Received: 24 May 2022 | Revised: 7 March 2023 | Accepted: 28 March 2023

DOI: 10.1111/ijn.13157

ORIGINAL RESEARCH

INTERNATIONAL JOURNAL of NURSING PRACTICE WILEY

A primary care psychoeducational group intervention for patients with depression and physical comorbidity: A qualitative study with a gender perspective

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Abstract

Objective: To explore the experiences and emotions of individuals with depression and physical comorbidity within the context of psychoeducational group interventions led by primary care nurses in Catalunya (Spain).

Method: A psychoeducational group intervention was conducted in the first semester of 2019 with 13 primary care teams (rural/urban) and 95 participants with depression and physical comorbidity. The qualitative research and phenomenological perspective were based on 13 field diaries and 7 semi-structured interviews carried out with the observer nurses. The interviews were recorded and transcribed. Codes were identified by segmenting the text into citations/verbatim accounts and emerging categories/subcategories by regrouping the codes. The results were triangulated among the researchers to identify and compare similarities and differences.

Results: Four major themes were found: (a) gender differences; (b) coping strategies and changes observed during the intervention; (c) functions of the group as a therapeutic element; and (d) the nurses' perceptions of the group experience. Gender differences were identified in relation to experiences and emotions.

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Funding information
This study received a research grant from XB Projects in Primary Care in Barcelona of the Institut Català de la Salut. In addition, it has obtained a research award from the Catalan Association of Mental Health Nursing (ASCISAM).

Conclusions: As some patients acquired skills/behaviours during the intervention that helped them initiate changes and the nurses were satisfied with the intervention, it is important to include this information when planning effective interventions for patients with this profile.

KEYWORDS
chronic physical illness, depression, gender, nurses, primary health care, psychoeducation, qualitative research

Summary statement

What is already known about this topic?

- There are gender differences in the prevalence of depression.

What this paper adds?

- This study describes the experiences and emotions of women with depression and physical comorbidity within the context of psychoeducational group intervention.

The implications of this paper:

- The study provides information about the experiences and emotions of women with depression. It will be important to include this qualitative information when planning effective interventions directed at patients with this profile.

1 | INTRODUCTION

Depression affects more than 300 million individuals and is a frequent cause of morbidity, disability and loss of productivity (Knapp et al., 2007; Organización Mundial de La Salud, 2013). Indeed, the World Health Organization estimates that by 2030 it will represent a major worldwide health problem (Organización Mundial de La Salud, 2008). Currently, depression is one of the principal reasons for the loss of quality-adjusted life years (Fernández et al., 2010). Whilst it is present in 20% of individuals suffering from a chronic physical condition, its correct treatment has been reported to increase life expectancy and quality (Haddad, 2009). In primary care (PC), it is common to find depression in conjunction with physical comorbidity, and chronic pathologies may interfere with its diagnosis (Menear et al., 2015). It is, therefore, necessary to manage this condition with proven non-pharmacologic treatment, for instance, psychoeducational group interventions (Casañas et al., 2012, 2014; Raya Tena et al., 2015; Sandberg & Roaldset, 2019). Studies that qualitatively evaluate nursing interventions tend to provide data concerning the barriers and facilitators of their implementation, the satisfaction of the professional health workers and patients, and improvements obtained (Ashcroft et al., 2021; Clignet et al., 2017; Graves et al., 2016; Knowles et al., 2015; Rørtveit et al., 2020). In our case, we have examined the experiences and emotions of individuals who present both depression and physical comorbidity within the context of a psychoeducational group intervention. This has been achieved through the narratives of the observer nurses and their field diaries. Taking into account that the percentage of depression in women is higher than in men and that an improvement in depressive symptomology is not necessarily accompanied by a better quality of life (Graves et al., 2016), it is crucial that other aspects that may play a role be examined. A considerable number of authors (Bacigalupe et al., 2020; Cabezas-Rodríguez et al., 2020; Kuehner, 2017; Montesó-curto & Aguilar-Martín, 2014) have questioned the biological-genetic hypothesis regarding the increased vulnerability of women to present worse mental health. There are qualitative studies in which patients attribute the main cause of their depression to the negative events and circumstances of their lives (Pols et al., 2018). It is thus necessary to investigate which experiences or life conditions can explain such inequalities from a gender perspective.

