest that this new clinical-rooted MTP (from a BST approach) could have the potential to be adopted as part of a continuing professional-training programme for GPs' management of mental-health patients. To some extent, it could ultimately enhance GPs' work-related health factors such as burnout, job satisfaction and psychological well-being. Nonetheless, so far, any strong claim can be stated.

Conclusions

This study provides inside into GPs' work-related health and psychological well-being in a period where these aspects might have been worsening. It highlights the need to adopt multimodal training interventions aimed at developing GP's psychological resources and capacities. This research may help the instructors to recognize the utility of a new intensive training programme for GPs. This personalised approach may assist GPs especially when treating mental-health patients in areas such as on how to correctly conduct a psychopathological examination; on learning verbal and non-verbal language techniques aimed at producing behavioural changes; or on searching for social and community services that might be suitable for distinct patients.

Abbreviations

BPRS: Brief Psychiatric Rating Scale; BST: Brief Systemic Therapy; CCMs: Collaborative Care Models; CG: Control Group; EG: Experimental Group; FR: *Font-Roja* Job Satisfaction Questionnaire; GP: General Practitioner; MBI: Maslach Burnout Inventory; MTP: Multimodal Training Programme; OMI: Struening and Cohen's Opinion about Mental Illness Questionnaire

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Authors' contributions

The authors have participated in this research as follows: Designing the work: CB; CS, ER, OC, NP, BF, CA, Dr. CB and JF. Acquiring the data: CB, BG, CS, ER, OC, NP, BF, CA, Dr. CB, JF and DR. Interpreting the data: CB, OC and RT. Drafting the work/ revising the work critically for intellectual content: CB, BG, CS, ER, OC, NP, BF, CA, Dr. CB, JF, DR and RT. All authors read an approved the manuscript.

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Availability of data and materials
The datasets generated and/or analysed during the current study are not publicly available due to the *Data* Protection and *Confidentiality Policy*; however, they are available from the corresponding author on reasonable request.

Ethics approval and consent to participate
The protocol was approved by the Clinical Research Ethics Committee (CEIC) of the regional public primary-care research authority, in accordance with the Helsinki Declaration and our own national law on the protection of personal data. Written consent was obtained from all participants prior to taking part in the study.

Consent for publication
Not applicable.

Competing interests
All the authors declare that they have no competing interests.

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References

1. Pérez-Ciordia I, Guillén-Grima F, Brugos A, Aguinaga I. Job satisfaction and improvement factors in primary care professionals. An Sist Sanit Navar. 2013;36:253–62 http://www.ncbi.nlm.nih.gov/pubmed/24008528. Accessed 9 Jun 2017.
2. Zantinge EM, Verhaak PF, de Bakker DH, van der Meer K, Bensing JM. Does burnout among doctors affect their involvement in patients' mental health problems? A study of videotaped consultations. BMC Fam Pract. 2009;10:60. https://doi.org/10.1186/1471-2296-10-60.
3. Wang Z, Liu H, Yu H, Wu Y, Chang S, Wang L. Associations between occupational stress, burnout and well-being among manufacturing workers: mediating roles of psychological capital and self-esteem. BMC Psychiatry. 2017;17:364. https://doi.org/10.1186/s12888-017-1533-6.
4. Aronsson G, Theorell T, Grape T, Hammarström A, Hogstedt C, Marteinsdottir I, et al. A systematic review including meta-analysis of work environment and burnout symptoms. BMC Public Health. 2017;17:264. https://doi.org/10.1186/s12889-017-4153-7.
5. Theorell T, Hammarström A, Aronsson G, Träskman Bendz L, Grape T, Hogstedt C, et al. A systematic review including meta-analysis of work environment and depressive symptoms. BMC Public Health. 2015;15:738. https://doi.org/10.1186/s12889-015-1954-4.
6. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172:1377. https://doi.org/10.1001/archinternmed.2012.3199.
7. Thommasen HV, Lavanchy M, Connelly I, Berkowitz J, Grzybowski S. Mental health, job satisfaction, and intention to relocate. Opinions of physicians in rural British Columbia. Can Fam Physician. 2001;47:737–44 http://www.ncbi.nlm.nih.gov/pubmed/11340754. Accessed 17 Sep 2019.
8. Dreher A, Theune M, Kersting C, Geiser F, Weltermann B. Prevalence of burnout among German general practitioners: comparison of physicians working in solo and group practices. PLoS One. 2019;14:e0211223. https://doi.org/10.1371/JOURNAL.PONE.0211223.
9. Soler JK, Yaman H, Esteva M, Dobbs F, Asenova RS, Katic M, et al. Burnout in European family doctors: the EGPRN study. Fam Pract. 2008;25:245–65. https://doi.org/10.1093/fampra/cmn038.
10. Galam E, Vauloup Soupault C, Bunge L, Buffel du Vaure C, Boujut E, Jaury P. 'Intern life': a longitudinal study of burnout, empathy, and coping strategies used by French GPs in training. BJGP Open. 2017;1:bjgpopen17X100773. https://doi.org/10.3399/bjgpopen17X100773.
11. Allen T, Whittaker W, Sutton M. Does the proportion of pay linked to performance affect the job satisfaction of general practitioners? Soc Sci Med. 2017;173:9–17. https://doi.org/10.1016/j.socscimed.2016.11.028.
12. Shrestha D, Joyce CM. Aspects of work life balance of Australian general practitioners: determinants and possible consequences. Aust J Prim Health. 2011;17:40. https://doi.org/10.1071/PY10056.
13. Nylenna M, Gulbrandsen P, Førde R, Aasland OG. Unhappy doctors? A longitudinal study of life and job satisfaction among Norwegian doctors 1994–2002. BMC Health Serv Res. 2005;5:44. https://doi.org/10.1186/1472-6963-5-44.
14. Meier LL, Tschudi P, Meier CA, Dvorak C, Zeller A. When general practitioners don't feel appreciated by their patients: prospective effects on well-being and work-family conflict in a Swiss longitudinal study. Fam Pract. 2015;32:181–6. https://doi.org/10.1093/fampra/cmu079.
15. Karasek RA Jr. Job demands, job decision latitude, and mental strain: implications for job redesign. Adm Sci Q. 1979;24:285. https://doi.org/10.2307/2392498.
16. Gibson J, Checkland K, Coleman A, Hann M, McCall R, Spooner S, et al. Eighth national GP Worklife survey. 2015. https://www.research.manchester.ac.uk/portal/en/publications/eighth-national-gp-worklife-survey(a76ed99e-c54e-4ba4-a20e-ce432322689e)/export.html. Accessed 9 Jun 2017.
17. Asuero AM, Queraltó JM, Pujol-Ribera E, Berenguera A, Rodriguez-Blanco T, Epstein RM. Effectiveness of a mindfulness education program in primary health care professionals: a pragmatic controlled trial. J Contin Educ Heal Prof. 2014;34:4–12. https://doi.org/10.1002/chp.21211.
18. Franco JC. Reducing stress levels and anxiety in primary-care physicians through training and practice of a mindfulness meditation technique. Aten Primaria. 2010;42:564–70. https://doi.org/10.1016/j.aprim.2009.10.020.
19. Gardiner M, Lovell G, Williamson P. Physician you can heal yourself! Cognitive behavioural training reduces stress in GPs. Fam Pract. 2004;21:545–51. https://doi.org/10.1093/fampra/cmh511.
20. Gardiner M, Kearns H, Tiggemann M. Effectiveness of cognitive behavioural coaching in improving the well-being and retention of rural general practitioners. Aust J Rural Health. 2013;21:183–9. https://doi.org/10.1111/ajr.12033.
21. Hamilton-West K, Pellatt-Higgins T, Pillai N. Does a modified mindfulness-based cognitive therapy (MBCT) course have the potential to reduce stress and burnout in NHS GPs? Feasibility study. Prim Health Care Res Dev. 2018;19:591–7. https://doi.org/10.1017/S1463423618000129.
22. Holt J, Del Mar C. Reducing occupational psychological distress: a randomized controlled trial of a mailed intervention. Health Educ Res. 2006;21:501–7. https://doi.org/10.1093/her/cyh076.
23. Regehr C, Glancy D, Pitts A, LeBlanc VR. Interventions to reduce the consequences of stress in physicians. J Nerv Ment Dis. 2014;202:353–9. https://doi.org/10.1097/NMD.0000000000000130.
24. Gilmartin H, Goyal A, Hamati MC, Mann J, Saint S, Chopra V. Brief Mindfulness Practices for Healthcare Providers – A Systematic Literature Review. Am J Med. 2017;130:1219.e1–1219.e17. https://doi.org/10.1016/j.amjmed.2017.05.041.
25. Murray M, Murray L, Donnelly M. Systematic review of interventions to improve the psychological well-being of general practitioners. BMC Fam Pract. 2016;17:36. https://doi.org/10.1186/s12875-016-0431-1.

26. Avey JB, Luthans F, Smith RM, Palmer NF, Wu L, Schroeder C. Impact of positive psychological capital on employee well-being over time. J Occup Health Psychol. 2010;15:17–28. https://doi.org/10.1037/a0016998.
27. Magaard JL, Liebherz S, Melchior H, Engels A, König H-H, Kriston L, et al. Collaborative mental health care program versus a general practitioner program and usual care for treatment of patients with mental or neurological disorders in Germany: protocol of a multiperspective evaluation study. BMC Psychiatry. 2018;18:347. https://doi.org/10.1186/s12888-018-1914-5.
28. Goodrich DE, Kilbourne AM, Nord KM, Bauer MS. Mental health collaborative care and its role in primary care settings. Curr Psychiatry Rep. 2013;15:383. https://doi.org/10.1007/s11920-013-0383-2.
29. Departament de Salut. Generralitat de Catalunya. Barcelona: ENAPISC, El procés assistencial en salut mental i addiccions a la xarxa d'atenció primària; 2019.
30. Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, et al. General practice activity in Australia 2014–15. Sidney: General practice series number 40; 2016. http://sydney.edu.au/medicine/fmrc/publications/Feature_Care of middle-aged people in general practice.pdf.
31. Kovess-Masféty V, Saragoussi D, Sevilla-Dedieu C, Gilbert F, Suchocka A, Arveiller N, et al. What makes people decide who to turn to when faced with a mental health problem? Results from a French survey. BMC Public Health. 2007;7:188. https://doi.org/10.1186/1471-2458-7-188.
32. Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012. Gac Sanit. 2012;26:20–6. https://doi.org/10.1016/j.gaceta.2011.10.009.
33. Baxter AJ, Patton G, Scott KM, Degenhardt L, Whiteford HA. Global epidemiology of mental disorders: what are we missing? PLoS One. 2013;8: e65514. https://doi.org/10.1371/journal.pone.0065514.
34. Fleury M-J, Imboua A, Aubé D, Farand L, Lambert Y. General practitioners' management of mental disorders: a rewarding practice with considerable obstacles. BMC Fam Pract. 2012;13:19. https://doi.org/10.1186/1471-2296-13-19.
35. Beyebach M. Integrative brief solution-focused family therapy: a provisional roadmap. J Syst Ther. 2009;28:18–35. https://doi.org/10.1521/jsyt.2009.28.3.18.
36. Geyerhofer S, Komori Y. Integrating poststructuralist models of brief therapy. Br Strateg Syst Ther Eur Rev. 2004;1:162.
37. Navarro Góngora J. Técnicas y programas en terapia familiar. Paidós; 1992.
38. Yllá L, González-Pinto Arrillaga A, Ballesteros J, Guillén V. Evolution of attitudes of the population towards the mental patient. Actas Esp Psiquiatr. 2007;35:323–35 http://www.ncbi.nlm.nih.gov/pubmed/17597433. Accessed 7 Jul 2017.
39. Núñez González E, Estévez Guerra GJ, Hernández Marrero P, Marrero Medina CD. An extended version of the Font-Roja job satisfaction questionnaire. Gac Sanit. 2007;21:136–41 http://www.ncbi.nlm.nih.gov/pubmed/17419930. Accessed 7 Jul 2017.
40. Gil-Monte P, Peiró JM. Validez factorial del maslach burnout inventory en una muestra multiocupacional. Psicothema. 1999;11:679–89.
41. Peralta V, Cuesta MJ. Psychometric properties of the positive and negative syndrome scale (PANSS) in schizophrenia. Psychiatry Res. 1994;53:31–40 http://www.ncbi.nlm.nih.gov/pubmed/7991730. Accessed 7 Jul 2017.
42. Lum AW, Kwok KW, Chong SA. Providing integrated mental health services in the Singapore primary care setting--the general practitioner psychiatric programme experience. Ann Acad Med Singap. 2008;37:128–31 http://www.ncbi.nlm.nih.gov/pubmed/18327348. Accessed 5 Jul 2019.
43. Tatlow-Golden M, Prihodova L, Gavin B, Cullen W, McNicholas F. What do general practitioners know about ADHD? Attitudes and knowledge among first-contact gatekeepers: systematic narrative review. BMC Fam Pract. 2016; 17:129. https://doi.org/10.1186/s12875-016-0516-x.
44. Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction. 2012;107:39–50. https://doi.org/10.1111/j.1360-0443.2011.03601.x.
45. Arrillaga Arizaga M, Sarasqueta Eizaguirre C, Ruiz Feliu M, Sánchez EA. Attitudes of primary care health staff to the mentally ill patient, psychiatry and the mental health team. Aten Primaria. 2004;33:491–5. https://doi.org/10.1016/s0212-6567(04)70820-3.
46. Reavley NJ, Mackinnon AJ, Morgan AJ, Jorm AF. Stigmatising attitudes towards people with mental disorders: a comparison of Australian health professionals with the general community. Aust New Zeal J Psychiatry. 2014;48:433–41. https://doi.org/10.1177/0004867413500351.
47. Merrett A, Jones D, Sein K, Green T, Macleod U. Attitudes of newly qualified doctors towards a career in general practice: a qualitative focus group study. Br J Gen Pract. 2017;67:e253–9. https://doi.org/10.3399/bjgp17X690221.
48. Matía Cubillo ÁC, Cordero Guevara J, Mediavilla Bravo JJ, Pereda Riguera MJ, González Castro ML, González SA. Evolución del burnout y variables asociadas en los médicos de atención primaria. Aten Primaria. 2012;44:532–9. https://doi.org/10.1016/j.aprim.2010.05.021.
49. Soler JK, Yaman H, Esteva M. Burnout in European general practice and family medicine. Soc Behav Personal an Int J. 2007;35:1149–50. https://doi.org/10.2224/sbp.2007.35.8.1149.
50. Arigoni F, Bovier PA, Mermillod B, Waltz P, Sappino A-P. Prevalence of burnout among Swiss cancer clinicians, paediatricians and general practitioners: who are most at risk? Support Care Cancer. 2009;17:75–81. https://doi.org/10.1007/s00520-008-0465-6.
51. Hall LH, Johnson J, Heyhoe J, Watt I, Anderson K, O'Connor DB. Exploring the Impact of Primary Care Physician Burnout and Well-Being on Patient Care. J Patient Saf. 2017;1:1. https://doi.org/10.1097/PTS.0000000000000438.
52. Hall LH, Johnson J, Watt I, O'Connor DB. Association of GP wellbeing and burnout with patient safety in UK primary care: a cross-sectional survey. Br J Gen Pract. 2019;69:e507–14. https://doi.org/10.3399/bjgp19X702713.
53. Brooks SK, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed? J Ment Health. 2011;20:146–56. https://doi.org/10.3109/09638237.2010.541300.
54. Rosenman R, Tennekoon V, Hill LG. Measuring bias in self-reported data. Int J Behav Healthc Res. 2011;2:320–32. https://doi.org/10.1504/IJBHR.2011.043414.
55. Beckman HB, Wendland M, Mooney C, Krasner MS, Quill TE, Suchman AL, et al. The impact of a program in mindful communication on primary care physicians. Acad Med. 2012;87:815–9. https://doi.org/10.1097/ACM.0b013e318253d3b2.

