



Articles

Adopting New Identities When a Partner has Depression: An Interpretative Phenomenological Analysis

Fiona E. Glenn^{*a}, Kenneth M. McFadyen^b, Zounish Rafique^c

[a] Hillingdon Drug and Alcohol Service, Uxbridge, United Kingdom. [b] Staffordshire and Keele Universities Doctorate in Clinical Psychology, Stoke-on-Trent, United Kingdom. [c] South Staffordshire and Shropshire NHS Foundation Trust, Stafford, United Kingdom.

Abstract

In Western cultures, the mental distress of a partner has been associated with significant impacts for the individual, with feelings of stress and burnout associated with the caregiving role (e.g. Stjernswärd & Östman, 2008). Research has begun to explore the lived experience of being in a couple relationship with an individual experiencing depression, however further research is needed, particularly with regard to the roles and identities they adopt in response to the depression. Five adults participated in the research; all were in heterosexual relationships with a partner who had experienced depression during the course of their relationship. Participants were recruited through support services and from general community settings. Interviews were conducted using a semi-structured interview format, with the use of an interview schedule. Analysis was conducted using Interpretive Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) to identify the meaning made from this experience. Three superordinate themes emerged from the data, conceptualizing depression, re-evaluating the relationship, and negotiating new identities. This research demonstrated the importance of support for those in a relationship with someone experiencing depression, particularly in the complex task of negotiating changing roles and in moderating the emotional impact upon themselves. There is a need for greater awareness of the impact of these experiences on their partners.

Keywords: depression, mental health, roles, carers, Interpretative Phenomenological Analysis

Interpersona, 2013, Vol. 7(2), 282–298, doi:10.5964/ijpr.v7i2.143

Received: 2013-08-30. Accepted: 2013-11-17. Published (VoR): 2013-12-20.

*Corresponding author at: Hillingdon Drug and Alcohol Service, 64 High Street, Uxbridge, Middlesex, UB8 1JP. E-mail: f.glenn@nhs.net



This is an open access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Introduction

Depression in Relationships

Depression has been rated as one of the most common mental health conditions, as assessed by the [World Health Organization \(2012\)](#). The influence of social and relationship factors have been explored using a number of research questions and methodologies, and in Western cultures results indicate that those with a family member or spouse who have been experiencing depression express feelings of burden, stress, and mental distress themselves (see [Rehman, Gollan, & Mortimer, 2008](#) for a review). In addition, within adult couple relationships, research has demonstrated that while depression may have significant impacts for the relationship, the ending of a relationship is also associated with increased signs of depression (see [Coleman & Glenn, 2009](#) for a review). Thus depression impacts on relationships between adults in a bidirectional manner and is influenced by a variety of factors, making this difficult to describe and understand.

Attempts to understand this multifactorial relationship have been primarily understood through quantitative research, leading to significant insights within discrete areas. Greater understanding has been developed of the connection between relationship functioning and impact of life stressors on depression (Trombello, Schoebi, & Bradbury, 2011) and the impact of depression on communication processes (Harper & Sandberg, 2009). However, across mental health professions there is agreement that individuals sharing their experiences can contribute a meaningful and helpful understanding of the situation (Cutcliffe & Goward, 2000; Roberts, 2000; Wertz, 2005). This may also contribute to greater insights about how they perceive and respond to that individual's depression. Within this context of increased understanding there is a potential to provide improved support, which might result in professionals being better able to meet the needs of the individuals with depression, and their families.

Qualitative research methodologies have highlighted the processes occurring in the recognition of depression, the emotional impact of the depression, the process of seeking support from professionals, changes to the dynamics of relationships, as well the positive impacts of the depression on personal growth (e.g. Hansen & Buus, 2013; Harris, Pistrang, & Barker, 2006; Hedman Ahlström, Skärsäter, & Danielson, 2009). To date research has not yet explored whether partners of those experiencing depression develop a conceptualization of the depression, and whether this impacts on the meaning they draw from the depression and the impact it has on the couple relationship. The conceptualization is unlikely to draw upon psychological knowledge and theory; nonetheless the development of a "*hypothesis about the causes, precipitants, and maintaining influences*" (Eells, 2007, p. 4) of the depression may confer benefits through allowing a partner to understand the depression, and thus respond in ways displaying greater empathy, and potentially reduce feelings of frustration directed at their partner.

The experience of offering support to a loved one with depression has been explored by others. Those in couple relationships with depression frequently described their partner as being their most important source of support; however their partners discussed many uncertainties they faced (Harris et al., 2006). Research participants have described feeling unsure how to help or what to say, and often felt that they had made things worse (Harris et al., 2006; Stjernswärd & Östman, 2008). Partners, siblings and parents caring for a person experiencing depression have identified feelings of helplessness regarding their own ineffectiveness in helping with the depression (Hight, Thompson, & McNair, 2005). Participants described strongly wishing to be able to help the person themselves, and feeling sad that they were unable to. They identified an on-going fear of recurrence and in some cases grief, where they felt the person would not achieve their potential.