The qualitative research presented here is nested within the PSICODEP (psychoeducation, comorbidity, and depression) study, a clinical trial that obtained favourable results for depression remission and therapeutic response in individuals who presented both this condition and physical comorbidity. The participants received a psychoeducational group intervention given by previously trained PC nurses (Casañas et al., 2019; Raya-Tena et al., 2021). Analysis of the data gathered from the nurses' diaries during the 12 intervention sessions, and their narratives regarding the individuals who attended them, can provide valuable information regarding dimensions not quantitatively researched. Such aspects may be crucial when planning interventions directed at patients with this profile.

1.1 | Objectives

Objectives were to investigate the experiences and emotions of individuals presenting depression and physical comorbidity with observer nurses within the context of a psychoeducational group intervention carried out by PC teams (PCT) in Catalunya (Spain). Specifically, objectives sought:

- To identify the coping strategies of the individuals receiving the intervention and the changes and behaviours adopted during its duration.
- To establish the needs perceived by the observer nurses who carried out the psychoeducational group intervention.

2 | METHODS

2.1 | Research design

A qualitative study with a phenomenological focus and deductive approximation was performed (Elo & Kyngäs, 2008). The participants' experiences were interpreted based on their life paths, their relationship with depression and the physical comorbidities they presented, and the influences that marked their lives and how they affected their decisions (Gaos, 2016; Neubauer et al., 2019).

2.2 | Context—The PSICODEP study

This study forms part of a wider, multi-centre study in which 27 PCT from around Catalunya (Spain) took part (Raya-Tena et al., 2021). The PSICODEP study evaluated the efficacy of a psychoeducational group intervention conducted by PC nurses for individuals with depression and physical comorbidity. The intervention was made up of 12 weekly 90-minute sessions given by two nurses (one leading the session and the other observing). The session schedules are detailed in the protocol (Psicodep, 2018). The project fieldwork was finished in the first semester of 2019.

2.3 | Participants

The sample units were composed of psychoeducational groups from the territories participating in the PSICODEP project. Thirteen field diaries were obtained during the intervention from the 13 rural/urban PCT. A total of 95 patients (Mean age 68.4 years, SD: 8.8) participated, and 83% were women. The sole inclusion criterion was that the PCT provided the researchers with the diaries from all the group intervention sessions. The study also included seven semi-structured questionnaires for the nurses who had taken part as observers during the intervention. The nurses had a mean age of 47.8 years (range: 43–58) and a mean of 19 years of experience in PC. They were all women, and only one had no previous experience in carrying out group interventions (Table 1).

2.4 | Data collection

This was performed in two steps. First, information recorded by the observer nurse in the field diary from the 12 sessions of the psychoeducational group intervention of the PSICODEP was gathered (Psicodep, 2018). During the sessions, the observer nurses did not actively participate, and they recorded in the diaries all the contextual holistic observations: the placing of the participants in the room and their participation and interaction. The nurses also registered their perception of the participants' states of mind by observing their non-verbal language and any changes, achieved goals and emotions/experiences that the participants described. The participants were aware that they were being observed and the reasons for this, as they had been previously informed about the intervention at the commencement of the sessions.

The second step consisted of the principal investigator carrying out semi-structured interviews with the observer nurses. The interview was based on the analysis of the field diaries (Table 2). The nurses had been previously contacted by email to explain the reason for the interview and its objectives. All the interviews were recorded and transcribed during the first semester of 2021 with a licensed corporative digital platform due to the COVID-19 pandemic, with the exception of one nurse who requested a face-to-face interview.

2.5 | Ethical considerations

The study was approved by the Research Ethics Committee of the Institut d'Investigació en Atenció Primària Idiap Jordi Gol (code 21/056-P). A fact sheet and informed consent were sent to the

TABLE 1 Profile of participant observer nurses.