Publisher's Note

9. SUMMARY OF RESULTS

In our **first study (*Art-1*)**, the results showed that both therapy models were found to be, in general, equivalent in treatment outcome measures (in terms of the percentage of therapeutic discharges, drop-outs, relapses and the use of other mental health services during the follow-up period). The similarity between the groups was also confirmed, when analysing the data through psychiatric diagnosis. Nonetheless, in our sample, IBST did not prove to be any shorter than CBT.

In the **second study *(Art-2)***, we first evaluated the indicators relating to how patients managed their mental health problems. The results obtained indicated that MTP, when compared with the routine clinical mental health support programme for primary care, produced statistically significant improvements in certain administrative health parameters, but not in opinions and attitudes toward mental illness.

Secondly, regarding the GPs management of their own burnout, job satisfaction and psychological well-being, the MTP participants showed better scores on global psychopathological state and better evolution of work satisfaction. Psychopharmacology use dropped in both groups; in contrast, the MTP did not improve burnout levels

8. GENERAL DISCUSSION

Since 2001, the World Health Organisation (WHO) has made recommendations to reduce the huge gap between the number of patients suffering from anxiety and depression and the number seeking and receiving minimal adequate treatment. The organisation indicated that treatments should be made more readily available in primary care, and training of mental health professionals should be increased [136]. In connection to this, in our dissertation two compiled scholarly articles were devoted to examining the effectiveness of IBST in primary care for (a) patients and (b) GPs, respectively. We wanted to investigate IBST's feasibility and usefulness for clinical purposes through clinically-based studies. Our general results show the potential of IBST in primary care for both collectives. Nonetheless, IBST still lacks solid research overall, which means it is therefore so far unattainable to make any strong statement in the sense that IBST is somehow necessary or preferable.

Before discussing our studies' results and implications in more detail, we would like the reader to consider beforehand the controversies surrounding *effectiveness* and *efficacy* in *psychotherapy*. Although a deep analysis of this issue is beyond the scope of this research, it should be considered that results from randomised controlled trials (RCTs) are regarded to give the most reliable information on treatment outcome (efficacy); yet, the generalisability of efficacy results in terms of daily practice (effectiveness) might be diminished by the design of RCTs [137]. Along this line, we have favoured methodologies with a high ecological validity when evaluating their effectiveness in routine clinical practice.

The effectiveness of IBST; comparison with existing literature

First study (*Art-1*): with regard to IBST's effectiveness in primary care with patients, we concluded that our results provided some preliminary data suggesting that IBST might be an effective and efficient treatment in public mental health practice, comparable to well-established treatments like CBT. Nevertheless, despite these good results, the advances made by IBST are weak when compared with CBT's empirical background [125, 127].

Given current empirical evidence it is understandable that CBT is still the main treatment approach across the *Improving Access to Psychological Therapies* (IAPT) proposals for primary care, as is the case in Britain and Norway [138, 139]. This large-scale initiative

involved mass training of new therapists to provide stepped- care psychological treatment following the National Institute for Health and Care Excellence guidelines. In United Kingdom, after the full national rollout, the programme has continuously been monitored, with the latest annual report showing an average recovery rate of 50.8% [138]. Here we would like to notice that in our research sample, IBST also reached over 50% of successful *therapeutic discharges* (*Art-1*). In this context, we hope that in the future, as a result of theses on IAPT-like treatments, several other therapy models will gain more recognition such as the IBST, according to the new research data provided. In fact, the clinical reality is that no single psychotherapy is effective for all patients and situations, no matter how good it is for some; one-size-fits-all therapy is proving impossible [140]. Besides, it is indicated that the IAPT's good results (such as in our research) should be interpreted with caution, as they may be prone to *selection bias* [139, 141].

Second study (*Art-2*): it seems that in the future the high prevalence and burden of disease associated with mental disorders will require more work towards prevention. This means that GPs will play a central role in providing evidence-based and patient-centred care, and will be recommended to expand their current (mainly) biomedical practices [142]. In this context, our research regarding IBST's effectiveness in primary care with GPs shows promising findings for MTP (with an IBST approach) instruction for GPs. Nonetheless, as is the case for patients (*Art-1*), more evidence is also required (with larger samples and randomised controlled trials) to support the programme being officially adopted both as part of a continuing professional-training programme for the management of mental-health patients, as well as for GPs to manage their own work-related health problems. So far, although more robust empirical data is also required, it is currently included in "*evidence-based*" training packages for GPs in Australia: the *Focussed Psychological Strategies Skills Training* (FPS ST) and *Focussed Psychological Strategies Continuing Professional Development* (FPS CPD) [27, 143]. Each training course includes 10 (FPS CPD) to 20 hours (FPS ST) minimum of education (amongst other interactive activities, they use a combination of technology, peer learning groups and locally available resources). The aim is to develop skills related to providing evidence-based psychological interventions as part of a GP mental health treatment plan for common mental health disorders. Similarly, although maybe more humble in purpose, in Great Britain, Health Education England will be offering the *Health Awareness for GPs programme* on a national basis, an e-learning resource that was initially launched with 3

sessions [144]. Besides *interpersonal therapy*, all the aforementioned interventions are mainly CBT based interventions, which means they face similar disadvantages as when they are applied to patients. For instance, CBT focuses on the individual's capacity to change themselves (their thoughts, feelings and behaviours), and does not usually address wider problems in systems or families that often have a significant impact on an individual's health and wellbeing. In any case, beyond the pros and cons of CBT, we hope that MTP (with an IBST approach) could end up being an appealing alternative for those GPs that did not have success with CBT based training.

The feasibility and usefulness of ISBT for clinical purposes

Our experience in the application of ISTB in primary care within a multidisciplinary collaborative care structure (which includes a multidisciplinary team with different preferences and sensibilities, where different interventions take place at the same time) has provided us with some challenges to our traditional therapeutic procedures and scientific development:

(a) The structure of IBST therapy sessions: we introduced some changes into the therapy session structure that is usually proposed [45, 47–49]. Even though these adaptations could cause some controversy among brief systemic professionals, we again found them to be useful and worthwhile for the entire team involved. The most important differences relate to the first session, where new clinical information is recorded (from then onwards), providing a better case contextualisation for our understanding.

As in all systemic therapies, our basic therapeutic scheme is to start any case with a deliberate effort at relationship-building, trying to work out a collaborative therapeutic project with the client. Nonetheless, from the very first session, we fill in an anamnesis that from our point of view it represents a positive step to more comprehensively define the case. This means we do not proceed directly to focus only on our client's demands. This anamnesis contains the following data, aside from the IBST's key therapeutic information:

1. Client demands.

2. Personal history of medical diseases, personal history of psychiatric disorders and drug abuse, family history of psychiatric disorders.
3. Psychological exploration.
4. Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV-TR) usage. There is a debate around this manual's limitations, its review process, and its goals and content. In any case, it has oriented and facilitated inter-professional case discussions, and it is another communication tool among others (frequent inter-professional meetings, joint inter-professional sessions with the patient, and so on), which we do not pose a barrier (the mental health label does not lead the session's structural process). So, even though use of the DSM-IV-TR might be controversial, we continue to favour a positive vision of mental disorders, prevailing a non-pathologising mental health discourse [112].
5. Psychiatric and non-psychiatric medication that is currently being taken.

Some authors could argue that it might not be necessary for a successful intervention to put together such an anamnesis. On the contrary, we think it is a worthwhile endeavour given our clinical experience:

- Avoids or limits the psychotherapy process: instead of focussing on the client's demands right from the beginning in our first clinical interview, gathering the anamnesis information has proved to be very useful in helping us identify a hypothyroidism case that was initially diagnosed as a major depression disorder; it was used to emphasise the need to assess a suspected obstructive sleep apnoea in a patient with obesity who was complaining about sleep problems, anxiety and depressive symptoms; and to reveal our client's sole interest in pursuing social security benefits or other legal demands.
- Reconstituting the treatment plan with our multidisciplinary team of mental health professionals: for instance, asking our clients delicately but thoughtfully about drug usage that was otherwise unrevealed resulted in discovering the presence of an addiction in many occasions, which undoubtedly reframed our intervention (we can recall a case of cocaine abuse when a patient, after years of psychiatric and psychological treatment for major depression disorder, finally admitted and announced his drug usage; there was also the case of a woman complaining about fatigue and depression where she actually fundamentally misused her opiate pain medication).

- Low probability of jeopardising treatment adherence and outcome: if it is properly explained and the anamnesis information gathering proceeds smoothly, we don't usually find strong opposition from clients. Along this line, Richmond and colleagues compared the effectiveness of an SFBT intake interview (a non-directive examination in which questions are not prearranged) and a problem-focused diagnostic intake interview based on the *Structured Clinical Interview* for DSM-IV Axis I Disorders (SCID-I) (a structured interview that offers a set amount of standardised questions). The sample was made up of 30 participants attending the intake interviews for counselling. Surprisingly, this study failed to show that the SFBT intake interview was superior on a measure of outcome optimism and goal clarity [145].

Besides the anamnesis information, from the very first visit another clinical document is filled in: the *IBST intervention protocol* (see Appendix II). This is where the client's goals, complaints and demands, aetiology attributions, and attempted solutions, amongst other therapy information, is recorded. The *IBST intervention protocol* will guide us through all therapy sessions. It should be noted that this protocol doesn't necessary need to be filled in completely for each patient because we will only gather that information we consider fundamental to solve the problem.

Another matter that deserves to be mentioned is whether or not the presence of a clinical psychology team who have received *Brief Family Therapy* formation is required. Whenever it's possible we clearly favour a therapeutic team alliance. If that is not possible, an external case supervision is recommended. In our case, only one other member of the clinical psychology staff had BST training at that time.

Finally, regarding IBST's **contraindications,** there are a number of problems or mental disorders that, from our point of view, merit the addition of different concepts and techniques to our usual approach; for instance, psychosis spectrum disorders, bipolar disorder, some personality disorders and mental retardation. So, while IBST appears to be an effective strategy in delivering a short-term intervention for many patients, further

work is necessary to target those mental disorders for whom a longer-term option should be sought as first treatment choices from the start.

