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Pains, Joys, and Secrets: Nurse-Led Group Therapy for Older Adults with Depression

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This is the first study of nurse-led group therapy in Mexico. Forty-one depressed older adults with a median age of 71 participated in nurse-led cognitive behavioral group therapy once a week for 12 weeks. Participants' scores on the Patient Health Questionaire-9 showed mild to moderate improvement. Participants experienced positive results in personal growth, changing negative thoughts, and relationships with family. An important therapeutic factor was the support of fellow group members. The nurses experienced positive personal and professional growth. Difficulties included physician resistance and a too-rigid cognitive behavioral group therapy model. A combination of cognitive behavioral therapy and supportive group therapy is recommended.

"I have realities in my past, not only the reality of work done and love loved, but of sufferings bravely suffered. These sufferings are even the things of which I am most proud, though these are things which cannot inspire envy." —Viktor Frankl (1959).

One of every eight older Mexican adults experience symptoms of major depression (Garcia-Peña et al., 2008). This signals a serious national health problem for some of Mexico's most vulnerable citizens. The risk factors for depressive illness are a complete definition of vulnerability: being an older woman, either widowed or single, with a low educational level, a chronic illness, retired, a sedentary lifestyle, a dysfunctional family, and, especially, an indigenous woman (Nance, 2004). Each of these factors increases the risk of depression (Nance, 2010).

Clinical research focused on effective treatment can make a significant contribution towards decreasing the disability, morbidity, and mortality for the many older adults, especially women, who suffer from depression. Successful outpatient treatment should also reduce costs to the health care system. Despite abundant prevalence studies (Belló, Puentes-Rosas, Medina-Mora, & Lozano, 2005; Junghans & Espino, 1998; Slone et al., 2006; Wagner, Gallo, and Delva, 1999), there is an absence of clinical research in Mexico on the treatment of depression in older adults (Nance, 2010).

Nursing has made a substantial contribution to the care and health promotion of older adults. Since the 1950s nurses have been leaders in therapeutic milieu groups. Today, nurses lead psychoeducational groups, therapeutic milieu groups, time-limited groups, spirituality groups, behavioral groups, self-help groups and cognitive behavioral groups (Lala, 2002). In Mexico, these practices in psychiatric and mental health nursing are only recently being implemented. The role of the nurse in group therapy with the elderly is just now being defined.

This article reports on the first use of nurses as group therapy leaders in Mexico. Three nurses from an outpatient family medicine clinic of the Mexican Institute of Social Security (Instituto Mexicano de Seguro Social, or IMSS) in Mexico City, with training and supervision from a Clinical Nurse Specialist of the Mexican Institute of Geriatrics, pioneered this innovative therapeutic role. The IMSS is a government supported health insurance program, with its own hospitals and clinics. The IMSS is Mexico's largest health care provider, and the largest employer of nurses.

METHODS

Design

This report focuses on the qualitative results portion of a randomized clinical trial of cognitive behavioral group therapy in older depressed adults (Garcia-Pena et al., 2010); the clinical trial was primarily a quantitative study. Qualitative research is interested in how meaning is constructed and how people make sense of their lives and their worlds. The primary goal of qualitative research is to uncover and interpret those meanings (Merriam, 2009). For this article, the author chose to focus on the meaning of the experience of the participants in group and of the nurses in their new role as group therapists.

Physicians at the outpatient clinic were to screen patients over 60 for depression using the Patient Health Questionaire-2 (PHQ-2; Corson, Gerrity, & Dobscha, 2004; Kroenke, Spitzer, & Williams, 2003) and refer them to the study. They were then given the PHQ-9 (Wulsin, Somoza, & Heck, 2002), Mini

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Mental State Examination (Folstein, Folstein, & McHugh, 1975; Blesa et al., 2001) and demographic questionnaires by a separate group of data management personnel.