Considering the impact of gender specifically, women in relationships with male partners experiencing depression felt that in some cases their partners had adopted a child role, and felt a desire to exhibit care. At the same time, these women described resisting an emotional caregiver role, through feeling challenged and ineffective at resolving the depression (Bottorff, Oliffe, Kelly, Johnson, & Carey, 2013).

In research by Harris et al. (2006), participants identified working together towards things improving, describing this as a 'team effort'. Where this worked, underlying this was an agreement of what constituted effective support, trust and acceptance. In some cases where there was disagreement between couples it seemed that attempts to help had actually contributed to a slowing down of the recovery process. In addition, practical solutions seemed to participants to be appropriate at some times, particularly as depression improved, and less helpful when at its most severe.

Despite significant developments in understanding these couple relationships and the experience of supporting a partner with depression, previous papers are limited in the extent to which they explore partner's understandings

of depression, and the adoption of new roles and identities. Further, to date, the meaning participants draw from these identities has not been explored.

Caring and Mental Health

National surveys have estimated that within the United Kingdom, one in four adults meet criteria for the diagnosis of a mental health condition (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). When a partner experiences mental health difficulties, people may cope using a range of responses. One of those considered in research to date is the adoption of roles. Roles provide definitions of expected behavior within a socially constructed setting, with the individuals internalizing these roles over time resulting in additions to their self-concept and new identities. As a consequence, some partners, following the emergence of depression may internalize these roles, as part of their identity (Stryker, 1980).

In addition to the socially constructed views of carer, there are legal definitions, dependent upon the completion of caring related tasks:

“A carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems” (Department of Health, 2008).

However, the extent to which an individual completing caring related tasks identifies with the term ‘carer’ may vary depending upon the nature of the condition of the person they are supporting, personal and interpersonal factors and across a variety of situations. Henderson (2001) highlights some of the dilemmas of partners adopting caring roles following their loved one’s diagnosis of ‘manic depression’. She argues that the role of ‘carer’ as a legally defined term has not been adequately considered with how this integrates with the relationship of the couple. Partners may have potentially different needs, as well as shared concerns, and experiences, making the provision of care within a romantic relationship complex. Further, the status of ‘carer’ as a social construction defined through social relationships and additionally as a legal concept results in added complexity. The intersection of relational, socially constructed, and legally defined terms may not always support the adoption of a clear identity. Individuals in these positions may therefore experience role ambiguity and tensions from the need to manage and negotiate these boundaries.

Across a wide range of research methodologies, in a number of Western cultures the adoption of caring roles for a partner has been associated with significant mental health impacts (e.g. Benazon & Coyne, 2000; Jeglic et al., 2005; Stjernswärd & Östman, 2008). Those caring for a partner experiencing depression have been shown to have more signs of depression, and these signs were explained by levels of caregiving stress and burden (Jeglic et al., 2005). Couple relationships where one partner is experiencing depression may involve the adoption of new roles, which may be seen from a number of perspectives. Partners may describe the change to, loss or gaining of new identities in these relationships, their perception of how this occurred, and their feelings towards this.

Research investigating the impact of depression on those providing care to a loved one with depression has assumed that relatives and partners identify with the term ‘carer’ (Hight, Thompson, & McNair, 2005). No research to date has sought to understand how participants understand the adoption of this role, or other ways in which participants may frame their provision of care. In research exploring the impact of depression on relatives, participants described increased adoption of a caregiving role where depression was more severe (Stjernswärd & Östman, 2008). For these relatives, caregiving was identified as including vigilance toward the person with depres-

sion, and was associated with feelings of burnout, stress, and exhaustion. Caring for a relative was associated with not living their own life, and instead to be 'living in the shadow of depression'. This role of caring was conflated with understandings of parent-child roles. Participants also described a reluctance to reinforce the caring role and described feeling unwilling to be over-protective.

Aims

The central research question is, what is it like to be in a couple relationship with a partner who has experienced depression, and what meaning do people develop from this situation?

This study used qualitative interviews analyzed using an Interpretative Phenomenological Approach (IPA), to develop rich understanding of the perspectives of participants, with an interpretive account, and attention paid to the complexity and context of their experiences (Smith, Flowers, & Larkin, 2009; Smith & Osborne, 2003). IPA is a research methodology informed by phenomenology, the study of human experience; and hermeneutics - the study of text interpretation. This combination allows an understanding of both how a participant perceives their experience at a conscious level, as well as seeking to develop an understanding of their deeper experience. This understanding of one individual's experience is further developed through analysis across cases while maintaining grounded in the individual's understanding, developing interpretations from the content of the person's speech, the contradictions, and complexity of the way in which they express this, and in the light of existing psychological understanding (Smith et al., 2009).

Epistemological Position

This research accepts one form of a contextualist approach. Contextual approaches consider that the data and analysis cannot be separated from the context in which they are generated (Larkin, Watts, & Clifton, 2006). This context may include the social, cultural and theoretical settings in which the data is gathered, and requires the researcher to be reflective of their own contribution to the research. This research has been conducted in a Western culture, in England, and by an English researcher, and there will be a number of impacts as a result. Mental health difficulties have been linked to social inequalities, including deprivation and poverty (Murali & Oyebode, 2004), however, participants in the research and their partners have access to support services through the National Health Service, and other voluntary sector services, factors specific to the location in which this research has been conducted.