(b) *IBST practice and replicability*: in this dissertation we expected to have contributed towards a better operational definition in terms of strategic treatment management, although this is still insufficient. In this context, it would be also necessary to develop specialised IBST therapy manuals and research protocols, albeit not presented in a rigid manner, in order to facilitate the reproducibility of our clinical and research work. *Replicability* is a priority issue because accumulating reproducible evidence is the scientific community's method of self-correction and is the best available option for achieving good quality knowledge.

Moreover, with our humble original research contribution, we hope to have strengthened IBST as an evidence-based practice, as such therapies are associated with higher quality and greater accountability [146]. Despite all the controversies surrounding the identification and dissemination of *Empirically Supported Treatments* (EST) [147], we consider that IBST can reach an acceptable compromise and balance between research constraints and the need to provide evidence-based practices for our clients (using the word 'evidence' in its broadest sense). Secondly, IBST is committed to providing more clinically-rooted, versatile and humanistic interventions, bending the therapy to the client's situation and needs and not the other way around. Along these lines, we can find a broad framework in the biopsychosocial model of *Empirically Supported Therapeutic Relationships* (ESTR) [75, 148, 149]. The ESTR represents an appealing alternative to the *biomedical approach*, which for some authors has divided the field along scientist and practitioner lines [107].

Strengths and limitations

In terms of the limitations of our studies, first there are the modest sample sizes that influenced statistical significance and power, since statistically significant differences are more difficult to identify in smaller samples. Secondly, treatment integrity and fidelity were not assessed or supervised in *Art-1*. Thirdly, the therapist did carry out a strict adherence to a psychotherapy manual in *Art-1* that might alleviate future replication

surveys. Instead, he showed fidelity to IBST's premises and procedures throughout all clinical setting requirements. So, here we faced a dilemma better explained by Alberto Rodríguez: "*In the same way that in a driving academy they teach to handle the different aspects involved in driving (traffic rules, changing gear, turning, braking), but they do not explain what to do if a truck comes up with another one front: accelerate? or stop ?; It will depend on the context, and this cannot be described because the possibilities are endless. We can conclude, then, that "manualization" is easier for some models than for others, creating bias in research results"* [150].

In terms of the strengths of our studies, we would like to emphasise, first, that they were conducted in real clinical practices with all the accompanying constraints: high service demand, work overload, restrictions on the frequency of follow-up meetings, etc. Second, our research involved different professionals, from the different institutions shown in *Art-2*. Third, these surveys received no public or private funding.

Implication for practice

Although further research with methodological improvements is required, our preliminary findings suggest that IBST, when delivered within a CCMs model, could be potentially useful in primary care: first, it might be an effective and efficient treatment for public mental health practice, comparable to well-established treatments like CBT. Second, IBST, when applied within a multimodal training programme (MTP), could be adopted as part of a continuing professional-training programme for GPs to manage mental-health patients. Nonetheless, as yet no strong claim can be stated.

11. CONCLUSIONS AND FUTURE INVESTIGATIONS

a) General conclusions

- This dissertation provides insight into the effectiveness of promising psychotherapy treatment both for patients and GPs in primary care. In general, IBST provides satisfactory results.
- We are still far from concluding that IBST has solid empirical evidence in primary care or in other clinical domains. We assume that this is an ongoing process, as is the case for other psychotherapeutic models.
- It has been useful to adopt a CMM framework in our interventions in primary care.
- There needs to be an improvement in the epistemological bases for IBST. Despite the pros and cons related to the integration of theories and techniques from different psychotherapy models, we strongly feel that IBST is a worthwhile endeavour that deserves more clinical and research analysis.

b) Conclusions regarding IBST for patients

- Our study provides preliminary data suggesting that IBST might be an effective and efficient treatment in public mental health practice, comparable to well-established treatments like CBT in routine clinical practice.
- We still do not know which ingredients in IBST are really effective, nor under which circumstances they operate, nor for what situations they are more or less useful.
- The clinical operational guidelines for IBST need to be developed further. There are still no well-researched practices that could provide a sound ground for their integration over the course of psychotherapy sessions.

C) Conclusions regarding IBST for GPs

- Our encouraging data supports that MTP (with an IBST approach) might by a useful training programme for GPs who are managing mental health patients, as well as to manage their own work-related health problems.

Future Investigations

We would like to mention that we are currently working on new investigations aimed at providing more empirical data to support the effectiveness of IBST in primary care and other clinical settings. This relates in particular to IBST in a group format, both for anxiety disorders in primary care systems, and long-term drug addiction at outpatient addiction centres.

Finally, we hope this dissertation in some way boosts more clinical research into IBST in different domains, as well as encouraging further peer collaboration.

12. REFERENCES

1. Baxter AJ, Patton G, Scott KM, Degenhardt L, Whiteford HA. Global epidemiology of mental disorders: what are we missing? PLoS One. 2013;8:e65514. doi:10.1371/journal.pone.0065514.

2. Saxena S, Funk M, Chisholm D. World health assembly adopts comprehensive mental health action plan 2013-2020. The Lancet. 2013;381:1970–1.

3. World Health Organization (WHO). Mental Health Action Plan 2013-2020. 2013;:1–44. doi:ISBN 978 92 4 150602 1.

4. Pastor J. El psicólogo en AP: un debate necesario en el sistema nacional de salud. Papeles del psicólogo. 2008;3:271–90.

5. Kovess-Masféty V, Saragoussi D, Sevilla-Dedieu C, Gilbert F, Suchocka A, Arveiller N, et al. What makes people decide who to turn to when faced with a mental health problem? Results from a French survey. BMC Public Health. 2007;7:188. doi:10.1186/1471-2458-7-188.

6. Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012. Gac Sanit. 2012;26:20–6. doi:10.1016/j.gaceta.2011.10.009.

7. Departament de Salut. Generralitat de Catalunya. ENAPISC, El procés assistencial en salut mental i addiccions a la xarxa d'atenció primària. Barcelona; 2019.

8. Fernández A, Saameño JÁB, Pinto-Meza A, Luciano JV, Autonell J, Palao D, et al. Burden of chronic physical conditions and mental disorders in primary care. Br J Psychiatry. 2010;196:302–9. doi:10.1192/bjp.bp.109.074211.

9. Gili M, Roca M, Basu S, McKee M, Stuckler D. The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. Eur J Public Health. 2013;23:103–8. doi:10.1093/eurpub/cks035.

10. Clark NM. The Multiple Challenges of Multiple Morbidities. Heal Educ Behav. 2011;38:219–21. doi:10.1177/1090198111410554.

11. Vermani M, Marcus M, Katzman MA. Rates of detection of mood and anxiety

disorders in primary care: a descriptive, cross-sectional study. Prim care companion CNS Disord. 2011;13. doi:10.4088/PCC.10m01013.

12. Stange KC, Ferrer RL. The paradox of primary care. Ann Fam Med. 2009;7:293–9. doi:10.1370/afm.1023.

13. Comité Español de Representantes de Personas con Discapacidad. Informe Derechos Humanos y Discapacidad, España 2018. Madrid: Grupo editorial Cinca; 2019. http://www.infocoponline.es/pdf/Informe-derechos-humanos-discapacidad-2018.pdf.

14. Marmot M, Friel S, Bell R, Houweling TA, Taylor S, Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet. 2008;372:1661–9. doi:10.1016/S0140-6736(08)61690-6.

15. Goldberg D, Huxley P. Mental Illness in the Community: The pathway to psychiatric care. London: Tavistock Publications; 1980.

16. Ministerio de sanidad consumo y bienestar social. Marco Estratégico para la Atención Primaria y Comunitaria. 2019. https://www.mscbs.gob.es/profesionales/proyectosActividades/docs/Marco_Estrategico_APS_25Abril_2019.pdf.

17. Wahass SH. The role of psychologists in health care delivery. J Family Community Med. 2005;12:63–70.

18. McDaniel SH, DeGruy F V. An introduction to primary care and psychology. Am Psychol. 2014;69:325–31. doi:10.1037/a0036222.

19. World Health Organization (WHO). Mental health: strengthening our response. 2018. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

20. Lambert MJ. Bergin and Garfield's handbook of psychotherapy and behavior change. Hoboken, NJ: John Wiley & Sons; 2012.

21. Goldbeck-Wood S, Fonagy P. The future of psychotherapy in the NHS. BMJ. 2004;329:245–6. doi:10.1136/bmj.329.7460.245.

22. Leichsenring F, Leibing E. Psychodynamic psychotherapy: A systematic review of techniques, indications and empirical evidence. Psychol Psychother Theory, Res Pract. 2007;80:217–28. doi:10.1348/147608306X117394.

23. Jung XT, Newton R. Cochrane Reviews of non-medication-based psychotherapeutic and other interventions for schizophrenia, psychosis, and bipolar disorder: A systematic literature review. Int J Ment Health Nurs. 2009;18:239–49. doi:10.1111/j.1447-0349.2009.00613.x.

24. Fisher CA, Skocic S, Rutherford KA, Hetrick SE. Family therapy approaches for anorexia nervosa. Cochrane Database Syst Rev. 2018;10:CD004780. doi:10.1002/14651858.CD004780.pub3.

25. National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. Third. U.S. Department of Health and Human Services; 2018.

26. Purgato M, Gastaldon C, Papola D, van Ommeren M, Barbui C, Tol WA. Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises. Cochrane Database Syst Rev. 2018;7:CD011849. doi:10.1002/14651858.CD011849.pub2.

27. The Australian Psychological Society. Evidence-based psychological interventions in the treatment of mental disorders: A literature review. Fourth. Melbourne: The Australian Psychological Society; 2018.

28. Leichsenring F, Steinert C. Is Cognitive Behavioral Therapy the Gold Standard for Psychotherapy? JAMA. 2017;318:1323. doi:10.1001/jama.2017.13737.

29. Rowland N. Evidence submitted by the British Association for Counselling and Psychotherapy (NICE 92). 2007. https://publications.parliament.uk/pa/cm200607/cmselect/cmhealth/503/503we18.htm.

30. Open Science Collaboration OS. Estimating the reproducibility of psychological science. Science (80-). 2015;349:aac4716–aac4716. doi:10.1126/science.aac4716.

31. Guidi J, Brakemeier E-L, Bockting CLH, Cosci F, Cuijpers P, Jarrett RB, et al. Methodological Recommendations for Trials of Psychological Interventions. Psychother Psychosom. 2018;87:276–84. doi:10.1159/000490574.

32. Stirman SW, DeRubeis RJ, Crits-Christoph P, Brody PE. Are Samples in Randomized Controlled Trials of Psychotherapy Representative of Community Outpatients? A New Methodology and Initial Findings. J Consult Clin Psychol. 2003;71:963–72. doi:10.1037/0022-006X.71.6.963.

33. Ogrodniczuk JS, Piper WE, Joyce AS. Residual symptoms in depressed patients who successfully respond to short-term psychotherapy. J Affect Disord. 2004;82:469–73. doi:10.1016/j.jad.2004.03.007.

34. Westen D, Novotny CM, Thompson-Brenner H. The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. Psychol Bull. 2004;130:631–63. doi:10.1037/0033-2909.130.4.631.

35. Norcross JC, Lambert MJ. Psychotherapy relationships that work III. Psychotherapy. 2018;55:303–15. doi:10.1037/pst0000193.

36. Thielke S, Thompson A, Stuart R. Health psychology in primary care: recent research and future directions. Psychol Res Behav Manag. 2011;4:59. doi:10.2147/PRBM.S12996.

37. Linde K, Sigterman K, Kriston L, Rücker G, Jamil S, Meissner K, et al. Effectiveness of psychological treatments for depressive disorders in primary care: systematic review and meta-analysis. Ann Fam Med. 2015;13:56–68. doi:10.1370/afm.1719.

38. Thornicroft G. Improving access to psychological therapies in England. Lancet (London, England). 2018;391:636–7. doi:10.1016/S0140-6736(17)32158-X.

39. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Lancet. 2007;370:841–50. doi:10.1016/S0140-6736(07)61414-7.

40. Gatchel RJ, Oordt MS. Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration. Washington: American Psychological Association; 2003. doi:10.1037/10592-000.

41. Goodrich DE, Kilbourne AM, Nord KM, Bauer MS. Mental Health Collaborative Care and its Role in Primary Care Settings. Curr Psychiatry Rep. 2013;15:383. doi:10.1007/s11920-013-0383-2.

42. Bluestein D, Cubic BA. Psychologists and Primary Care Physicians: A Training Model for Creating Collaborative Relationships. J Clin Psychol Med Settings. 2009;16:101–12. doi:10.1007/s10880-009-9156-9.

43. Chang J, Phillips M. Michael White and Steve de Shazer: New directions in Family Therapy. In: Gilligan, S. & Price R, editor. Therapeutic conversations. New York, NY: Norton; 1993.

44. Furman B, Ahola T. The Never Ending Story: Or the Problem as Solution. Aust New Zeal J Fam Ther. 1991;12:53–5. doi:10.1002/j.1467-8438.1991.tb00840.x.

45. Selekman MD. Pathways to change : brief therapy solutions with difficult adolescents. New York, NY: Guilford Press; 1993.