	Characteristics of the nurses interviewed						
Participant	Age	Gender	Years in primary care	Previous experience in groups	Scope	Adjusted morbidity groups	Health centre area
P1	43	Woman	18	Yes (diabetes)	Urban	1	Central Catalunya
P2	46	Woman	18	Yes (smoking cessation)	Urban	2	South metropolitan
P3	48	Woman	15	Yes (psychoeducational)	Urban	1	Barcelona city
P4	48	Woman	19	No	Urban	2	Central Catalunya
P5	56	Woman	28	Yes (psychoeducational)	Urban	1	Barcelona city
P6	47	Woman	20	Yes (expert patient)	Rural	No	Central Catalunya
P7	47	Woman	15	Yes (psychoeducational)	Rural	No	Central Catalunya

participants. Those returned by email with an appropriately encrypted signature were also included in the study. Participants were informed that taking part was voluntary, confidentiality was guaranteed, and they could leave the intervention at any given moment.

2.6 | Data analysis

Prior to analysis, the texts obtained with the tools employed in the data collection were prepared. With respect to the field diaries, the notes and texts that the nurses recorded during the 12 psychoeducational group intervention sessions were examined. The interviews were transcribed verbatim.

Analysis of thematic content was performed in two stages. In the first, a deductive analysis was carried out of the field diaries and any entries which appeared were codified. All the researchers took part in this analysis in order to select those aspects to be assessed more in-depth in the interview in case they did not appear spontaneously in the narrative.

In the second stage, the interviews were analysed for qualitative content according to the methods of Graneheim et al. (2017); Graneheim and Lundman (2004). Repeated readings of the transcriptions were performed in order to become familiar with the content. This was carried out, in a similar manner, with the diaries, by identifying segmented codes in the texts in citations and verbatim accounts and the emerging categories and subcategories by regrouping the same thematic codes. Categories were compared, and significant threads that appeared were identified (Table 3).

In order to ensure data quality, the interview transcriptions were divided among the researchers so as to be analysed in pairs with a third researcher available if required.

On completion of the analysis, results were pooled with all the research teams in order to compare similarities and differences. Finally, results were triangulated with other publications and broader theoretical frameworks. Data transferability was managed with the use of direct citations in the presentation of the results. The research team strictly followed the rigorous criteria described by Lincoln and Guba (1985) as they are the best known in our context and have been previously employed by other authors (Calderon, 2009).

TABLE 2 Question guide.

Initial question asked in the interview: Could you explain to me in detail a story that you remember for some reason, of all the individuals who participated in the group?
Questions to go into depth: - What were the main ailments present in the group? - What emotions did the group participants mainly express? - What do you think is the reason most participants were women? - What kind of changes do you think took place in the participants throughout the sessions? - What has the experience of the groups meant for you, as a nurse? - How did the group behave? What do you think it offers the participants? - Would you like to add something else to the interview?

3 | RESULTS

Following data analysis, four main themes were identified: (a) gender differences; (b) coping strategies and changes observed during the group intervention; (c) the functions of the group as a therapeutic element in itself; and (d) the nurses' perceptions of the group experience.

TABLE 3 Content analysis example.

Theme	Differences in gender		
Unit of meaning (quote or verbatim)	Code	Subcategory	Category
'I don't know, I'm still wrong and maybe men are people … it's not that they're more assertive … but as a condition they don't have to take care … they don't have to do many things and maybe here, me, all my people come with prejudices … but they may not reach these extremes of anxiety or these extremes that we women reach because socially some things are expected of us and others are expected of men' (P3)	Men do not have to take care of themselves They do not reach the extremes of anxiety that women reach Some things are expected socially and others are expected of men	Social role man/woman	Gender
'so far women have been caregivers and when they stop caring and leave the couple they don't really know how to take care of themselves and this is when depression starts right? (P7)	Women have been caregivers They do not know how to take care of themselves	Experiences (life)	
'He was a man who never, because that, did not show part of his feelings. He was very in passing, very superficial in everything' (P2)	Man who never showed his feelings	Expression of emotions	

3.1 | Differences related to gender

From the participants' descriptions of their experiences, it was possible to identify gender as a differentiating feature. Whilst the female participants explained situations of care overload and lack of time to enjoy their autonomous role as women, their male counterparts frequently described the loss of role due to losing their employment and poorly expressed feelings of bereavement. Gender differences were apparent in these situations; whilst with the group, women could weep easily and freely explain intimate circumstances, the men maintained their reserve and participated much less.