A significant challenge to the original study design was the lack of participation by the physicians. Only three participants were referred to the study, and all by the same doctor. Clinic physicians said the PHQ-2 created an excessive workload. To remedy this, the nurses actively recruited older adults in the clinic waiting areas. Through direct recruiting, bypassing the physicians, the project obtained sufficient participants.

The intervention consisted of nurse-led cognitive behavioral therapy groups, which met once a week for 12 weeks. The control group continued with their usual care in the outpatient clinic. Contact was not maintained with them except for the interviews at the conclusion of the study, when the individuals from both groups were re-interviewed and re-tested by the data management personnel.

The author examined the results from a qualitative perspective. Each nurse kept a field diary where she recorded her thoughts, feelings, and processes. The nurses used the field diaries to record their clinical observations of the participants, the groups, and the group process. The author provided regular clinical supervision and kept his own field notes. At the conclusion of the study the author interviewed the participants in their groups and individually.

Sample and Setting

Those participants who met the criteria for moderate depression (dysthymia) were randomly assigned to either the control or the intervention group. Thirty-nine persons were in the control group and 41 in the intervention group. Median age was 71 years.

The clinic is a very busy Family Medicine Clinic with an attached small psychiatric hospital. The clinic is in a lower-middle class to middle class neighborhood in an urban area of Mexico City, with good access to public transportation and city services. There are many parks, restaurants, and coffee shops nearby. Most of the study participants were born and raised near the clinic.

Ethical Review

An Ethics Committee of the IMSS approved the study, which conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Tokyo, 2004). Written informed consent was given by all participants, including consent to use their comments anonymously.

Instruments, Reliability, and Validity

The study used the Spanish translation of the PHQ-2 (Corson, Gerrity, & Dobscha, 2004; Kroenke, Spitzer, & Williams, 2003) and an abbreviated version of the Spanish PHQ-9 (Wulsin, Somoza, & Heck, 2002), consisting of two screening items for depression. The PHQ-9 has been used to screen for depression as part of a case management program (3CM, LLC, 2009) for the treatment of depression.

Reuland et al.'s (2009) comprehensive review of Spanish language depression screening instruments found one fair-quality study from Spain (Baca et al., 1999) and one poor-quality study from Honduras (Wulsin, Somoza, & Heck, 2002) of the 9-item PRIME-MD (antecessor of the PHQ-9), which showed sensitivities ranging from 72% to 77% and specificities ranging from 86% to 100%. The 2-item PRIME-MD (original version of the PHQ-2) was found to be 92% sensitive, but only 44% specific for depression in one study with Puerto Ricans (Robison, Gruman, Gaztambide, & Blank, 2002).

With geriatric outpatients, the 15-item Spanish language version of the Geriatric Depression Scale (GDS) had sensitivities ranging from 76% to 82%, and specificities ranging from 64% to 98%. Available evidence suggests that the original PRIME-MD-2 may be inaccurate (nonspecific) in US Spanish-speaking populations. For depression screening in Spanish-speaking outpatients, fair evidence supports the diagnostic accuracy of the CES-D and PRIME-MD-9 in general primary care and the GDS-15-Spanish for geriatric patients (Reuland et al., 2009).

Informed of this, the physicians who participated in the study design selected the PHQ-9 and the PHQ-2 as an easily administered rapid screening instrument for depression by primary care physicians.

The Spanish version of the MMSE, a well-validated, reliable instrument was used to evaluate both groups before and after the intervention phase (Blesa et al., 2001).

Therapeutic Group Format

Three nurses were trained as group leaders in cognitive behavioral therapy. Training consisted of 30 hours of class time, given by the author, with the participation of a psychiatric resident. The author is an experienced group therapist and clinical nurse specialist (CNS) in adult psychiatric and mental health nursing, and provided regular clinical supervision to the nurse-group leaders. The nurses were technical nurses (graduates of non-university based programs); two have a certification in psychiatric nursing. The nurses each led groups of six to eight patients in weekly sessions for 12 weeks.