46. Todd TC, Selekman MD. Beyond structural-strategic family therapy: Integrating other brief systemic therapies. In: Family therapy approaches with adolescent substance abusers. Needham He. 1991. p. 241–7.

47. Beyebach M. Integrative Brief Solution-Focused Family Therapy: A Provisional Roadmap. J Syst Ther. 2009;28:18–35. doi:10.1521/jsyt.2009.28.3.18.

48. Geyerhofer S, Komori Y. Integrating Poststructuralist Models of Brief Therapy. Br Strateg Syst Ther Eur Rev. 2004;1:46–64.

49. Navarro Góngora J. Técnicas y programas en terapia familiar. Paidós; 1992.

50. Rodríguez-Arias JL. Terapia familiar breve : guía para sistematizar el tratamiento psicoterapéutico. Madrid: Editorial CCS; 2006.

51. Watzlawick P, Bavelas JB, Jackson DD (Don DA. Pragmatics of human communication : a study of interactional patterns, pathologies, and paradoxes. New York, NY: Norton & Comapany; 1967.

52. Weakland JH, Fisch R, Watzlawich P, Bodin AM. Brief Therapy: Focused Problem Resolution. Fam Process. 1974;13:141–68. doi:10.1111/j.1545-5300.1974.00141.x.

53. Fisch R, Weakland JH, Segal L. The tactics of change : doing therapy briefly. San Francisco, CA: Jossey-Bass; 1982.

54. Watzlawick P, Weakland JH, Fisch R. Change : principles of problem formation and problem resolution. New York: Norton & Company; 1974.

55. De Shazer S. Keys to solution in brief therapy. New York, NY: W.W. Norton; 1985.

56. Lloyd H. More Than Miracles: The State of the Art of Solution-focused Brief Therapy by Steve de Shazer and Yvonne Dolan with Harry Korman, Terry Trepper, Eric McCollum and Insoo Kim Berg. J Fam Ther. 2008;30:115–6. doi:10.1111/j.1467-6427.2008.00419_4.x.

57. Berg IK. Family-based services : a solution-focused approach. New York, NY: W.W. Norton; 1994.

58. De Jong P, Berg IK. Interviewing for solutions. 3rd editio. Belmont, CA, United States: Cengage Learning; 2007.

59. Weiner-Davis M, Shazer S, Gingerich WJ. Building on pretreatment change to construct the therapeutic solution: an exploratory study. J Marital Fam Ther. 1987;13:359–63. doi:10.1111/j.1752-0606.1987.tb00717.x.

60. De Shazer S. Patterns of brief family therapy: an ecosystemic approach. New York, NY: Guilford Press; 1982.

61. O'Hanlon B, Weiner-Davis M. In search of solutions : a new direction in psychotherapy. New York, NY: W.W. Norton; 1989.

62. Bavelas J, De Jong P, Franklin C, Froerer A, Gingerich W, Kim J, et al. Solution Focused Therapy Treatment Manual for Working with Individuals. 2nd Version. Solution Focused Brief Therapy Association (SFBTA); 2013.

63. White M (Michael K, Epston D. Narrative means to therapeutic ends. New York, NY: W. W. Norton; 1990.

64. White M (Michael K. Maps of narrative practice. New York, NY: W. W. Norton; 2007.

65. Dickerson V. Introduction to the Special Section-Continuing Narrative Ideas and

Practices: Drawing Inspiration from the Legacy of Michael White. Fam Process. 2009;48:315–8. doi:10.1111/j.1545-5300.2009.01284.x.

66. Wells RA, Phelps PA. The Brief Psychotherapies. In: Handbook of the Brief Psychotherapies. Boston, MA: Springer US; 1990. p. 3–26. doi:10.1007/978-1-4899-2127-7_1.

67. Garfield SL, Bergin AE, Dryden W. Handbook of Psychotherapy and Behavior Change. J Cogn Psychother. 1987;1:264.2-265. doi:10.1891/0889-8391.1.4.264a.

68. Patterson CH. Understanding psychotherapy : fifty years of client-centred theory and practice. Monmouth: PCCS Books; 2000.

69. Tasca GA, Sylvestre J, Balfour L, Chyurlia L, Evans J, Fortin-Langelier B, et al. What clinicians want: Findings from a psychotherapy practice research network survey. Psychotherapy. 2015;52:1–11. doi:10.1037/a0038252.

70. Albeniz A, Holmes J. Psychotherapy Integration: Its Implications for Psychiatry. Br J Psychiatry. 1996;169:563–70. doi:10.1192/bjp.169.5.563.

71. Zarbo C, Tasca GA, Cattafi F, Compare A. Integrative Psychotherapy Works. Front Psychol. 2015;6:2021. doi:10.3389/fpsyg.2015.02021.

72. Norcross JC, Goldfried MR. Handbook of psychotherapy integration. Oxford University Press; 2005.

73. Feixas G, Botella L. Psychotherapy integration: Reflections and contributions from a constructivist epistemology. J Psychother Integr. 2004;14:192–222. doi:10.1037/1053-0479.14.2.192.

74. Kozarić-Kovacić D. Integrative psychotherapy. Psychiatr Danub. 2008;20:352–63.

75. Castonguay LG, Eubanks CF, Goldfried MR, Muran JC, Lutz W. Research on psychotherapy integration: building on the past, looking to the future. Psychother Res. 2015;25:365–82. doi:10.1080/10503307.2015.1014010.

76. Stricker G, Gold JR, editors. Comprehensive Handbook of Psychotherapy Integration. Boston, MA: Springer US; 1993. doi:10.1007/978-1-4757-9782-4.

77. Hardy NR, Brosi MW, Gallus KL. Integrative Systemic Therapy: Lessons on

Collaboration and Training for the 21st Century. J Marital Fam Ther. 2019;45:206–18. doi:10.1111/jmft.12332.

78. Pinsof WM, Breunlin DC, Russell WP, Lebow J, Rampage C, Chambers AL. Integrative systemic therapy : metaframeworks for problem solving with individuals, couples, and families. Washington,: APA Books; 2018.

79. Pinsof WM. Integrative problem-centered therapy : a synthesis of family, individual, and biological therapies. New York, NY: BasicBooks; 1995.

80. Bavelas JB, De Jong P, Jordan S, Korman H. The theoretical and research basis of co-constructing meaning in dialogue. J Solut Br Ther. 2014;2:24.

81. De Shazer S. Words were originally magic. New York, NY: W.W. Norton; 1994.

82. De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., Berg IK. More than miracles: The state of the art of solutionfocused brief therapy. New York, NY: Routledge; 2007.

83. Hendrick S. Un modèle de thérapie brève systémique intégrée. Thérapie Fam. 2007;28:121. doi:10.3917/tf.072.0121.

84. Beyebach M, Morejón AR. Some Thoughts on Integration in Solution-Focused Therapy. J Syst Ther. 1999;18:24–42. doi:10.1521/jsyt.1999.18.1.24.

85. Rohrbaugh MJ. Old Wine in New Bottles: Decanting Systemic Family Process Research in the Era of Evidence-Based Practice. Fam Process. 2014;53:434–44. doi:10.1111/famp.12079.

86. Heatherington L, Friedlander ML, Diamond GM, Escudero V, Pinsof WM. 25 Years of systemic therapies research: Progress and promise. Psychother Res. 2015;25:348–64. doi:10.1080/10503307.2014.983208.

87. Saggese ML, Foley FW. From Problems or Solutions to Problems and Solutions: Integrating the MRI and Solution-Focused Models of Brief Therapy. J Syst Ther. 2000;19:59–73. doi:10.1521/jsyt.2000.19.1.59.

88. De Shazer S, Berg IK, Lipchik E, Nunnally E, Molnar A, Gingerich W, et al. Brief therapy: focused solution development. Fam Process. 1986;25:207–21.

89. Stricker G, Gold JR. An Introduction to Psychotherapy Integration. NYS Psychol. 2001;13:7–12.

90. Eisenberg J, Wahrman O. Two models of brief strategic therapy: the MRI model and the de Shazer model. Isr J Psychiatry Relat Sci. 1991;28:8–18.

91. De Shazer S. Putting difference to work. New York, NY: W. W. Norton; 1991.

92. De Shazer S, Berg IK. "What works?" Remarks on research aspects of Solution-Focused Brief Therapy. J Fam Ther. 1997;19:121–4.

93. Lipchik E. Beyond technique in solution-focused therapy : working with emotions and the therapeutic relationship. New York, NY: The Guilford Press; 2002.

94. Lazarus AA, Messer SB. Does chaos prevail? An exchange on technical eclecticism and assimilative integration. J Psychother Integr. 1991;1:143–58. doi:10.1037/h0101225.

95. Walter JL, Peller JE. Becoming solution-focused in brief therapy. New York, NY: Brunner/Mazel; 1992.

96. Beyebach M, Herrero de Vega M. 200 tareas en terapia breve. Barcelona: Herder; 2010.

97. Watzlawick P, Nardone G, Blanco Moreno M del C, Díez Aragón RA. Terapia breve estratégica : pasos hacia un cambio de percepción de la realidad. Barcelona: Paidós Ibérica; 2000.

98. Gonçalves MM, Stiles WB. Narrative and psychotherapy: Introduction to the special section. Psychother Res. 2011;21:1–3. doi:10.1080/10503307.2010.534510.

99. Madanes C. Strategic family therapy. San Francisco, CA: Jossey-Bass Publishers; 1981.

100. Minuchin S. Families and family therapy. Cambridge, MA: Harvard University Press; 1974.

101. Wampold BE, Imel ZE. The great psychotherapy debate: the evidence for what makes psychotherapy work. New York, NY: Routledge; 2015.

102. Horvath AO, Del Re AC, Flückiger C, Symonds D. Alliance in individual psychotherapy. Psychotherapy. 2011;48:9–16. doi:10.1037/a0022186.

103. Zhang A, Franklin C, Currin-McCulloch J, Park S, Kim J. The effectiveness of strength-based, solution-focused brief therapy in medical settings: a systematic review and meta-analysis of randomized controlled trials. J Behav Med. 2018;41:139–51. doi:10.1007/s10865-017-9888-1.

104. Kim J, Jordan SS, Franklin C, Froerer A. Is Solution-Focused Brief Therapy Evidence-Based? An Update 10 Years Later. Fam Soc J Contemp Soc Serv. 2019;100:127–38. doi:10.1177/1044389419841688.

105. Cameron CL. Brief Psychotherapy: A Brief Review. Am J Psychother. 2006;60:147–52. doi:10.1176/appi.psychotherapy.2006.60.2.147.

106. Horigian VE, Anderson AR, Szapocznik J. Taking Brief Strategic Family Therapy from Bench to Trench: Evidence Generation Across Translational Phases. Fam Process. 2016;55:529–42. doi:10.1111/famp.12233.

107. Deacon BJ. The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. Clin Psychol Rev. 2013;33:846–61. doi:10.1016/j.cpr.2012.09.007.

108. Fernández Méndez J, Luengo Castro MA, García Haro J, Cabero Álvarez A, González Díaz MD, Braña Menéndez B, et al. Effectiveness of Brief Psychotherapy in Community Mental Health Centers I: Design, treatments and procedures. Rev la Asoc Española Neuropsiquiatría. 2010;30:563–80.

109. Teismann MW. Jealousy: systematic, problem-solving therapy with couples. Fam Process. 1979;18:151–60.

110. Watzlawick P, Coyne JC. Depression Following Stroke: Brief, Problem-Focused Family Treatment. Fam Process. 1980;19:13–8. doi:10.1111/j.1545-5300.1980.00013.x.

111. Kim JS. Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. Res Soc Work Pract. 2008;18:107–16. doi:10.1177/1049731507307807.

112. Chang J, Nylund D. Narrative and Solution-Focused Therapies: A Twenty-Year Retrospective. J Syst Ther. 2013;32:72–88. doi:10.1521/jsyt.2013.32.2.72.

113. Gingerich WJ, Eisengart S. Solution-Focused Brief Therapy: A Review of the Outcome Research*. Fam Process. 2000;39:477–98. doi:10.1111/j.1545-5300.2000.39408.x.

114. Ribeiro AP, Bento T, Salgado J, Stiles WB, Gonçalves MM. A dynamic look at narrative change in psychotherapy: A case study tracking innovative moments and protonarratives using state space grids. Psychother Res. 2011;21:54–69. doi:10.1080/10503307.2010.504241.

115. De Shazer MK. Cancer narratives and an ethics of commemoration: Susan Sontag, Annie Leibovitz, and David Rieff. Lit Med. 2009;28:215–36.

116. Ribeiro AP, Braga C, Stiles WB, Teixeira P, Gonçalves MM, Ribeiro E. Therapist interventions and client ambivalence in two cases of narrative therapy for depression. Psychother Res. 2016;26:681–93. doi:10.1080/10503307.2016.1197439.

117. Bischof GP. Solution-Focused Brief Therapy and Experiential Family Therapy Activities: An Integration. J Syst Ther. 1993;12:61–73. doi:10.1521/jsyt.1993.12.3.61.

118. Jordan K, Quinn WH. Session two outcome of the formula first session task in problem- and solution-focused approaches. Am J Fam Ther. 1994;22:3–16. doi:10.1080/01926189408251293.