> 'Women, ahh … housewives … many have never had an autonomous role as a woman … following the housewife's pattern, as a servant, with limited education (…) all or most of them came [to Catalunya] as immigrants … arriving at the time of their parents.' (P6)

> 'With men we have the issue of losing their jobs or their roles (…) or the man was the breadwinner and when he lost that position, and the wife had to do it, he felt terrible! And that's what we have and creates the problem (…) It's hard for men and they feel ashamed.' (P7)

The main emotions that women displayed in the group were anhedonia and sadness; in contrast, men tended to present anger and rage. Life events, such as marrying young, taking care of a sick relative, having to leave one's hometown or beginning work at a very young age, also appeared in the observer nurses' entries.

> '(…) there are people who at eight, nine, ten years were already working … I've been working for years … they used to say their childhood had been stolen. At those ages they were already looking after other people's children and the parents …' (P7)

3.2 | Coping strategies and changes observed during the group intervention

During the first sessions, coping strategies were related to avoidance behaviours and lack of assertiveness. The participants described difficulties in setting limits and saying 'no'. Long-term consequences of a patriarchal society reappeared in which women were not used to having an opinion or making decisions, and empowerment in this regard was crucial.

> '(…) we have siblings but when they are brothers they don't look after their parents, their sisters have to do it, and I think that this lack of assertiveness, of communication with other relatives or other people definitely leads to being trapped … not knowing how to say "no" leads to a life (…) a life of being a carer and someone who looks after others but who feels alone.' (P3)

> 'It's that …Men spend little time on women. Men need to change a bit. That's to say, maybe it's necessary [for women] to be a bit more egoist and learn to say "no". Men need to know and realize that they can also do things for themselves.' (P1)

Our findings with respect to women also show a lack of skills in resolving problems, not knowing how to manage them, and presenting low self-esteem, which hinders decision-making from motivating changes. During the intervention, and increasingly as time passed, they became able to express their distress and share their problems which they felt were often common to the group. Thanks to their participation in the group, they were able to dedicate time to themselves, something they had not done before, and incorporate knowledge acquired during the sessions.

> '(…) perhaps everything seemed very bleak, in a way of speaking, but they started to say well, look, let's make a deal (…) I think men have to improve, first for that of identifying themselves, they have all experienced the same (…) I saw them … I don't know how to say … freer.' (P1)

> '(…) that nobody has listened to the men, there was no opportunity that someone would listen to you, to show what they were worried about. There was no time, we had to cook, didn't we? At home (…) we played music and they said play music at home because they said leaving home with music made them feel more relaxed' (P6)

3.3 | The functions of the group as a therapeutic element in itself

The group acted as a socializer and emotional catalyst. It represented a safe environment in which the expression of emotions was helped by the fact that confidentiality was a basic condition to be respected by all the participants.

> '(…) what happens in the group stays there, and that is how it should be. I think he opened up because he could see he could open up, that there was trust with us and the people who were there. Knowing that you're not going to be on trial. That there're going to be no judgements of value …Nobody is going to criticize or anything like that.' (P2)

'(…) I feel [women] are very alone sometimes and the fact that they can get together and end up forming a group like a second family, in a safe environment where you know you can talk about things and you know that it will stay there … it's a place that's not home, it's a marvelous environment, and a very protected space.' (P7)

Sharing experiences and common problems generated empathy and cohesion among the group members. Solidarity, mutual support, trust and the links formed during the intervention represented strong points that helped to move forward. Distinct perspectives on the same problem encouraged the participants to explore different ways to follow the advice given by the others.

'The women see it as a place to find themselves, to talk, to solve problems and specially to have company (…) together they form a tightly-knit group. They made a group and gave a mobile phone (…) and they said: if that happened to me I'd do it differently …(…) as if you meet people the same as you and say … well, see? I'm not the only one.' (P1)

'Bonds were made, especially with the group and they said now what? Now that we do this each week? We speak and laugh here and explain our problems, and now what are we going to do?' (P4)

3.4 | The nurses' perceptions of the group experience

The observer nurses perceived the group intervention as a useful tool to be developed autonomously within their professional role with prior training. They felt personal satisfaction and mutual learning with the group.