Specifically, a critical realist social constructionist approach is adopted, in which an external reality is shaped by multiple causal powers, and society, language and culture may be both these agents of influence, as well as impacted upon through this process (Elder-Vass, 2012). This approach considers the need for both considering the detail of qualitative data, though additionally adding a layer of interpretation, which allows the subject area to be fully researched.

Method

The study received ethical approval from Staffordshire University. The research follows guidelines published by the British Psychological Society (2011).

Sampling and Recruitment

Participants were recruited from across the Staffordshire and Shropshire regions of England. A variety of methods were used in recruitment. These included the distribution of posters across public libraries, the involvement of three third sector organizations in distributing posters and information letters about the study to their members. The inclusion criteria were that participants would be aged over 18 years, that during the course of their relationship their partner had experienced depression, and sought forms of help for this (including for example accessing the GP, antidepressant medication, or support services). A clinical diagnosis of depression was not an inclusion criterion. A total of ten people indicated their interest in participating in the research project, three of whom did not meet inclusion criteria (as their couple relationship had ended). One participant chose not to participate in the research following discussion with her partner, and a further person who had indicated their interest could not be contacted following information about the study being posted to her. Of the five participants who did participate in the research project, two were recruited through local organizations, and a further three were recruited through posters displayed in libraries in the region. Three of the participants were male and two were female, with information presented in Table 1.

Table 1

Ages, Professional Backgrounds, Relationship Profile, and Parenting Status of Participants.

Participant number	Identification name	Age	Job role	Relationship status and duration of relationship	Parenting status
1	Mike	62	Retired	Married, 7 years	Stepfather
2	Sandra	59	Health professional	Married, 30 years	Biological parent
3	Gillian	53	Domestic Housekeeper	Married, 21 years	Biological parent
4	Steve	59	Business and Administration professional	Married, 30 years	Biological parent
5	James	47	Science and Engineering professional	Married, 25 years	Biological parent

Note. All names presented are pseudonyms to protect identity.

All participants were White British and were in long-term marriages (range 7-30 years). Partners of participants had accessed a variety of interventions for their depression from mental health services, including from the GP, Community Mental Health Teams, Psychiatrists, a local rapid response and assessment team and voluntary sector organizations. Only one partner had not accessed support services, having previously self-administered 'antidepressant' medication as a General Practitioner. One participant had sought help for depression in the period of the relationship, from a Primary Care health service. Participants had received from organizations including local carers' services and voluntary sector organizations.

Participants contacted the researcher by telephone to indicate their interest in participating in the research project. At this point, the research project was discussed and initial questions answered, and then it was ensured that participants met inclusion criteria. Following this, an Information Sheet was sent to participants by post and upon confirmation of consent to participate, interview arrangements were confirmed. Participants were informed that confidentiality procedures would be followed at all times, with identifying information removed to preserve anonymity. Participants read and signed their informed consent prior to interview conduction.

Tools / Measures

Interviews were conducted following a semi-structured interview format. An interview schedule was developed prior to interviews to ensure that topics related to the research question were explored. Previous research was not used to guide the topic guide, as a result of the need to 'bracket off' prior assumptions (Smith, Flowers, & Larkin, 2009, p. 68). Instead questions were developed alongside research supervisors in order to ensure that they were broad and open, to allow the participant's personal world to be shared. Questions included 'Can you tell me how you first became aware of the depression?', and 'Can you describe any impacts the depression has had on your relationship?' During interviews a flexible approach was used in order to ensure that unexpected and relevant topics were explored.

Subsequent to the research interview, participants completed a brief demographic questionnaire. Given the highly emotive potential content of the interviews, participants were given time to discuss the nature of the interview with the researcher, and debriefing information was provided at the end of the interview procedure. This gave the information of the Research supervisors, and of support services they may wish to contact.

Data Collection

All interviews were conducted by the researcher face-to-face and on an individual basis in participants' homes, or in community settings. Interviews were digitally recorded and additional reflective notes on the interview process made by the researcher to support the later analysis. Following this, interviews were transcribed in a strict verbatim style by the researcher, noting all utterances, hesitations, and pauses. Feedback from participants following the interviews suggested that they had spoken openly. A number commented on having not disclosed their situations so fully in other contexts, and described a positive impact, despite some topics feeling somewhat more difficult to discuss due to their emotionally salient nature.

Analysis

Interviews were analyzed following the methodology proposed by Smith, Flowers, and Larkin (2009). Interpretative Phenomenological Analysis (IPA) seeks to understand individuals' experiences and their understanding of their personal world, through researchers facilitating the emergence of the phenomenon and in turn making sense of it. This understanding is gained through the researcher examining participants' accounts reflexively, being aware of their own perspective with regard to the topic and awareness that the existing knowledge and attitudes that the researcher brings to the topic can only be partially bracketed (or separated) from their analysis of the data (Smith et al., 2009, p. 25). IPA was chosen as it was felt to be the most appropriate method of exploring the lived experience and meaning made from being in a relationship when a partner has depression. Other methodologies considered included Grounded Theory (Glaser & Strauss, 1967) which would have allowed a theory to be generated about how such an impact occurs; or Discourse Analysis (Phillips & Hardy, 2002), which would have given information about how people speak about their experiences, the narratives and discourses present. Neither of these methodologies was considered to be as able to directly answer the research question.