119. Rodríguez-Arias JL, Otero Larrea M, Venero Celis M, Ciordia Rada N, Vázquez Fondó P. Estudio de evaluación de resultados en terapia familiar breve. Papeles del Psicólogo. 2004;25.

120. Muñiz Torrado JA. Informe sobre una evaluación de resultados del modelo de terapia familiar breve en el ÁMB. Papeles del psicólogo. 2004;25.

121. Nardone G, Watzlawick P. The art of change : strategic therapy and hypnotherapy without trance. San Francisco: Jossey-Bass Publishers; 1993.

122. Macdonald AJ. Brief therapy in adult psychiatry. J Fam Ther. 1994;16:415–26. doi:10.1111/j.1467-6427.1994.00806.x.

123. Gask L, Bower P, Lamb J, Burroughs H, Chew-Graham C, Edwards S, et al. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: narrative review and development of a conceptual model for

complex interventions. BMC Health Serv Res. 2012;12:249. doi:10.1186/1472-6963-12-249.

124. Lamb J, Dowrick C, Burroughs H, Beatty S, Edwards S, Bristow K, et al. Community Engagement in a complex intervention to improve access to primary mental health care for hard-to-reach groups. Heal Expect. 2015;18:2865–79. doi:10.1111/hex.12272.

125. Cape J, Whittington C, Buszewicz M, Wallace P, Underwood L. Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. BMC Med. 2010;8:38. doi:10.1186/1741-7015-8-38.

126. Ricou M, Marina S, Vieira PM, Duarte I, Sampaio I, Regalado J, et al. Psychological intervention at a primary health care center: Predictors of success. BMC Fam Pract. 2019;20:116. doi:10.1186/s12875-019-1005-9.

127. Twomey C, O'Reilly G, Byrne M. Effectiveness of cognitive behavioural therapy for anxiety and depression in primary care: a meta-analysis. Fam Pract. 2015;32:3–15. doi:10.1093/fampra/cmu060.

128. Zhang A, Franklin C, Jing S, Bornheimer LA, Hai AH, Himle JA, et al. The effectiveness of four empirically supported psychotherapies for primary care depression and anxiety: A systematic review and meta-analysis. J Affect Disord. 2019;245:1168–86. doi:10.1016/j.jad.2018.12.008.

129. Niv N, Frousakis N, Zucker BG, Glynn S, Dixon L. A brief family intervention for depression in primary care. J Fam Ther. 2018;40:100–19. doi:10.1111/1467-6427.12147.

130. Real Pérez M, Rodríguez-Arias JL, Cagigas J, Aparicio MM, Real MA. Brief family therapy: an option for the treatment of somatoform disorders in primary care. Atención Primaria. 1996;17.

131. Real Pérez M, Rodríguez-Arias JL, Cagigas Viadero J, Aparicio Sanz M, Real Pérez M. Terapia familiar breve. Ahorro en el gasto sanitario de la patología somatomorfa. Cuad Ter Fam. 2000;46:167–73.

132. Schade N, Beyebach M, Torres P, González A. Terapia Familiar Breve y Atención

Primaria: Un Caso de Trastorno Somatomorfo. Ter psicológica. 2009;27:239–46. doi:10.4067/S0718-48082009000200009.

133. Schade N, Torres P, Beyebach M. Cost-efficiency of a brief family intervention for somatoform patients in primary care. Fam Syst Heal. 2011;29:197–205. doi:10.1037/a0024563.

134. NHS Choices. NHS Choices annual report 2010. London; 2010. https://www.nhs.uk/about-the-nhs-website/professionals/developments/documents/annual-report/annual-report-2010.pdf.

135. Hahn S. Understanding noninferiority trials. Korean Journal of Pediatrics. 2012;55:403–7.

136. World Health Organization (WHO). The world health report 2001 - Mental Health: New Understanding, New Hope. Geneva: World Health Organization; 2001.

137. van der Lem R, van der Wee NJA, van Veen T, Zitman FG. Efficacy versus Effectiveness: A Direct Comparison of the Outcome of Treatment for Mild to Moderate Depression in Randomized Controlled Trials and Daily Practice. Psychother Psychosom. 2012;81:226–34. doi:10.1159/000330890.

138. The National Health Service (NHS). Psychological Therapies, Annual Reports on the use of IAPT services - NHS Digital. 2019. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services. Accessed 29 Mar 2020.

139. Knapstad M, Lervik LV, Sæther SMM, Aarø LE, Smith ORF. Effectiveness of Prompt Mental Health Care, the Norwegian Version of Improving Access to Psychological Therapies: A Randomized Controlled Trial. Psychother Psychosom. 2019;89:90–105. doi:10.1159/000504453.

140. Norcross JC, Wampold BE. Psychotherapy relationships that work. Volume 2, Evidence-based therapist responsiveness. Third Edit. Oxford University Press; 2019.

141. Ellenberg JH. Selection bias in observational and experimental studies. Stat Med. 1994;13:557–67.

142. Lake J, Turner MS. Urgent Need for Improved Mental Health Care and a More

Collaborative Model of Care. Perm J. 2017;21.

143. General Practice Mental Health Standards Collaboration. Mental health training standards 2020–22: A guide for general practition. East Melbourn: Vic: RACG; 2019.

144. Health Education England. The Mental Health Awareness for GPs programme. 2020. https://www.e-lfh.org.uk/programmes/mental-health-awareness-for-gps/.

145. Richmond CJ, Jordan SS, Bischof GH, Sauer EM. Effects of Solution-Focused Versus Problem-Focused Intake Questions on Pre-treatment Change. J Syst Ther. 2014;33:33–47. doi:10.1521/jsyt.2014.33.1.33.

146. Spring B. Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. Journal of Clinical Psychology. 2007;63:611–31. doi:10.1002/jclp.20373.

147. Castelnuovo G. Empirically supported treatments in psychotherapy: towards an evidence-based or evidence-biased psychology in clinical settings? Front Psychol. 2010;1:27. doi:10.3389/fpsyg.2010.00027.

148. Castonguay LG, Beutler LE. Principles of therapeutic change: A task force on participants, relationships, and techniques factors. J Clin Psychol. 2006;62:631–8.

149. Ackerman SJ, Benjamin LS, Beutler LE, Gelso CJ, Goldfried MR, Hill C, et al. Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. In: Psychotherapy. American Psychological Association Inc.; 2001. p. 495–7.

150. Morejón AR. La investigación de resultados y el futuro de la psicoterapia: alternativas a los tratamientos empíricamente validados. Papeles del psicólogo. 2004;25:8–9.

13. APPENDIX

CARGA ACTUAL DE LOS MÉDICOS DE FAMILIA; ¿UNA NECESIDAD DE INTERVENCIÓN PSICOLÓGICA?

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Resumen

Este estudio estaba dirigido a determinar en una muestra de Médicos de Atención Primaria (MAP) (a) su actual nivel de *burnout*, satisfacción profesional, bienestar psicológico y actitudes hacia la salud mental; (b) la influencia del *burnout*, satisfacción profesional y algunas variables socio-demográficas sobre el bienestar psicológico. Se desarrolló un estudio observacional-transversal con 38 MAPs. Se administraron cuestionarios para evaluar el *burnout*, satisfacción profesional, actitudes hacia la salud mental y una entrevista psiquiátrica para evaluar el bienestar psicológico. Algunos indicadores administrativos y de gestión sanitaria fueron también considerados. Los niveles de *burnout* (median= 38, *IQR*= 29, 54) y satisfacción laboral (median= 75.5, *IQR*= 73, 79) fueron moderados. Sólo el 5.26% de los MAPs informó de un alto *burnout*. La *ansiedad*, la *depresión* y las *preocupaciones somáticas* fueron los síntomas psiquiátricos predominantes. El 55.26% presentaron síntomas de *moderados* a *extremadamente severos* en al menos un síntoma psiquiátrico. Los modelos regresión logística reflejaron como el *burnout* desarrollaba un papel clave sobre los síntomas psiquiátricos. Los MAPs presentaron unos resultados heterogéneos en los diferentes parámetros de salud laboral analizados y altos niveles de síntomas psiquiátricos. Concluimos que existes una necesidad de proteger y mejorar la salud laboral y el bienestar psicológico de los MAPs.

Palabras clave: médicos de atención primaria; *burnout*; satisfacción laboral; bienestar psicológico.

Abstract

This study was aimed at determining in a sample of in a sample of General practitioners (GPs) (a) their current level of burnout, professional satisfaction, psychological well-being and the attitudes towards mental health; (b) the influence of burnout, professional satisfaction and some socio-demographic variables on the level of psychological well-being. A transversal observational study with 38 GPs was carried out. Self-report measures were administered to assess burnout, professional satisfaction, attitudes toward mental health and a psychiatric interview to evaluate psychological well-being. Some administrative and health care management indicators were also considered. Burnout (median= 38, *IQR* = 29, 54), and job satisfaction levels were moderate (median = 75.5, *IQR* = 73, 79). Only 5.26% of GPs reported a high burnout. Anxiety, depression and somatic concerns were the predominant psychiatric symptoms. Focusing only on these worrying cases, a 55.26% of GPs presented from moderate to extremely severe symptoms in at least one psychiatric symptom. Regression models reflected like burnout played a key role work on psychiatric symptoms. GPs presented heterogeneous (generally moderate) levels across the different work-related health parameters analyzed and high levels of psychiatric symptoms. We conclude that there's a need to protect and improve GPs' work-related health and psychological well-being.

Key words: general practitioners; burnout; job satisfaction; psychological well-being.

Introducción

El *burnout*, la satisfacción laboral y el bienestar psicológico son tres factores relacionados de salud laboral primordiales que requieren ser valorados y controlados en cualquier ambiente laboral, y por lo tanto en los servicios de atención primaria. En primer lugar, la satisfacción laboral es considerada como un elemento a tener en cuenta a la hora de valorar la calidad de gestión asistencial en atención primaria, contribuyendo su estudio a la identificación de posibles oportunidades de mejora que aumenten la calidad de los servicios ofrecidos.[23] Cuando la satisfacción de las necesidades y motivaciones personales es desatendida, puede fácilmente acontecer el síndrome de *burnout*, caracterizado por la sensación de desapego, la despersonalización y la inadecuación profesional, con la consiguiente pérdida de calidad asistencial.[24] Apoyar a los médicos en la reducción de su estrés laboral y en el aumento de su motivación y productividad conduce a mejores resultados en áreas tales como una mayor satisfacción de los pacientes, un mejor cumplimiento del tratamiento, mejoras en la morbilidad y la mortalidad y un descenso tanto en la probabilidad de hospitalización como del periodo de ingreso, que a su vez afecta a los costes de asistencia.[21] Por lo tanto, intervenir sobre el nivel de *burnout*, satisfacción laboral y bienestar psicológico de los MAPs puede mejorar la calidad del servico que están ofreciendo.

Comparado con otros países europeos, en España existe poca literatura científica sobre la extesión y evolución del *burnout*, satisfacción laboral y bienestar psicológico de los MAPs. Se sugirió que el grado de satisfacción laboral de los MAP era intermedio antes de la crisis económica[24], pero en consecuencia, ésta puede haber alterado no sólo el nivel de satisfacción laboral, sinó también el de factores relacionados como el *burnout*. En un estudio prospectivo realizado entre 2005 y 2007, se observó un aumento significativo de la prevalencia de *burnout*, estimándose una incidencia de *burnout* de 1 / 113.5 MAPs anual.[14] Finalmente, en relación al bienestar psicológico, usando cuestionarios autoadmistrados, en 2006 se estimó una prevalencia de morbilidad psiquiátrica del 25,7% entre los MAPs y pediatras[7], mientras que en población general, en el año 2014 se estimó que el 8,5% de la población de 15 años o más tenía riesgo de sufrir algún trastorno mental, el 6,5% de los hombres y el 10,5% de las mujeres.[9]

Los datos epidemiológicos previamente expuestos podrían ser obsoletos dada la influencia que nuevos factores podrían haber ejercido. En primer lugar, la cartera de servicios de los MAP ha aumentado[25], incrementándose la presión para atender un mayor número de pacientes con más complejas y variadas patologías, entre ellas de salud mental. Hemos que tener en cuenta que la atención primaria de salud es la vía de acceso al sistema de salud mental para el 70% de la población.[19] En España, al compararse con el periodo previo a la crisis económica de 2006, una investigación de 2010 reveló aumentos sustanciales y significativos de la proporción de pacientes con alteraciones del ánimo (19.4% en depresión mayor), ansiedad (8.4% en trastorno de ansiedad generalizada), somatomorfas (7.3%) y trastornos relacionados con el consumo de alcohol (4.6% en trastorno por dependencia al alcohol) entre aquellos que visitaban los servicios de atención primaria.[12] Tanto en las reuniones de coordinación como en encuestas cualitativas de los centros de atención primaria, nuestros MAPs nos revelaron que, junto con los pacientes con trastornos

musculo-esqueléticos, los pacientes con patologías mentales son el grupo de pacientes que más han contribuido al empeoramiento de su nivel de *burnout*, satisfacción laboral y bienestar psicológico.