A programmed guide for outpatient cognitive behavioral therapy has been used in the treatment of depression in older adults (Ciechanowski et al., 2004). Cognitive behavioral therapy combines behavior modification and cognitive therapy. The cognitive area refers to thoughts, beliefs, and assumptions. Cognitive behavioral therapy involves identifying irrational and distorted thoughts and replacing them with realistic and helpful thoughts. These changes in thinking then lead to changes in behavior and to changes in feelings and moods, which will then alleviate anxiety, depression, and irrational fears, and break the vicious cycle of depression: that of inactivity, depressed mood, and depressed thought.

The groups followed a structured program, the Spanish version of the Group Therapy Manual for Cognitive Behavioral Treatment of Depression (Muñoz, Aguilar-Gaxiola, & Guzmán, 2000). Muñoz and Mendelson (2005) recount multiple uses of the manual with positive results in various minority and ethnic populations with different problems. Some of these programs included intensive case management, social and economic interventions, and monetary payments to clients. Clinical research data on improvement in depression with the use of the program manual, or the use of the program in older adults, were not addressed. Successful use of the manualized program with Puerto Rican adolescents has been cited by Rosselló & Bernal (1999) and Rosselló, Bernal, & Rivera-Medina (2008).

A didactic portion of the program covered how patterns of thought and behavior influence feelings to worsen or to improve depression. Participants were helped to identify depressive thoughts and to change them for more realistic, positive thoughts, and to measure their mood states daily with a "mood thermometer," drawn with gradients.

Participants were assisted in setting short- and long-term goals; developing their personal plans for experiencing pleasurable activities; substituting realistic, positive thoughts for negative, depressive thoughts; improving social relationships; and forming and maintaining social support networks.

Qualitative Observations, Reliability, and Validity

The nurses kept a field diary of group processes and of their own processes, thoughts, feelings, and reflections. They completed their diary entries as soon as possible after each group session. The notes included the session and a weekly progress summary on each participant and each group as a whole.

After the last group session, the author interviewed the nurses as a group, and then individually, using a semi-structured format and taking notes during the interviews. Participants were interviewed in their groups at the conclusion of the final session. A third of the group members also chose to be interviewed individually.

The use of the field diary was a strategy to enhance objectivity and reduce bias. The author took measures to monitor and examine feelings that might influence the interview process or compromise the validity of the results (Hutchinson & Wilson, 1992), including keeping his own field diary of the weekly supervision sessions with descriptions, direct quotations, and observations. During supervision, the author and the nurses compared their perceptions and observations of the groups, the individual participants, and the nurse's process as group leaders.

Information from the interviews and field diaries was analyzed using principles of Pattern Coding. Pattern Coding is appropriate for the development of major themes from the data; the search for rules, causes, and explanations in the data; the examination of social networks and patterns of human relationships; and for the formation of theoretical constructs and processes (Miles & Huberman, 1994).

Table 1.
Stressful Life Events

Stressful Life Events within the past 2 years	Intervention Group	Control Group
Death of close family member	66%	40%
Serious illness of close family member	44%	27.5%
Serious illness	31.7%	12.5%
Increased difficulty in usual activities or walking	63.4%	40%
Loss of vision or hearing	73%	50%
Financial problems	39%	50%

RESULTS

Participant Profile

The average participant was a retired, Catholic, widowed, or divorced woman with a chronic medical problem, between the ages of 60 and 80, with a primary school education or less, who lived with family members. Family relationships, and relationships with spouses, were frequently described as conflictive or abusive. During group sessions 80% of the Intervention Group said they had experienced abusive childhoods. The three most common chronic medical conditions were hypertension (70.7%), diabetes (36.6%), and rheumatoid arthritis (34.1%).

Demographically very similar, the Intervention Group had experienced more serious physical illness and disability, and had suffered more losses, both familial and functional within the past two years than did the Control Group (see Table 1). These stressful life events are high risk factors for depression.

Quantitative Results

A mild to moderate improvement in levels of depression was seen, as measured by the PHQ-9 at the conclusion of the study (see Table 2).