IPA is concerned with understanding the individual and seeks to provide 'detailed, nuanced analyses of particular instances of lived experience' (Smith et al., 2009, p. 37) rather than seeking to establish universal causal laws influencing behavior. As such this process of analysis utilizes thorough and systematic analysis with depth, with participant numbers being lower than other methodologies to facilitate this depth.

Interviews were analyzed in a process of interpretative revision, following the approach suggested by Smith et al. (2009). This involved moving between considering the part and whole, with attention paid to the use of single words and phrases; the sentences in which these were embedded; the interview and the collection of interviews. Line by line analysis of the transcript was conducted, considering descriptive, linguistic, and conceptual elements of individual transcripts in conceptual coding. During this phase consideration was given to reflecting on the researcher's responses and interpretations, and provisional meanings were noted in the researcher's reflective diary. Following this, emergent themes were explored, in order to maintain complexity, and at the same time reduce the volume of material to a more manageable level. This involved re-organizing the data, while maintaining a sense of the whole. Themes were developed by using the notes developed to develop concise statements of the comments made in the transcript, so they represented both the original words and thoughts of participants, but also the researcher's interpretation of them. On the conclusion of the analysis of interviews in their own case, the researcher followed an iterative approach, returning to interviews to ensure that themes were not missed. Cross case analysis was conducted to capture patterns across themes and these were subsequently clustered to form super-ordinate themes. Connections between these themes were established, with the development of a graphical structure, with related themes considered together and abstracted for the development of super-ordinate themes. Research supervisors involved in the project examined the themes in order to ensure their validity.

Results

Interviews were analyzed and three superordinate themes emerged, which have been focused upon in this analysis, with existing themes developed in other research not presented here. Limited changes have been made to quotes to preserve anonymity of participants, and to prevent distraction through repeated filler words.

Superordinate and subordinate themes are presented in Table 2. These were organized as 'Conceptualizing depression', 'Re-evaluating the relationship', and 'Negotiating identities'. The source of all quotes is given in brackets following the quote, using a pseudonym presented in Table 2. Square brackets have been used to indicate where details from the transcript have been changed in order to preserve anonymity.

Table 2

Superordinate and Subordinate Themes Developed From Analysis

Superordinate theme	Subordinate theme
Conceptualizing depression	Recognizing depression Understanding the origin of depression
Re-evaluating the relationship	The emergence of different realities Communication Intimacy
Negotiating identities	Identifying as a carer Fluid identities

Conceptualizing Depression

This theme aimed to capture participants' experiences of trying to understand the depression and what this meant for them. Participants described how they first realized their loved one was experiencing depression, and their experiences in trying to understand and find meaning from the depression.

Participants recognized their partner's depression before the partner themselves had labeled it as this, except in one case where the couple had met later in life. Typically they reported that depression had emerged following a significant life event, or series of life events. The signs of depression included behavioral '*he was just short with everybody*' (Gillian), '*Certainly drinking more and every day drinking*' (Sandra). Emotional signs were noted, '*she just couldn't cope*' (Steve). For one participant in particular, there was a clear physiological sign she associated with depression, her husband's significant increase in weight.

"He started to eat and I think his depression has manifested itself in an eating disorder that he compensates emotionally by eating, so he always feels hungry, he never feels full. And he blossomed from 11 and a half stone to probably about 26 stone now, possibly more, I don't know, possibly even more" (Sandra).

The meanings participants drew of the depression can be seen as conceptualizations of the depression. For Sandra, the parallel between her partners' weight and his depression were so close they appeared to have become inseparable, and an outward expression of his emotional distress, a distress not acknowledged by others outside of the immediate family unit, "*It's like for god's sake it's like the elephant in the room, well he is the elephant in the room*" (Sandra).

Participants described the depression as comprehensible – a reasonable reaction to the experiences their partners had undergone, including childhood trauma, physical health difficulties, or significant life transitions. They identified how these experiences continued to have significant impacts on them when the depression arose, "*... her daily life is invariably wrapped up with the past*" (Mike) and had affected their partner, giving them "*low self-esteem, low self-worth*" (James). At the same time, they understood the depression to be an illness, treatable with medication. A number of participants drew parallels with physical health conditions:

"You definitely need that support it's just like a - it's just like a bad leg or something you need some help with that. Mental illness is no different really" (Steve).

Steve drew some of his understanding of his wife's depression from his experience of his mother's stays in psychiatric hospitals throughout his childhood, drawing comparisons between experiences as a child and his subsequent responses when faced with the situation in his marital relationship.