En segundo lugar, el impacto directo de la crisis económica española (la cuál se ha mantenido desde 2008) tanto sobre el estado de salud de la población com el sistema de salud español. Ésta ha tenido un impacto sobre el gasto sanitario, la cobertura del sistema, la capacidad del sistema para responder a las necesidades de la población y patrones de uso *versus* los servios sanitarios privados.[5] La actual situación económica ha contribuido a un aumento de la presión asistencial en atención primaria; sólo en Cataluña, pese a la variabilidad de datos entre las fuentes, las plazas de MAPs se han visto reducido alrededor de 1000 durante los últimos cuatro años.[27]

En tercer lugar, hemos de mencionar el despliegue del *Programa de Suport de Salut Mental a l'Atenció Primària* (llamado PSP), basado en el *Collaborative Care Model* que aboga tanto por la atención especializada como la formación de los equipos de atención primaria. En 2012 el PSP atendió a 3.363 personas, siendo un 45% tratados por trastornos de adaptación, un 35% por problemas de la vida cotidiana que crean tensión y el malestar, un 15% por trastornos depresivos y un 5% por un trastorno mental grave.[8,9] El PSP ha contribuido a una reducción en el número de nuevos casos que finalmente llegan a los servicios especializados de salud mental, ya que aunque la tasa de prevalencia atendida en la red de salud mental (casos con trastornos mentales tratados por año) se ha mostrado estable desde el año 2008 (2008: 2,18 vs. 2012: 2,5), la tasa de incidencia dada (nuevos casos con trastorno mental por año) disminuyó del 1,24 en 2008 al 0,85 en 2012. Así pues, observamos como el PSP está teniendo un claro efecto beneficioso tanto para los MAP como para la red de salud mental. No obstante, quizás los servicios salud mental especializados como el nuestro se han visto más beneficiados de este programa ante esta reducción de tasas de incidencia, no habiéndose reportado (aparentemente) también en atención primaria. .

Dada la influencia que pudiera haber ejercido los factores previamente citados, los objetivos del presente estudio fueron determinar en una muestra de MAPs (a) su nivel actual de *burnout*, satisfacción laboral y bienestar psicológico y actitudes respecto la salud mental; (b) la influencia del *burnout*, satisfacción laboral y algunas variables socio-demográficas y de gestión sanitaria sobre el nivel de bienestar psicológico.

Método

Realizamos un estudio observacional transversal, con análisis de regresión logística. Los registros psicométricos de los MAPs tuvieron lugar en enero de 2016.

Criterios de inclusión

Los participantes tenían que ser MAPs trabajando en entidades públicas de atención primaria. Además, estas unidades debían de pertenecer al sector asistencial que da cobertura nuestro centro de salud mental ambulario (CSMA).

Participantes y estrategia de reclutamiento

Todos los MAPs involucrados con el *Programa de Suport de Salut Mental a l'Atenció Primària* (PSP) de nuestro sector fueron invi-

tados a participar en el estudio. Pertenecen a cuatro unidades de atención primaria, cubriendo una población de aproximadamente 95.313 habitantes en 2016.

Después de realizarse una sesión clínica sobre la gestión de los pacientes psiquiátricos en atención primaria dirigida a los MAPs, se presentaron los objetivos y la metodología de nuestro estudio, ofreciéndose la posibilidad de involucrarse. Posteriormente, a todos aquellos MAPs que finalmente aceptaron se les entregó los cuestionarios psicométricos. Además, se les programó una entrevista clínica (siendo el mismo para todos) con un evaluador independiente (un psiquiatra que estaba efectuando el *MIR*), para evaluar su bienestar psicológico. Este evaluador era ciego respecto a los objetivos del estudio y estaba entrenado en la administración del *Brief Psychiatric Rating Scale* (BPRS) por parte de un psiquiatra senior. Además de la aplicación del BPRS a todos los MAPs, este evaluador recopiló todos los cuestionarios previamente rellenados por los MAPS al finalizar las entrevistas. Todas las entrevistas del evaluador independiente se realizaron dentro de un período máximo de 15 días.

Instrumentos

En primer lugar, las siguientes variables administrativas y sanitarias facilitadas por la autoridad sanitaria catalana (*Institut Català de la Salut* (ICS)) fueron registradas como indicadores objetivos de carga laboral:
(a) *Total de visitas efectuadas anualmente por cada MAP para todo tipo de patologías*; (b) *Total de visitas efectuadas anualmente por cada MAP ligadas a salud mental*; (c) *Accesibilidad*: porcentaje de visitas requeridas para las 48h siguientes que han sido satisfechas por cada profesional anualmente. En todos los tres casos se obvió los datos de pacientes envuletos en programas de atención domiciliaria, pacientes crónicos complejos y pacientes con enfermedades crónicas avanzadas.

En Segundo lugar, los siguientes intrumentos fueron administrados a cada participante:
(a) Cuestionario socio-demográfico diseñado *ad-hoc* para este estudio. Tiene ítems relacionados con información personal, social y laboral.
(b) Versión extendida del *Cuestionario Font-Roja de Satisfacción Laboral*. Este cuestionario ha sido ampliamente utilizado en muchos estudios españoles, presentando unas adecuadas propiedades psicométricas (*alpha Cronbach* 0.791).[18] Tiene 26 ítems en *escala likert* [1-5]. Contiene 9 dimensiones: *satisfacción por el trabajo; tensión relacionada con el trabajo; competencia profesional; presión en el trabajo; promoción profesional; relación interpersonal con los superiores; relación interpersonal con los compañeros; características extrínsecas de estatus; monotonía laboral.*
(c) *Maslach burnout Inventory* (MBI). MBI es el instrumento más utilizado para medir *burnout*. La adaptación española ha demostrado ser fiable y válida.[11] Tiene 26 ítems que capturan tres dimesiones del *burnout*: agotamiento emocional o *emotional exhaustion* (EE), despersonalización o *depersonalization* (DP), y realización personal o *personal accomplishment* (PA). La puntuación *Total MBI* se obtuvo como: [EE+DP+LPA]. The LPA (falta de realizción personal o *lack of personal accomplishment*) se calculó como: [LPA = 48 - PA]. Utilizamos los puntos de corte propuestos por Doulougeri, Georganta y Montgomery para el MBI: Puntuaciones EE ≥ 27 son consideradas como *alta*, 19–26 como *media*, ≤18 como *baja*; Puntuaciones DP ≥10 como *alta*, 6–9 como *media*, ≤5 comos *baja*; Puntuaciones PA >40 comos *alta*, 34–39 como *media*, <33 como *baja*; Puntuaciones *Total MBI* con

percentil >75 como *alta*, 25-75 como *media*, <25 como *baja*.

(d) *Struening And Cohen's Opinion About Mental Illness Questionnaire (Cuestionario de Opinión sobre Enfermedad Mental, OMI)*. Adaptado para su uso en España por Yllá y Guimón con adecuadas propiedades picométricas.[28] Tiene 63 ítems, de los cuales se infieren 5 dimensiones: negativismo o *negativism*; social/*interpersonal etiology* o etiología social/*interpersonal*; autoritarismo o *authoritarianism*; restrictividad social o *restrictiveness*; prejuicio o *prejudice*.

2. Medidas psicométricas hetero-aplicadas:

- *Brief Psychiatric Rating Scale* (BPRS). Esta entrevista semi-estructurada es una de las escalas más antiguas y ampliamente utilizadas por los clínicos y los investigadores para medir los síntomas psiquiátricos. Entre las diferentes versiones disponibles, en España se validó dentro de *The Positive and Negative Syndrome Scale* (PANSS).[20] Los 18 ítems son calificados por un clínico entrenado en base al comportamiento observado y del habla. El intérvalo de tiempo considerado es la semana anterior a la calificación. La presencia y gravedad de los síntomas psiquiátricos se califican en una escala de likert que varía de 1 *(no informado)* a 7 *(muy grave)*; por lo tanto, las puntuaciones posibles varían de 18 a 126 indicando las más bajas psicopatología menos grave. Entre los disponibles, se usaron los puntos de corte para la puntuación total propuestos por Leucht y colegas por su solidez, a pesar de ser sólo generalizables a los pacientes con esquizofrenia y almenos síntomas positivos moderados: 31 como *levemente enfermo*; 41 como *moderadamente enfermo*; 53 como *muy enfermo*. En cualquier caso, el BPRS puede ser una herramienta útil para determinar la presencia de un trastorno mental, pero insuficiente si se aplica en solitario.

Consideraciones éticas y de financiación

El protocolo de investigación fue aprobado por el Comité de Ética en Investigación Clínica (CEIC) de la *Unidad de Soporte a la Investigación* regional del *Institut Universitari d'Investigació en Atenció Primària* (IDIAP), siguiendo la ley contenida en la Declaración de Helsinki y en la ley nacional de protección de datos personales.

Análisis estadístico

Las características de la muestra se describieron calculando medianas y rangos intercuartiles (*IQR*) para variables numéricas y frecuencias absolutas y relativas (%) para variables binarias y categóricas

Para evaluar el efecto del *burnout*, la satisfacción laboral y las variables socio-demográficas sobre el bienestar psicológico, se ajustaron cuatro modelos de regresión logística sobre los síntomas del BPRS más prevalentes. En cada modelo, la presentación de -o no- de cualquier grado de síntomas fue explicado por el MBI total, total del *Cuestionario Font Roja-AP de Satisfacción Laboral*, edad, sexo y experiencia laboral.

Las distribuciones observadas fueron ilustradas usando diagramas de caja.

Todas las estadísticas se realizaron usando el R Development Core Team software (2011).

Resultados

Valores socio-demográficos

Nuestra muestra estubo compuesta predominantemente de mujeres (78.95%) de mediana edad (mediana= 49 años, *IQR* = 42.25, 56). La mayoría cursó el MIR (78.95%) y

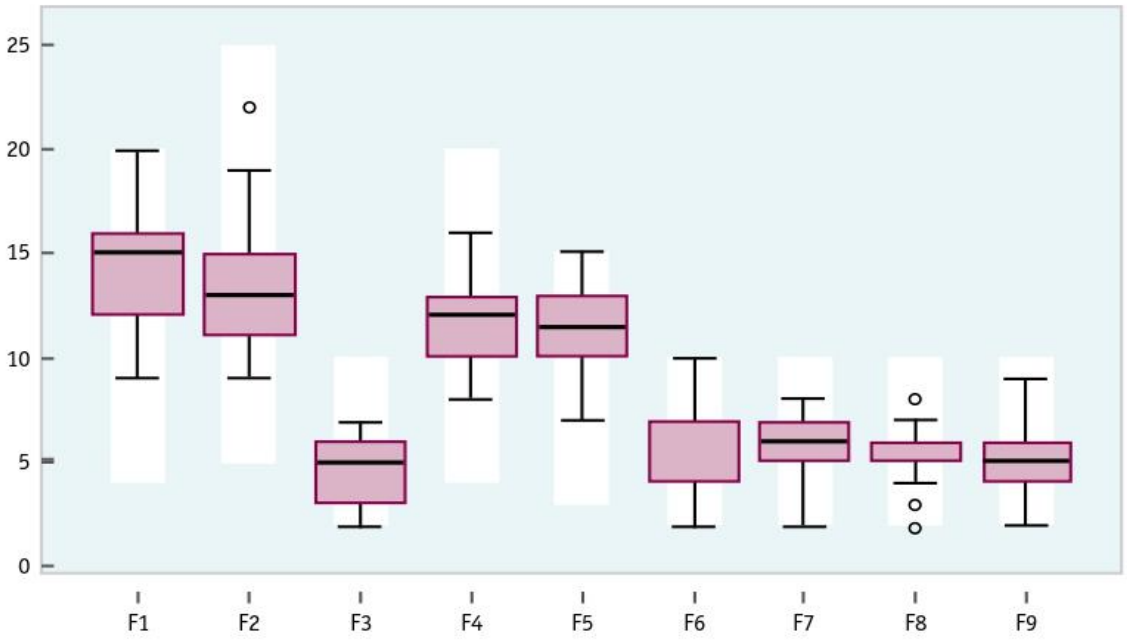
ostenta muchos años de experiencia profesional (17 [12.25, 28]). Había una mayoría de contratos indefinidos (65.79%) y turnos laborales mixtos (68.42%). La mayoría había recibido escasa formación en salud mental durante el último año (0 [0, 10]).

Valores administrativos y clínicos

En relación a los datos administrativos, la mediana del *total de visitas efectuadas anualmente por cada MAP para todo tipo de patologías* fue 4404 (*IQR* = 4004.25, 4816.25). La mediana del nivel de accesibilidad fue de 91.60 (*IQR* = 72.88, 100). Finalmente, la mediana del total de visitas efectuadas anualmente por cada MAP ligadas a salud mental fue 355 (*IQR* = 291, 434).