'(…) I believe I learnt from them. It was a nice experience because we shared many sentiments and experiences, it was enriching and as a nurse I think it would be good to implement it.' (P4)

'Helping people to express everything they have experienced and relate to it a little, bring it out (…) we have to encourage them to believe in themselves in order to be able to decide. To know what they have to do. That they learn to cope. That they don't depend on what you have to say to them … that they learn for themselves.' (P6)

The main difficulties identified were: having to closely follow the intervention protocol, not previously knowing the group participants as the selection was blinded, and, as observers, not being able to actively participate.

'It's that the selection of the group and the distribution in groups was done by the professionals, and we didn't really know any of the participants (…) there was quite a difference among the patients, which is good, isn't it?' (P2)

'(…) having to be in the study and follow it "to the letter", all the structure was a bit complicated.' (P3)

'Watching from outside is good because you see a perspective from outside and perhaps you see something a bit different (…) The problem is that you can't intervene and that's hard, I found it difficult not to say anything.' (P1)

Proposed areas of improvement included holding the psychoeducational group intervention sessions out of the PC centres so that other population groups could attend, incorporating administrative staff to carry out bureaucratic procedures, and working more closely with referral psychologists to resolve doubts and give support to the intervention.

4 | DISCUSSION

Our study findings related to the experiences and emotions of individuals who present depression and physical comorbidity within the context of a psychoeducational group intervention are of interest. The results provide valuable information concerning patient coping strategies and the therapeutic functions of the group. The research enhances the health professionals' vision of the patients' experiences and their own participation in the intervention.

Gender differences were apparent in the female participants' discourse. They were communicated as a perception of care overload and in the expression of emotions, gender roles and life events. Previous studies have reported differences in depression in men and women (Girgus et al., 2017; Haroz et al., 2017). Certain behaviours, generally associated with feminine characteristics, such as weeping, emotional lability and the need to explain so as to obtain external validity, can all favour the diagnosis of depression in women. In contrast, aggressive and individualistic behaviours, and poor emotional expressivity are considered more typical of men (Benedicto, 2018). According to Carmen Valls (2020), the patriarchal definition of femininity and masculinity places a burden upon the bodies of both men and women. The female body is destined for the care of others and becomes ill due to the overload that it has been socially assigned. In contrast, the male one is dominated by self-control which it cannot escape and which does not permit sentiments to be expressed as men are expected to demonstrate strength.

Over the years, feminist theory has supported the notion that attributing domestic tasks and caregiving to women is one of the greatest gender inequalities (López & Padilla, 2017). Diagnosis of depression and consumption of antidepressants are more frequent in

women than in men, and such social conditioning could be one of the causes. A recent systematic review studied beliefs about depression in patients with chronic pathologies. It found that most participants attributed their depressive state to negative life events and stress rather than the biomedical model (Alderson et al., 2012).

With respect to coping strategies and the changes observed during the group intervention, the participants went from presenting avoidance behaviours and difficulties to set limits, which, according to Lázarus and Folkman (1986), may attenuate the perception of threat but not lead to solutions, to improving confrontation by putting into practice skills acquired during the sessions. Carrying out techniques such as problem-solving, cognitive restructuring and improving self-care represent mechanisms that can help an individual overcome crisis situations. In this sense, interventions in which PC nurses employed psychological skills in patients with diabetes mellitus led to patient empowerment for the self-control of their chronic pathology (Graves et al., 2016). Other studies described that group relaxation and awareness activities had a potentiating effect on reducing discomfort (Ortega Maldonado & Salanova Soria, 2016).

In contrast to individual interventions, our group format provided additional therapeutic advantages. For instance, social support, the feeling of belonging to a group and problems common to the participants (Guimón, 2003). Other studies have placed particular emphasis on the relationship between trust and support that the nurse can provide and which is a key element in accessibility to mental health services and patient satisfaction (Ashcroft et al., 2021; Barley et al., 2012). This issue also appeared in the nurses' narratives, trust and the relationships established with the group participants was a crucial aspect.