Where participants were able to clearly identify an understanding regarding the origin of their partner's depression they reported feeling that this helped them to respond to the difficulties that this posed for them. They described reflecting on this as a way of managing difficult feelings that arose in the relationship as a result of the depression. However, where participants had been less able to understand the depression, and appeared to be related to unexplored relationship difficulties, significant frustration was apparent:

"But I just can't get this - and it makes me angry... and he must pick up on that, I'm sure he does... Because I feel, you've got a beautiful house; you've got two healthy children... I mean he's got a marriage... - what - the - hell - what - the - hell- why is he depressed?" (Sandra).

The process of finding meaning and explanation for the depression provided participants with an understanding that the depression was not their partners fault – blame could be, and was, attributed to another cause, external to the relationship. This appeared to play a buffering role to the emotional impact upon the relationship, and hope that where the external factor changed, the depression might too.

Re-Evaluating the Relationship

The impact of the depression in the relationship was so significant that it led to a dramatic re-appraisal of the relationship. Participants who once saw themselves and their partner as similar, close, and with a shared understanding became dramatically aware of the gulf that now existed between them.

Participants described global differences between themselves and their partners when the depression was present. Every aspect of their lives was different, from the activities they did, and the responsibilities they engaged in, to their personalities. Even pre-existing differences were now construed in light of the depression:

“... and then I think it is just a cultural thing... but no I don't think so, it's always there I don't - I think he'd say it's always there. Something I don't think he ever - it comes and goes in that it gets more acute at times but I think it's always there. That sort of low mood is always there” (Sandra).

The impact of the depression resulted in very strong difficulties in understanding their partner, and in empathizing with the difficulties they faced. It was as though they were living in different worlds at times.

“Frustrating that is, (emphasis) really is frustrating. Like I make some really big decisions at work, you're talking tens of thousands of pounds some of the decisions I have to make and eh I'll come home and sometimes she can't make a decision if she'll have a cup of tea or not. Whether I have a cup of tea or not or whether we'll go shopping or not” (James).

Not only were participants unable to identify with the difficulties their partner faced, their descriptions revealed that they felt their partner did not understand their own difficulties, and did not empathize in turn. For a number of participants their couple relationship had become two individuals living very different lives, with each unable to fully appreciate the experiences of the other.

These differences between partners sometimes meant that they had little to talk about, and even relationships where conversation had previously flowed well, were now marked by quietness. Communication became purpose driven, for example trying to improve the depression, or trying to negotiate around medical interventions (for the depression or other health difficulties). Some participants described having ‘*tried everything*’ (James), referring to a wide range of communication (including shouting, trying to reason their partner out of depression), where others tried to remain empathic, even where this was different to their natural response.

“... In the early days it made me sort of temperamental, you know. (Stumbles over words) You know, argumentative. It's a strange thing... Once I realized what was going on behind, when I learnt a bit more, obviously I tried to be supportive and (long pause) understanding... Because of the illness I feel that there's an extra, obviously it has an impact in the way that I as a person respond” (Mike).

Other participants described how the depression directly impacted on their partner's communication, through their perception that their partners didn't want to talk, either remaining silent, or becoming angry and shouting. This appeared to be particularly draining to participants who were trying to help their loved one, and instead now felt rejected.

“It's almost like we play a game about erm (hesitate) if he thinks I'm being nice it's almost like he thinks I'm trying to lull him into a (long pause) a place that he doesn't want to go to so - it's better to keep me battered out” (Sandra).

Participants described how the impacts of depression resulted in them feeling less close to their partner. Reductions in intimacy appeared in their accounts to embody changes to both the sexual and emotional aspect of their relationship. This resulted in significant frustration, at the same time they tried to contain this, by keeping in mind the cause of the depression.

"I know deep down that [wife] loves me very much she'd never do anything to harm that situation or anything like that, she has this problem of showing it, part and parcel of the upbringing, part and parcel of the depression, low self-esteem, low self-worth, she can't express feelings like that. It's one of the, it's one of the - it's something I'm aware of, something I put up with, I put up with is the wrong word, the wrong expression I suppose, one of the things I deal with cause I know [wife] is [wife] and that's one of the things she struggles with day to day thing like" (James).

Interviews highlighted the tension between the new divergence they saw between themselves and their partner, and at the same time keep in mind the other aspects of the person, the person without the depression. At times when depression was less severe this allowed the participant to see the other aspects of their partner and to keep these in mind when the depression was harder to live with.

Negotiating new Identities

The impact of the depression on the relationship was identified by participants as resulting in a number of new roles and identities within the relationship. In particular, many participants described a shift from their romantic role as a husband or wife to one of providing care. These new identities needed to be carefully negotiated between the couple and consensus about the roles each would take was rarely explicit and not always straightforward. Whilst for most participants this appeared to be a gradual process as depression became evident, for one couple who met later in life, the initial changes in the dynamic which preceded a caring role, appeared rapidly after the disclosure of depression:

"I felt a bit sort of unable to do anything, like watching an accident but then as I said to you a few moments after I felt, quite erroneously that I that I could change things that I could help things by... Normally I'm a glass half full type of person in other things and I just, I was arrogant about things, I just thought I could by as they say 'love could conquer all' as they say but I haven't in that way because it's so (pause) when it happens, it's so predictable its - but also (pause) quite sharp in its effect..." (Mike).