An MMSE score of less than 23 points (out of 30) was considered indicative of impairment, and a score of 23 or above indicated normal functioning. Both the Control Group and the Intervention Group showed mild to moderate improvement in their scores at the conclusion of the study (see Table 3).

Table 2.
PHQ-9 Scores

PHQ-9 Score: Intervention Group Start	PHQ-9 Score: Intervention Group Finish
11.8	7.43
PHQ-9 Score: Control Group Start	PHQ-9 Score: Control Group Finish
10.73	8.40

Table 3.
MMSE Scores

MMSE Score	Intervention Group Start	Intervention Group Finish	Control Group Start	Control Group Finish
≤23	46.3%	39%	45%	37.5%
>23	53.7%	61%	55%	62.5%

Qualitative Results

Using Pattern Coding, three important general themes were identified: the importance of mutual support (compañerismo), the positive changes experienced, and the program's rigid structure.

Group Participation and Compañerismo

The most frequently discussed theme was the importance of the mutual support and friendship of group members. Group members actively participated, calling those who were late or absent. Participants experienced universality early, and quickly formed cohesive groups. They exceeded the expectations set forth in the program manual.

Participants brought movies for an additional activity. The Spanish-Argentine film, Elsa and Fred, (Félez, 2005) is a good fit with the concepts of cognitive behavioral therapy. This romantic comedy of love between two older adults, with its positive message, was a particular favorite. Another favorite was Cherry Blossoms (Kügler, 2008), about grief, loss, new beginnings, and accepting life's hardships. The women brought popcorn for movie days, and tamales and cakes to share with their compañeras (fellow participants).

Representative quotes illustrate the importance of their compañeras. Sofia told the author "Here we were listened to, and our compañeras encouraged us. They made observations which I hadn't considered before." María (all names have been changed) said, "The opinions of my compañeras made me see life in a different way." With the support of her compañeras, she was finally able to move her late husband's ashes out of her bedroom and place them in the church cemetery.

Rosa suffered from the stress of caring for her prostate cancer-stricken husband, and her 92-year-old mother-in-law. She worked enthusiastically in the group. She encouraged others, expressed her opinions, and "offered my friendship and understanding to my compañeras." Feeling that her problems were resolving, Rosa said, "My compañeras guided me in the options that I have to resolve my problems."

At the end of the study, Blanca organized her group to continue to meet for activities. They made plans to meet at least once a month to play cards, dance, knit, or eat together. Social networks are essential in preventing or alleviating depression in the elderly, and these women have established what will hopefully be an ongoing support network.

Positive Changes

Participants expressed positive feelings about the groups and the results of therapy. Comments in this area had three major themes: positive change and personal growth (57%), changing negative thoughts (29%), and relationships with family (14%).

Positive Change and Personal Growth

One woman said, "Now I'm not so sad, not so sentimental. I feel like doing things and I don't feel so alone. This has made it possible to value myself again." Another woman said, "I have more energy, I enjoy doing things more, I feel younger, and I don't cry so much. My commitment is to take of myself and to keep moving ahead."

An older, chronically ill woman said; "I began to pay attention to my personal appearance. I don't like to miss the sessions." Another woman commented, "Tuesdays I feel content and cheerful when I think that I'm going to attend the group session. This is a way to feel better." Another summarized her experience: "I have learned to live and to enjoy the moment."

Changing Negative Thoughts

One woman said, "Mood regulation is a continual process and I have to keep working every day on this and confront the stress of daily life." Another commented, "I have learned how to manage my loneliness and now it's not so heavy." One older woman said, "It changed my way of being, of thinking. I have felt a lot of guilt and here in therapy I learned that I was wrong; now I feel like I have been set free. I have realized that I want to live my life and not go around loaded down with guilt." Another said "I have more confidence when I think that the problems that worry me have a solution, and that it is not all negative, that there are also good things. I am working on my negative thoughts."