The interviewed nurses felt capable of carrying out this type of intervention and were satisfied with its development and results. Prior training is, however, fundamental for the early detection and efficient management of individuals with depression and physical comorbidity (Albougami et al., 2021). A number of studies have identified the PC nurse as being the most suitable health professional for the diagnosis, follow-up, and support of these individuals, irrespective of providing scaled attention models or conducting psychoeducational group interventions (Aragonès et al., 2012; Li et al., 2019; Svenningsson et al., 2018). In concordance with other authors, the nurses did, nevertheless, mention certain difficulties, such as the lack of flexibility in the implementation of the study design (Richter-Sundberg et al., 2015). The PC health professionals thought coordination with medical specialists (MS) and their supervision was necessary so as to reduce the emotional burden that such interventions can represent (Roberge et al., 2016; Webster et al., 2016). Some studies have reported that the relationship between PC professionals and MS is beneficial when it is one of collaboration and not substitution when attending to the emotional distress of individuals with physical comorbidities (Knowles et al., 2015; Pons et al., 2020; Roberge et al., 2016).

It was surprising that the nurses' narratives did not mention the patients' chronic pathologies. Such a finding indicates what really concerns the individual and is considered most important. All the interviewed nurses fulfilled the criteria of expert nurses according to Patricia Benner's (1982) theory. This states that health professionals intuitively understand situations and focus on the core of the problems. According to Benner, expert nurses remember valuable information which they incorporate into their knowledge and apply to patient care.

4.1 | Limitations

The main limitation of the study is that we did not interview the patients participating in the group intervention. Moreover, by including different profiles, other findings may have been obtained. Finally, gathering data through a third party can lead to an information bias.

5 | CONCLUSIONS

The present study demonstrated gender differences regarding the experiences and emotions of the participants in this psychoeducational group intervention conducted by PC nurses. With respect to coping strategies, changes in some patients were observed during the intervention. Participants acquired more effective skills and behaviours, which helped diminish their discomfort.

The nurses felt satisfied with the psychoeducational group intervention. They considered that the MS teams are necessary to resolve any doubts that may arise during the intervention and provide support.

The study provided information on the experiences and emotions of women with depression. It will be important to include this qualitative information when planning effective interventions directed at patients with this profile.

AUTHORSHIP STATEMENT

Conceptualization, methodology and formal analysis: AR-T, JM-R, MB-P, GS-V and ABO. *Investigation*: AR-T, JM-R, MB-P, GS-V, ABO, MDS-G, SR-S, NL-T, and MFJH. *Resources and data curation*: AR-T and JM-R. *Writing—original draft preparation*: AR-T, JM-R, MB-P, GS-B and ABO. *Writing—review and editing*: AR-T, JM-R, MB-P and GS-V. *Visualization*: AR-T, JM-R, MB-P, GS-V, ABO, MDS-G, SR-S, NL-T, and MFJH. *Supervision*: MFJH. *Project administration*: AR-T. *Funding acquisition*: AR-T, JM-R and MDS-G. All authors have read and agreed to the published version of the manuscript.

ACKNOWLEDGEMENTS

We would like to express our gratitude to Mª Isabel Fernández San Martín, PhD in Preventive Medicine and Public Health, for her public health vision, and Mª José Fernández Sanmamed, an expert in Qualitative Research Methodology and Medical Specialist in Family and Community Medicine, for her critical review of the content.

CONFLICT OF INTEREST STATEMENT

All authors declare that they have no competing interests.

ETHICAL APPROVAL

The study was approved by the Research Ethics Committee of the Institut d'Investigació en Atenció Primària Idiap Jordi Gol (code 21/056-P). A fact sheet and informed consent were sent to the participants. Those returned by email with an appropriately encrypted signature were also included in the study. Participants were informed that taking part was voluntary, anonymity was guaranteed, and they could leave the intervention at any given moment.

DATA AVAILABILITY STATEMENT

I declare to make the investigation data available to the editor if necessary.

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How to cite this article: Raya-Tena, A., Martín-Royo, J., Bellido-Pérez, M., Sauch Valmaña, G., Berenguera Ossó, A., Soria-García, M. D., Ruíz-Serrano, S., Lacasta-Tintorer, N., & Jiménez Herrera, M. F. (2023). A primary care psychoeducational group intervention for patients with depression and physical comorbidity: A qualitative study with a gender perspective. *International Journal of Nursing Practice*, e13157. https://doi.org/10.1111/ijn.13157