Partners described a range of ways in which they provided care for the person with depression. These included attempts to 'fix' the depression, through being emotionally supportive, or communicating differently, accessing GP or mental health services on behalf of the partner, supervising medication, and identifying and working towards goals. The consequences of performing these tasks were varied, including frustration when things did not go to plan, to relief when difficulties were acknowledged by others:

"So I calls this Crisis team out and two lovely people came out, two lovely ladies and talked to her, got her dressed and that's possibly one of the things that they've looked at and realized there's something wrong, something more wrong than they anticipated" (James).

For some, the adoption of the caring role reaching the level of an identity appeared to be influenced by how they felt services perceived their relationship, rather than being self-defined. Additionally, one participant was ambivalent about perceiving her supportive behaviors as 'caring'.

“(Pause, sighs, speaks quietly) See that’s where erm... I didn’t, I went to work (pause) I left. I had to get him up, sorted, breakfast out (pause) make sure he had something for lunch (pause) and then I’d always be home for tea time so I just (pause) I don’t know. Caring wise for him I’ve always cared for him anyway but (pause) I don’t know (pause) I think it’s a bit of a hard question that one (Laughs quietly)” (Gillian).

For others, a desire to provide for and nurture appeared to go beyond this initial caring role, and instead aimed to provide what parents had failed to do during their partner’s childhood, in a form of re-parenting. These partners described wanting to change the persons experiences of family life. When this failed participants described finding this invoked significant negative emotions, though when it succeeded they felt joy at having been able to have a positive impact.

“it gives me a lot of pleasure really it does erm (long pause) it makes me happy especially when I see a smile on her face... Like I say, [Wife] is my family so you try and look after family don’t you, but family has never looked after her, and that’s part and parcel of who she is and why she is at this moment in time” (James).

As a result of the changing nature of intimacy in relationships a further identity of becoming a sibling was acknowledged by this participant. For him, the power dynamic in this role appeared to be more equal than in his ‘parenting’ role, at the same time, the reduction in intimacy at times of depression prevented his identity of a husband as being more salient.

“(Pause) Mine and [wife]’s relationship has deeply suffered. There’s been a lot of times where we’ve had, and I’ve felt we’ve had a brother sister relationship (pause) there’s times when we’ve gone months without touching each other, not even a kiss I must admit. And when we do get together it’s fantastic I can’t, I can’t knock her for that (long pause) but like I said, more often than that it’s been a brother sister relationship, this last five or six years” (James).

Participants also noted how the depression had affected their own view of the identity of the partner, particularly where the depression had emerged during the course of the relationship.

“Whereas before that I was ‘oh well’ almost ‘you know nothing touches him, he’s as hard as nails’, or like, ‘water off a ducks back’, (pause) it obviously wasn’t, it obviously wasn’t. And isn’t I don’t think, and isn’t” (Sandra).

These changes in roles and identities described by participants appeared to be fluid and varied, primarily related to the severity of the depression. Where greater caring was needed, participants reported the adoption of caring roles and feeling ‘like a carer’, though when depression had lifted they described returning to the earlier role. Such changes were far from easy to negotiate and the adoption of the carer identity was not accepted by all participants. The acceptance of the ‘carer’ identity was socially constructed within the couple relationship and within the broader social network. Where this network did not acknowledge the depression, and where the provision of care was rebuffed, participants themselves did not accept the carer identity.

“And you don’t identify yourself as a carer” (Researcher).

“No. No, I think my friends think I’ve got a lot to put up with sometimes... I think they think - they know he’s difficult and they know, they think he’s just difficult, they don’t see that it’s a symptom of his depression, they just think he’s difficult” (Sandra).

Participants' understanding of the care and support they gave their partners were influenced by their perception that others (including their partner, services, friends, and family), had of their caregiving. They described a range of 'caring' activities which were both aimed at relieving the immediate distress of their partner, as well as aiming to fundamentally change the nature of the depression through the provision of love and care. Negotiating the multiple roles they perceived within the relationship was challenging at times, especially when attempting to balance the demands of other work and family roles. At these times the emotional impact of the depression on the partner was particularly intense.

Discussion

Participants described a number of significant and difficult changes to the couple relationship following the emergence of their partner's depression. Developing an understanding of the depression allowed participants to externalize the difficulties, and see the partners' depression as being dependent upon external factors. This situated both the cause and hope for improvement on factors outside of the relationship, potentially reflecting experiences of their partner having been unable to control the depression, and having little hope for this in the future, potentially reflecting psychological theories of 'learned helplessness' (Seligman, 1975). When the depression was present, participants described feeling increasingly distant from their partners, communication changing dramatically, and a loss of or change to feelings of intimacy. Many of the participants were the first to recognize their partner's depression. The gradual adoption of the 'carer' identity appeared to emerge from the initial period at which depression became acknowledged, as well as through increasing provision of support, and acknowledgement of this identity by others. Other identities appeared to be present including parenting and being a sibling to the person with depression.