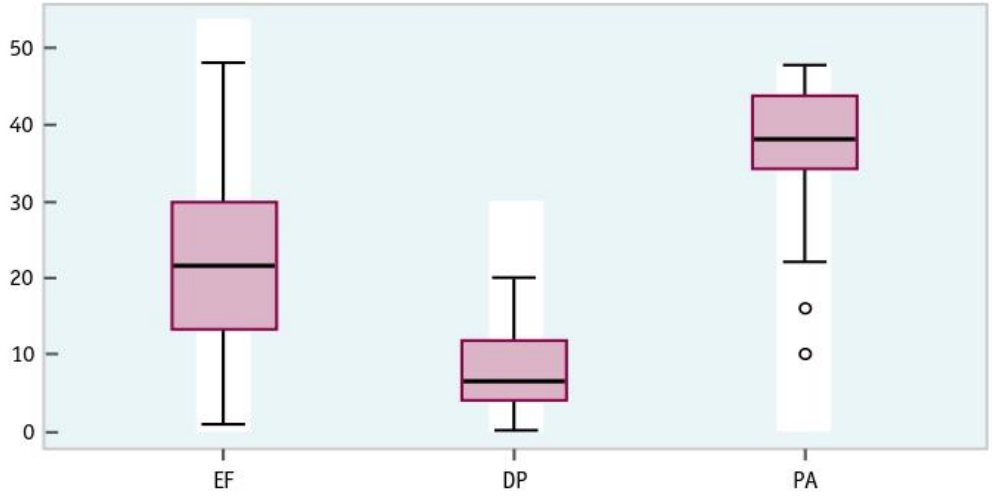
En conjunto, la mediana de la satisfacción laboral evaluada por el *Cuestionario Font Roja-AP de Satisfacción Laboral* fue 75.5 (*IQR* = 73, 79); las puntuaciones oscilaban entre 26 – 130 (Figura 1). En base este cuestionario, por un lado podemos observar una moderada *satisfacción por el trabajo* (F1) y *promoción profesional* (F5), pero por el otro una moderada *tensión relacionada con el trabajo* (F2) y *presión en el trabajo* (F4). La *relación interpersonal con los compañeros* (F7) tendía a ser más fluida que *con con los superiores* (F6).

Figura 1. Distribución de las dimensiones de la versión extendida del Cuestionario Font-Roja de Satisfacción Laboral



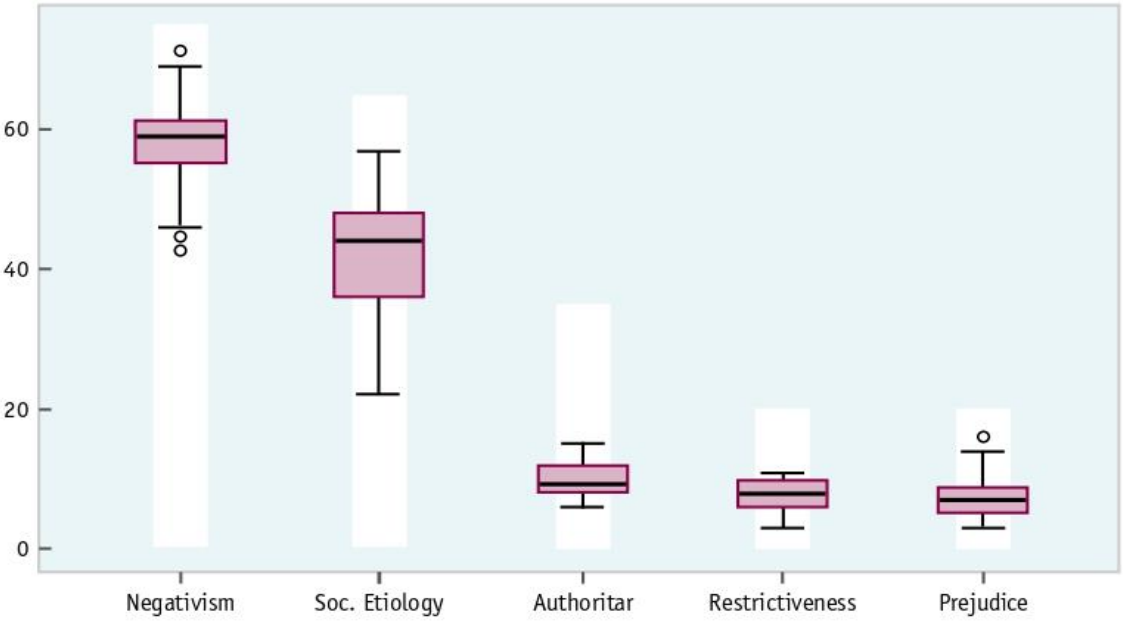
Notas: Diagramas de caja de los resultados. Dimensiones: F1: satisfacción por el trabajo; F2: tensión relacionada con el trabajo; F3: competencia profesional; F4: presión en el trabajo; F5: promoción profesional; F6: relación interpersonal con los superiores; F7: relación interpersonal con los compañeros; F8: características extrínsecas de estatus; F9: monotonía laboral. Los diagramas muestran los cuartiles y los outliers amb con un rango terórico en segundo plano.

Figura 2. Distribución de las dimensiones del Maslach Burnout Inventory (MBI)



Notas: EE: Emotional exhaustion; DP: Depersonalization; PA: Personal accomplishment.

Figura 3. Distribución de las dimensiones del Cuestionario de Opinión sobre Enfermedad Mental (OMI)



Notas: Diagramas de caja de los resulados. Dimensiones: *Negativism; Social/ interpersonal etiology; Authoritarianism; Restrictiveness; Prejudice*.

La mediana del nivel total de *burnout* calculada estaba en la *media*, situándose en 38 (*IQR* = 29, 54). Sólo 2 (5.26%) MAPs mostraron puntuaciones en *total MBI* en percentilies >75 . A parte, todas las puntuaciones en las 3 subescalas del 3 MBI estaban en la *media* (Figura 2): *emotional exhaustion* (EE) (mediana = 21.50, *IQR* = 13.25, 28.75); *depersonalization* (DP) (mediana = 6.50, *IQR* = 4.25, 11.75); *personal accomplishment* (PA) (mediana =38, *IQR* = 34, 43.75).

En relación a las Opiniones sobre las enfermedades Mentales medidas por el el cuestionario OMI, las puntuciones variaron a lo largo de las dimensiones del OMI (Figura 3). Observamos puntuaciones altas en *negativism* (mediana = 59, *IQR* = 55.25, 61); rango 0 – 75. Puntuaciones altas fueron tambien detectadas en *social/ interpersonal etiology* (mediana =44, *IQR* = 36.50, 48.27); rango 0 – 65. Punctuationes fueron medias en *Restrictiveness* (mediana = 8, *IQR* = 6, 10); rango 0 – 20. Puntuaciones medianas fueron tambien observadas en *prejudice* (mediana = 7, *IQR* = 5.25, 9); rango 0 – 20. Finalmente, puntuaciones bajas fueron observadas en *authoritarianism* (mediana = 9, *IQR* = 8, 11.75); rango 0 – 35.

En los resultados de los ítems del BPRS (Tabla 1) podemos observer como sólo un 10.5% de los MAPs no presentaba ningún nivel de *ansiedad*, desde el punto de vista de un juicio clínico. Otros síntomas psiquiátricos predominantes fueron niveles *leves* de *estado de ánimo depresivo* (18.4%), *preocupaciones somáticas* (13.2%), *hostilidad* (15.8%) y *sentimientos de culpabilidad* (10.5%). En realación a la coomorbilidad de síntomas, 36 (94.74%) de los MAPs presentaron simultáneamente más de un síntoma en el BPRS (en cualquier nivel del rango de severidad). Focalizándose sólo en estos casos preocupantes, 21 (55.26%) MAPs sufrián síntomas de *moderada* a *muy grave* severidad; entre ellos, sólo 7 (18.42%) MAPs presentaba más de un síntoma simultáneamente. Finalmente, la puntuación total del BPRS (mediana = 24, *IQR* = 22, 27), la Sub*escala Negativa* (mediana = 4, *IQR* = 4, 4) y la *Subescala Positiva* (mediana = 4, *IQR* = 4, 4) no fueron clínicament significativas. Sólo 3 (7.89%) sujetos presentaban puntuaciones en el total del BPRS ≥ 31 (como *levemente enfermo*), y ninguna ≥ 41 (como *moderadamente enfermo*).

Table 1. *Brief Psychiatric Rating Scale* (BPRS) (Parte 1)

Grado de Severidad							
	No informado	Muy leve	Leve	Moderada	Modeada Grave	Grave	Muy Grave
1.Preocupación Somática	24 (63.2%)	6 (15.8%)	5 (13.2%)	0	1 (2.6%)	2 (5.3%)	0
2.Ansiedad	4 (10.5%)	5 (13.2%)	9 (23.7%)	10 (26.3%)	4 (10.5%)	6 (15.8%)	0
3.Aislamiento Emocional	36 (94.7%)	1 (2.6%)	1 (2.6%)	0	0	0	0
4.Desorganización Conceptual	37 (97.4%)	1 (2.6%)	0	0	0	0	0
5.Sentimientos de culpabilidad	19 (50.0%)	12 (31.6%)	4 (10.5%)	3 (7.9%)	0	0	0
6.Tensión	38 (100.0%)	0	0	0	0	0	0
7.Manerismo y posturas corporales extrañas	38 (100.0%)	0	0	0	0	0	0
8.Grandeza	38 (100.0%)	0	0	0	0	0	0
9.Estado ánimo depressivo	14 (36.8%)	15 (39.5%)	7 (18.4%)	1 (2.6%)	0	0	1 (2.6%)

Table 1. *Brief Psychiatric Rating Scale* (BPRS) (Parte 2)

	Grado de Severidad						
	No informado	Muy leve	Leve	Moderada	Modeada Grave	Grave	Muy Grave
10. Hostilidad	13 (34.2%)	17 (44.7%)	6 (15.8%)	1 (2.6%)	1 (2.6%)	0	0
11. Suspicacia	33 (86.8%)	5 (13.2%)	0	0	0	0	0
12. Conducta Alucinatoria	37 (97.4%)	1 (2.6%)	0	0	0	0	0
13. Retraso Motor	38 (100.0%)	0	0	0	0	0	0
14. No Cooperativo	38 (100.0%)	0	0	0	0	0	0
15. Contenido inusual del pensamiento	38 (100.0%)	0	0	0	0	0	0
16. Afecto Aplanado	36 (94.7%)	2 (5.3%)	0	0	0	0	0
17. Excitación	24 (63.2%)	10 26.3%)	3 (7.9%)	1 (2.6%)	0	0	0
18. Desorientación	38 (100.0%)	0	0	0	0	0	0

Regresiones logísticas

Los modelos de regressión logísitca sobre los principales síntomas psiquiátricos de los MAPs mostraron como un aumento del *burnout* (COEF=1.10 (1.03, 1.21); *p* =0.019) y experiencia profesional (COEF= 1.34 (1.08, 1.99); *p* =.049) estaba asociado con una mayor posibilidad de sufrir depresión. A parte, tener baja edad (COEF= 0.62 (0.35, 0.84); *p* = 0.02) y *burnout* (COEF=0.94 (0.88, 0.99); *p* =0.024) estaba asociado con una baja probabilidad de sufrir hostilidad en cualquier nivel. Finalment, presentar un elevado *burnout* (COEF=1.08 (1.02, 1.17); p =0.026) o baja satisfacción laboral (COEF=0.69 (0.46, 0.90); p = 0.022) estaba asociado con mayores nivels de culpabilidad. En relación a la *ansiedad*, no encontramos diferencias estadísticamente significativas.

Table 2.Regresiones logísticas sobre los principales síntomas psiquiátricos de los MAPs

Psychiatric Symptoms	Variable	Coefficients[a]	P
1.Depresión			
	Edad	0.79 (0.56, 0.97)	0.075
	Género	1.32 (0.17, 10.24)	0.785
	Años de experiencia	1.34 (1.08, 1.99)	0.049*
	Burnout (total)	1.10 (1.03, 1.21)	0.019*
	Satisfacción Laboral (Total)	1.08 (0.94, 1.30)	0.307
2.Hostilidad			
	Edad	0.62 (0.35, 0.84)	0.02*
	Género	0.29 (0.01, 4.70)	0.437
	Años de experience	1.33 (1.03, 2.05)	0.093
	Burnout (total)	0.94 (0.88, 0.99)	0.024*
	Satisfacción laboral (total)	1.08 (0.85, 1.37)	0.513
3.Culpa			
	Edad	1.16 (0.92, 1.54)	0.245
	Género	Inf (0, Inf)	0.993
	Años de experiencia	1 (0.80, 1,23)	0.962
	Burnout (total)	1.08 (1.02, 1.17)	0.026*
	Satisfactión laboral (total)	0.69 (0.46, 0.90)	0.022*

[a] Coeficientes y 95% intérvalos de confianza del modelo de regresiones logísticas prediciendo los principales síntomas psiquiátricos de los MAPs.
*Nota *p <.05 ; ** p <.001*

Discusión

Los MAPs presentaron resultados heterogéneos una vez analizados los diferentes parámetros de salud laboral y psicológicos, observándose en nuestro estudio tanto fortalezas como debilidades.