Relationships with Family

One participant commented, "I felt like a burden to my children, but to express it here makes me feel like this burden has diminished." Another said "I fell into the monotony of living for others and not for myself."

Rigid Structure of the Program

The principal criticism expressed by participants and nurses was the lack of time given by the manual for the expression of feelings and discussion of personal problems, and that the overall length of the program was insufficient. The theme-of-the-week structure was appreciated, but the programmed exercises left little time for emotional topics. The participants and the nurses changed the groups from one hour to one and a half hours or even two hours.

One participant commented, "People need to talk about their family, their work, and their life." Another said, "We need more time, and smaller groups." Several participants said that the

patient manual was good, but "what we really need is more time to talk and express our emotions."

GOAL SETTING AND HOMEWORK ASSIGNMENTS

The advanced age and delicate health of many participants required a change in goal setting. At the request of the participants, long-term goals were changed from five years to one year, and short-term goals were changed from six months to one month.

Much of the manual relies on short, programmed sessions and regular homework assignments. Participants seldom did their homework and copied the homework pages, including the individual "mood thermometers," from each other in the lobby before group sessions. The "mood thermometer" was not a valid tool for our participants, but it was reliable, repeating one patient's mood score several times over.

NURSES' OBSERVATIONS

The nurses' emphasized their personal and professional growth, and their satisfaction in understanding and seeing the improvement of participants.

One nurse wrote:

> Professionally and personally, I learned a lot. It costs me some effort to speak in public or participate in groups. The first day I was a little nervous, but as time went on I developed confidence and did my best. It's a great experience to lead a session. These people want to be heard, and here they found a space to express their feelings, and to share aspects of their lives that they never would have told anyone. It gave them the confidence to keep on going. It gave them the opportunity to express their feelings, their sadness as well as their joys, and to share a little of their experience from their great journey through life. I have been given the privilege of listening to them in order to guide them and so that they may overcome their depression.

Another nurse wrote:

> It's an opportunity for personal and professional growth. At the beginning I felt a little afraid, because of the responsibility of this new task, but as the days went by my fear disappeared and my confidence increased. I was pleased by the consistency and enthusiasm the participants showed, and to observe the changes in their daily lives, which helped them get past their physical and emotional problems.

One nurse wrote, "We are so pleased by the changes, not only in their physical aspect, but also in their new attitude and their change in thinking. They are more animated, more participative."

Another finished her journal by writing:

> I am thankful for the atmosphere of respect and trust that was generated, and for the effort they made and their interest in trying to understand the contents of the manual. Through their stories they have given us the sensitivity to better understand them. What I have learned not only helped me professionally, it has changed my life. My way of thinking and acting have changed, thanks to this project and the people who have shared their knowledge and experience with us. I want to give thanks to the older adults for being the inspiration for these sessions, for being present with their life stories and their experiences. They give meaning and value to our work. And, a "thank you" to them for giving me another reason to be a better person in life.

Nurse Matilde Ríos closed her journal saying, "I feel good about the effort that each one of these people made to attend therapy; and for their trust to be able to come to our work table and expose their pains, their joys, and their secrets."

DISCUSSION

Use of Group Model and Cultural Factors

A group format was chosen for this study rather than an individual, home visit model, to take into account Mexican sociocultural factors. Generally, Mexicans value close social interaction and sharing of personal information. Family members have tight bonds (or are expected to), and it is common for adult children to live at home or nearby. Children are not encouraged to move away from home. The sense of connectedness is based on an emphasis on family tradition and the maintenance of the extended family, which also includes godparents and friends. The boundaries of the nuclear family are flexible with respect to the inclusion of relatives such as grandparents, uncles, aunts, or cousins and these family relationships have a high level of cohesion and interdependence (Falicov, 1982).

Cultures with a "collective self" emphasize interrelationships, cooperation, obedience, and reliability and have groups, rather than individuals, as the basic units of social perception (Triandis, 1989). Group therapy has been recommended for Mexican and Mexican American clients since the 1970s (Normand, Iglesias, & Payn, 1974). Connectedness refers to an individual's sense of relatedness and attachment to a group. Cohesion, or connectedness, is an important therapeutic factor in group therapy.