Participants reflected in a number of ways upon the changes to their relationship as a result of the depression. They described their partner being altered by it, and additionally that they were now viewing the relationship differently too. Participants who were able to understand the origins for the depression seemed more able to empathize with the subsequent impacts, bearing this in mind, despite the impacts of the depression on their relationship. The experience of these difficulties without an understanding of the reasons may leave individuals feeling bewildered and distressed, with one participant describing anger at this position. The link between understanding, meaning and increased empathy has been proposed as one of the key reasons for developing psychological formulation by psychological therapists (Eells, 2007). Finding meaning in adversity has been considered by existential phenomenologists to be essential to endurance (Frankl, 1946).

As a result of these changes to the individual, the relationships of participants appeared to change too. Intimacy, communication, and empathizing with each other became more difficult and new patterns in these relationships seemed to develop as a result. The experiences of participants, and the themes which emerged from interviews with them, can be understood through psychological processes identified in Cognitive Analytic Therapy (CAT, Ryle, & Kerr, 2002). This theory understands that problems, such as depression, occur between, rather than within individuals, emphasizing the relational aspect of difficulties. Individuals are seen to adopt reciprocal role procedures, whereby patterns of responding are established. 'Steve' had cared for his mother in childhood and maintained the home during her inpatient stays in psychiatric hospitals and his later responses to his wife's depression mirrored this experience, taking significant responsibility for caring and practical tasks around the home. Recognizing the repeated nature of these interactions and the resulting emotional and relational impacts may offer

the potential for new ways of responding to be established, and the relational aspect of the depression to be altered.

Social Identity Theory emphasizes the internalization of roles to form a resulting identification with these roles, becoming part of the self (Stryker, 1980). In this research, the recognition of an individual having become a 'carer' brings with it the potential provision of additional practical and financial support through services, as well as the potential for financial benefits or tax credits. This research has indicated that the perception of others regarding the caring role appears to have a significant impact on individuals' perception and internalization of these roles into their identity. As a result, mental health professionals may be well placed to consider whether a partner has adopted roles which may lead to them being considered a carer, using existing legal definitions (Department of Health, 2008).

Past research has indicated that those identified as carers may experience significant feelings of burden and stress, as well as their own mental health difficulties (e.g. Benazon & Coyne, 2000; Jeglic et al., 2005; Stjernswärd & Östman, 2008). The identity of 'carer' appears to be so closely bound up with the notion of burden that it may be that the adoption of this role results from feelings of burden or alternatively these emotions are implicit once the identity is adopted. Models of depression using quantitative data have demonstrated that the increased signs of depression associated with living with a partner with depression are fully mediated by caregiving stress (Jeglic et al., 2005). Sources of burnout for relatives of those with mental health conditions have been found to include the experience of stigma, frustration, anxiety, feelings of helplessness and social anxiety (Tsang, Tam, Chan, & Chang, 2003). The adoption of the carer role and potential feelings of burnout therefore has particular salience for mental health service provision, with the need to adequately respond to such difficulties and meet the needs of both the person with the mental health need, and their partner.

Predominant in the provision of mental health services in the UK is the Cognitive Behavioral Therapy (CBT, Beck, 1967). This therapeutic approach identifies depression as being maintained by the individual's emotional, behavioral, physiological and cognitive responses to triggers. Another helpful approach might be to support the couple relationship through identifying the close interweaving of the mental health of individuals and their partner, and the reciprocal roles adopted by them in their relationship. Through increased understanding of these roles and their consequences individuals may be able to identify other ways of responding, and providing exits from these patterns.

Conclusions

This research provides a number of implications for professionals working with clients who have depression, both in individual work and within broader care provision. Psychological assessments would benefit from exploring the experiences of those close to the identified client. This would allow a greater understanding of potentially helpful support, or alternatively help to identify maintaining factors in the depression. In addition, Psychologists may consider supporting clients to share psychological formulations with loved ones, which might support partners to recognize maintaining factors in the depression. This could support both members of the couple to develop a greater sense of agency, and to negotiate new identities.

Therapeutic models which reflect the relational aspect of depression, such as CAT, may prove helpful to both the client and their loved one, through helping those involved to recognize the roles they have adopted, and other ways of responding. This would allow partners in recognizing the adoption of caring roles, allowing a reconsider-

ation of these approaches if appropriate, or facilitating the accessing of support. In addition, supporting clients in sharing psychological formulations developed in therapeutic work with loved ones, may support partners through recognizing the origin of and maintaining factors in the depression, and providing a greater sense of agency.

Clinical Psychologists may be able to support other professionals in recognizing the needs of partners supporting a holistic approach to the client and the needs of their network. This may be through individual case discussion, and through the provision of service development and training.

This research contributes to a developing evidence base exploring individual's understandings of the impacts of having a partner with depression, in particular by exploring their adoption of new roles and identities in the context of depression. Mental health professionals and the services they work within may become more aware of the process of identifying as a carer, and may facilitate the identification of individuals with this identity where it may help individuals to access support.