Por un lado, observamos un empeoramiento de la carga de trabajo de los MAPs (según los indicadores administrativos y sanitarios) en comparación con los datos observados en las mismas unidades de atención primaria en los últimos años. Lamentablemente, estas medidas son sólo *intra-grupo* ya que hasta ahora carecen de comparación externa. Los recortes en el presupuesto sanitario, las dificultades para reemplazar las bajas por enfermedad o la disminución de las plazas de MAP pueden haber sido algunos elementos contribuyentes.

Asimismo, en la línea de publicaciones previas se observaron niveles moderados de *burnout* y satisfacción; no detectamos un empeoramiento significativo de estos dos parámetros en comparación con los señalados antes y durante la crisis económica española[24,14], o con aquéllos aportados por estudios internacionales.[26] Sólo 2 (5.26%) MAPs informaron una puntuación total en el MBI > 75 (como *alta*), cifras menos prevalentes las observadas en otros estudios realcionados.[17] Con respecto a las opiniones y actitudes hacia las enfermedades mentales, las puntuaciones en OMI no reflejaron un alto *prejuicio* hacia ellas, pero sí mostraron carencias en el manejo clínico de los pacientes psicopatología, que es congruente con estudios previos.[2] No obstante, proporcionar a los MAPs más habilidades y entrenamiento en salud mental podría mejorar las altas puntuaciones detectadas en el *negativism* (definido como actitud benévola, caritativa, simplista, paternal y autoritaria) y la *interpersonal etiology of mental disorders*.

Por otro lado, los resultados de la salud mental de los MAP fueron de algún modo polémicos. Sabíamos de antemano por estudios nacionales[7,13] e internacionales[6] que existe entre el 25 y el 30% de la morbilidad psiquiátrica entre los MAPs. Por lo tanto, en esta línea con la literatura, esperábamos una cifra superior que en la población general pero al mismo tiempo menor que las cifras anteriormente mencionadas después que el estado mental fuera evaluado más a fondo a través de una entrevista clínica psiquiátrica. Hasta ahora, después de revisar las principales bases de datos de investigación, todos los estudios españoles e internacionales sobre este tema sólo administran cuestionarios de salud auto-administrados como el *General Health Questionnaire* (GHQ), los cuales son útiles pero clínicamente menos precisos y profundos que las entrevistas clínicas. Nuestros resultados reflejan esta alta proporción de MAPs que presentan síntomas psiquiátricos pero mucho más de lo esperado teniendo en cuenta las consideraciones previas. Teniendo en cuenta que sólo los casos que la atención en salud mental podría ser de algún modo recomendada, 21 (55.26%) MAPs sufrían síntomas de *moderado* a *muy grave*. En relación a la coomorbilidad de síntomas, 36 (94.74%) MAPs presentaban más de un síntoma en el BPRS simultáneamente. Entre el subgrupo con síntomas *moderados* a *muy graves*, 7 (18.42%) MAPs presentaron más de un síntoma en el BPRS simultáneamente.

En cuanto al tipo de síntomas psiquiátricos observados, tal y como también se señala en la literatura, la ansiedad, la depresión y las preocupaciones somáticas fueron las predominantes.[4] El 89.5% de los MAP sufrían niveles de ansiedad de *muy leves* a *graves*.

Sorprendentemente, en nuestra muestra hubo un 15.8% de prevalencia de *hostilidad*. A pesar de que estas tasas más altas

de síntomas psiquiátricos, se considera que los MAPs tienden a ocultar sus problemas y seguir trabajando incluso cuando están enfermos.

Regresiones logísticas

Dados estos resultados en el bienestar psicológico, llevamos a cabo un modelo de regresión logística sobre los principales síntomas psiquiátricos. Nuestros resultados son difíciles de comparar con anteriores datos de investigación españoles sobre este tema porque aquí se realizó una entrevista psiquiátrica, informándose sobre síntomas en lugar de ofrecerse un índice global de morbilidad psiquiátrica.[7] Aquí podemos observar como el *burnout*, la satisfacción laboral y los factores socio-económicos ejercieron diferentes efectos sobre cada síntoma psiquiátrico. En cualquier caso, si queremos aumentar nuestra comprensión sobre el bienestar psicológico de los MAPs, se requeriría de un análisis más amplio y complejo.

Limitaciones y fortalezas del estudio

Tenemos que reconocer una serie de importantes limitaciones en nuestro estudio. En primer lugar, el tamaño de la muestra es modesto en comparación con otros estudios en este campo.[24] Sin embargo, es una proporción importante del total de nuestra población de estudio, estando en todo caso aseguranda la representatividad de este colectivo. En segundo lugar, si bien es clínicamente mejor que usar un cuestionario, la administración de nuestra entrevista clínica podría ser un tanto controvertida en la población general. El BPRS es una medida sólida psicométricamente, pero principalmente administrada en esquizofrenia. Sin embargo, hay evidencia científica que apoya su uso para detectar otros tipos de psicopatologías.[3] De hecho, teniendo el tiempo y los recursos requeridos, habría sido incluso mejor utilizar entrevistas mucho más largas y complejas como *The Structured Clinical Interview for DSM-5* (SCID-5). En este contexto de exploración psiquiátrica, podría haber sido también interesante analizar dominios más allá de los establecidos por el BPRS, como por ejemplo las conductas alimentarias o adictivas, síntomas psiquiátricos señalados por la literatura como más frecuentes que en población general.[15] Respecto a los datos administrativos, es difícil comparar nuestros datos con las de otros centros de salud debido a la disparidad de organización y características. Además, los propios indicadores no están exentos de la crítica.

Sin embargo, al menos para nuestro sistema de salud, podrían ser útiles en futuras investigaciones. Finalmente, debemos considerar que todas las comparaciones previas y posteriores a la crisis económica española son informales porque no fueron administradas herramientas que pudieran controlar la posible influencia ejercida por factores de confusión.

Como puntos fuertes de nuestro estudio, queremos enfatizar su validez ecológica. El estudio se llevó a cabo en la práctica clínica real, con todas las restricciones que esto acarrea: elevada petición de servicios, sobrecarga de trabajo, restricciones en la frecuencia de las visitas de seguimiento, etc.

Conclusiones

Dada la importancia de la salud laboral y los resultados mixtos detectados en nuestra muestra, podemos concluir que existe una necesidad de protegerla y mejorarla. La cuestión es qué intervención debe ser implementada, ya que todavía se requieren futuras investigaciones que desarrollen modelos que describan el fenómeno, identifiquen factores relacionados y estrategias efectivas de intervención. En este contexto, esperamos presentar en un futuro próximo los resultados de las nuevas intervenciones multimodales que estamos llevando a cabo. Su objetivo es facilitar a los MAPs mejores habilidades para hacer frente a esta mayor presión de asistencia con menores costes personales.

Conflicto de Intereses

Ninguno de los autores tiene intereses económicos u otros posibles conflictos de intereses que puedan afectar los objetivos o los resultados del presente manuscrito.

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Reconocimientos

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Referencias

1. Aranaz J, Mira J. Cuestionario Font Roja. Un instrumento de medida de la satisfacción en el medio hospitalario. Todo Hosp. 1988;52:63-6.

2. Arrillaga M, Sarasqueta C, Ruiz M, Sánchez A. Actitudes del personal sanitario de atención primaria hacia el enfermo mental, la psiquiatría y el equipo de salud mental. Aten Primaria. 2004;33(9):491-5.

3. Biancosino B, Picardi A, Marmai L, Biondi M, Grassi L. Factor structure of the Brief Psychiatric Rating Scale in unipolar depression. J Affect Disord. 2010;124(3):329-34.

4. Brooks SK, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed?. J Ment Health. 2011;20(2):146-56.

5. Carmona G, López LA, Mendoza OJ, Oleaga I. Impacto de la Crisis Económica en la Salud y en el Sistema Sanitario en España. Granada: Escuela Andaluza de Salud Pública; 2015.

6. Cohen D, Rhydderch M. Measuring a doctor's performance: personality, health and well-being. Occup Med. 2006;56:438–441.

7. Esteva M, Larraz C, Jiménez F. La salud mental en los médicos de familia:efectos de la satisfacción y el estrés en el trabajo. Rev Clin Esp. 2006; 206(2):77-83.

8. Gabinet de comunicació i premsa Institut d'Assistència Sanitària (IAS). El

programa de suport a la salut mental en l'Atenció Primària millora l'atenció integral dels trastorns mentals. Girona: Departament de Salut. Serveis Territorials a Girona; 2010

9. Generalitat de Catalunya. Departament de Salut. Enquesta de salut de Catalunya 2015. Principals resultats. Barcelona: Direcció General de Planificació i Recerca en Salut; 2015.

10. Gibson J, Checkland K, Coleman A, Hann M, McCall R, Spooner S et al. Eighth National GP Worklife Survey. Policy research unit in commissiong and the health care system (PRUComm). 2015. [Accessed January 31, 2017]. Available in:http://www.population-health.manchester.ac.uk/healtheconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf

11. Gil-Monte P, Peiró JM. Validez factorial del maslach *burnout* inventory en una muestra multiocupacional. Psicothema. 1999:11(3):679-89.

12. Gili M., Roca M, Basu S, McKee M, Stuckler D. The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. Eur J Public Health. 2013;23(1):103-8.

13. Lomeña JA, Martínez C, Negrillo M, Naranjo A. Malestar psíquico en profesionales de la salud: una aproximación a su estudio. Aten Prim. 1991;8: 549-54.

14. Matía AC, Cordero J, Mediavilla JJ, Pereda MJ., González ML, González A. Evolución del *burnout* y variables asociadas en los médicos de atención primaria. Aten Prim. 2012;44(9):532.

15. Miller, L. Doctors, their mental health and capacity for work. Occup Med. 2009;59:53–55.

16. Molina A, García MA, Alonso M, Cecilia P. Prevalencia de desgaste y psicomorbilidad en médicos de atención primaria de un área sanitaria de Madrid. Aten Prim. 2003;31:564-74.

17. Murray M, Murray L, Donnelly M. Systematic review of interventions to improve the psychological well-being of general practitioners. BMC Fam Pract. 2016;17:36.

18. Nuñez E, Estévez GJ, Hernández P, Marrero C. Una propuesta destinada a complementar el cuestionario Font-Roja de satisfacción laboral. Gacet Sanit. 2007;21(2):136-41.

19. Pastor, J. El psicólogo en AP: un debate necesario en el sistema nacional de salud. Papeles del psicólogo. 2008;3(29):271-90.

20. Peralta V, Cuesta MJ. Psychometric properties of the positive and negative syndrome scale (PANSS) in schizophrenia. Psychiatry Res. 1994;53(1):31-40

21. Pérez-Ciordia I, Guillén-Grima F, Brugos A, Aguinaga I. Job satisfaction and improvement factors in primary care professionals. An Sist Sanit Navar. 2013;36(2):253-262.

22. Picardi A, Battisti F, de Girolamo G, Morosini P, Norcio B, Bracco R. et al. Symp-

tom structure of acute mania: a factor study of the 24-item Brief Psychiatric Rating Scale in a national sample of patients hospitalized for a manic episode. J Affect Disorders. 2008;108(1-2):183-9.

23. Saturno PJ, Quintana O, Varo J. Qué es calidad? Tratado de calidad asistencial en atención primaria. Madrid: Dupont Pharma; 1997.

24. Sobrequés J, Cebrià J, Segura J, Rodríguez C, García M, Juncosa S. La satisfacción laboral y el desgaste profesional de los médicos de atención primaria. Aten Prim. 2003;31:227-33.

25. Sociedad Andaluza de Medicina familiar y Comunitaria. ¿Qué queremos los Médicos de Familia?. Sep 2013. [Accessed January 31, 2017]. Available in: http://www.samfyc.es/pdf/ReflexionesSAMFyC26092013.pdf

26. Soler JK, Yaman H, Esteva M. *burnout* in European general practice and family medicine. J Soc Behav Pers. 2007;35(8):1149–50.

27. Vall-llosera A, Zapater F. La atención primaria en Catalunya: una paulatina Regresión. Salud 2000. 2015;25,146.

28. Yllá L, González-Pinto A, Ballesteros J, Guillén V. Evolución de las Actitudes de la población frente al enfermo mental. Actas Esp Psiquiatr. 2007;35(5):323-35.

PROTOCOLO DE INTERVENCIÓN IBST

Cambios Pre-tratamiento

-……
-……
-……

Excepciones

-……
-……
-……

Problemas

*Aportados por el propio paciente. Indicar si/no son *Quejas.*

1)……
……
……
2)……
……
……
3)……
……
……
……

Objetivos

* Del paciente

- **……**
- **……**
- **……**

Atribución Etiológica

- Paciente:……
- Familiar (*nombre y de tipo filiación*): ……
……

Soluciones Intentadas

- ……
-……
-……
-……
-……
-……
-……
-……
-……

Denominador/es común

* En las *Soluciones Intentadas*

-……
-……

Tipo de lógica/s

- …...……
- ...……

Metáforas y demás analogías

* Usadas y/o de especial relevancia para el paciente

- ……
- ……..
- .……

***Tipo de cliente*:**

Intervención	Modalidad de cumplimiento	Resultado