Cohesiveness is the most universal of all the therapeutic factors in group therapy. The experience of sharing, of being accepted, and of successfully negotiating a group experience can be highly therapeutic. Cohesiveness is an important element in the experience of universality. In the group, patients hear others share similar concerns, feelings, and life experiences. The disconfirmation of the feeling of uniqueness in suffering offers considerable relief and a "welcome to the human race" experience (Yalom, 1983).

The groups rapidly attained cohesion and universality. These women understood each other's grief and loss. Social support from other clients has a direct impact on mental wellness. Having people to talk to on a daily basis had profound effects on the participants' mood. Being surrounded by individuals who share a common generational point of reference is a comfort, and emotionally, fellow clients are extremely supportive (Valadez, Lumadue, Gutierrez, & de Vries-Kell, 2006).

CONCLUSION

The nurses had a successful experience as group leaders; participants concurred. The course training was intensive, and sufficient for a highly structured cognitive behavioral group, but for a more flexible therapeutic group model, a longer and more in-depth course would provide a more solid foundation for the nurse leaders. Regular supervision from an experienced nurse therapist is necessary for an optimum therapeutic group experience.

The lack of interest from many physicians in the concerns of mental health is a serious problem. As they are the primary providers, and the first to encounter the patient, they need to provide effective treatment and referral, or abdicate their "leadership" role in favor of nursing. Studies of prevalence and risk factors have limited importance without the active participation of direct care health providers. One solution would be to increase the direct care presence and the expanded role of nursing in the clinics.

The weekly thematic structure of the cognitive behavioral therapy manual was useful, but required modification to allow for sufficient time for the expression of emotion, including grief and loss, and discussion of family issues. Participants developed cohesiveness rapidly, and remained cohesive throughout the group sessions, with several groups making plans to continue on their own. This non-pharmaceutical treatment resulted in mild to moderate improvement in the levels of depression as measured by the PHQ-9.

The final PHQ and the MMSE scores showed little significant improvement. The PHQ may not be accurate in diagnosing dysthymia in geriatric patients, and there are questions regarding reliability and validity in the Spanish version.

Falk (2006), using the GDS as the measure of depression, reported statistically significant success with nurse-led group therapy for the treatment of chronic depression with older adults. Sessions were held once a week for six months, and then once very two weeks on an ongoing basis. The nurse therapist used cognitive behavioral techniques, group therapy support processes, psychoeducational sessions, and complementary activities of music therapy, oral histories, culinary workshops, cultural events, and the arts. Yoga, Tai Chi, and meditation sessions were added for the management of chronic pain. Falk's results were limited by a very small sample size, but her use of a combination of structured activities, group therapy, and a longer time frame likely would have met the specific needs of these older Mexican women participants.

The qualitative results in our study showed definite improvement for the participants, in their comments about their improved attitude, their more positive thoughts, attending more to their personal appearance, and increasing their levels and qualities of activities. The lived experience of the participants speaks well for this nurse-led group therapy. A study of nurse-led group therapy for depressed elderly Mexicans should be made using supportive group therapy, cognitive behavioral techniques, and more group activities, rather than individual homework.

Interventions should be modified for older adults by slowing the pace at which material is presented, emphasizing a repeated review of material, and relying on multiple modes of information transmission to ensure that adequate exposure is achieved. These adaptations result in more treatment time than is needed with younger patients (Mackin & Areán, 2005). Given the comments of participants and nurses regarding the lack of time for activities and emotional topics, it is likely that participants in this study did not have adequate exposure to treatment.

Being able to converse with an individual who shared similar experience during a common period is comforting (Valadez et al., 2006). Cultural factors in Mexican women, such as compañerismo and comadrazgo (godmothers), may predispose this population to develop cohesion and share emotional content in groups. The structure and format of the therapeutic group should reflect this cultural reality.

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