Despite the strengths to this research a number of limitations should be noted which may affect the validity of the findings. All participants were White British, and were in long term heterosexual marital relationships. In addition, the self-selecting nature of participation in the research may have restricted the range of experiences described by participants. Strategies employed in an attempt to mitigate against this were the diversity of recruitment strategies used, including contacting support organizations, and advertisements in general community settings. Through these approaches, a range of socio-economic backgrounds were represented by participants. The research may not be considered generalizable to all individuals with a partner who has experienced depression. Participants were from a relatively homogenous cultural group, fitting with the methodology of IPA which presents a deep understanding of a limited number of individuals experience. For these reasons five participants was appropriate for this methodology, however, other methodologies with larger participant numbers may appropriate when seeking findings representative of this population.

As a result of the research method and the homogenous sample, the results from this research are considered to be specific to the experience of being in a relationship when a partner has depression. Findings relating to other forms of mental distress may or may not be similar, and future research in exploring these in depth would be a valuable contribution to the evidence base.

An approach to the research project was adopted where IPA theoretically consistent approaches to research methodology and analysis were adopted wherever possible. As such it was participant's own understanding of their partner's depression rather than the diagnosis of a condition which was used to identify depression. As a naturalistic sample, and given the high rates of comorbidity, additional diagnoses were not excluded from the research. However, all participants described their partner's experiences with services as being indicators of depression including two having been formally diagnosed with depression by Psychiatrists, a further two being prescribed anti-depressant medication by their General Practitioner (GP), and one partner having previously self-prescribed this medication (as a GP themselves). Additional diagnoses were discussed by participants including a number of physical health conditions, and bipolar disorder. However, in these cases participants were informed that interviews would focus upon the depression, and this was maintained throughout the research process. It is possible that the presence of these additional diagnoses may have affected the details shared by participants, however that the signs which are understood by participants to be depression (including low mood, loss of pleasure, changes to appetite and sleep) were those which were explored as having impacted upon the relationship, rather than the

impacts of other difficulties. It is this understanding of the depression and its impacts that were explored in this research.

Themes developed from interviews were not checked with participants as a result of the different positions the researcher and participants had adopted, with participants remaining within the 'natural attitude' and unable to undertake bracketing to view themes as having emerged from a co-construction of the data within the interview process. However, transcripts of interviews were shared with participants where this was requested. Participants suggested no changes to these transcripts.

Further research may be helpful in exploring how individuals with depression understand their partner's adoption of caring roles. With such shifts in their relationship being dependent upon the severity of depression, it may be that where this occurs, individuals with depression may experience feelings of guilt which may contribute to worsening depression. Those with depression may also experience feeling cared for, supporting them in the recovery from depression. Additionally, research has yet to sufficiently explore the impact of gender, presence of children and cultural backgrounds on the experience of being in a relationship when a partner has depression.

Notes

This research was conducted as part of the lead author's Doctoral training in Clinical Psychology, with the Staffordshire and Keele Universities Doctorate in Clinical Psychology.

References

- Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York, NY: Hoeber.
- Benazon, N. R., & Coyne, J. C. (2000). Living with a depressed spouse. *Journal of Family Psychology*, *14*, 71-79. doi:10.1037/0893-3200.14.1.71
- Bottoff, J. L., Oliffe, J. L., Kelly, M. T., Johnson, J. L., & Carey, J. (2013). Surviving men's depression: Women partners' perspectives. *Health*. Advance online publication. doi:10.1177/1363459313476965
- British Psychological Society. (2011). *Code of human research ethics*. Leicester, United Kingdom: British Psychological Society.
- Coleman, L., & Glenn, F. (2009). *When couples part: Understanding the consequences for adults and children*. London, United Kingdom: One Plus One.
- Cutcliffe, J. R., & Goward, P. (2000). Mental health nurses and qualitative research methods: A mutual attraction? *Journal of Advanced Nursing*, *31*, 590-598. doi:10.1046/j.1365-2648.2000.01314.x
- Department of Health. (2008). *Carers at the heart of 21st Century families and communities*. London, United Kingdom: Author.
- Eells, T. D. (2007). *Handbook of psychotherapy case formulation* (2nd ed.). New York, NY: Guilford Press.
- Elder-Vass, D. (2012). Towards a realist social constructionism. *Sociologica, Problemas e Práticas*, *70*, 9-24.
- Frankl, V. E. (1946). *Man's search for meaning*. London, United Kingdom: Hodder and Stoughton.

- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.
- Hansen, J. O., & Buus, N. (2013). Living with a depressed person in Denmark: A qualitative study. *The International Journal of Social Psychiatry*, 59(4), 401-406. doi:10.1177/0020764012438478
- Harper, J. M., & Sandberg, J. G. (2009). Depression and communication processes in later life marriages. *Aging & Mental Health*, 13(4), 546-556. doi:10.1080/13607860902774485
- Harris, T. J. R., Pistrang, N., & Barker, C. (2006). Couples' experiences of the support process in depression: A phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, 1-21. doi:10.1348/147608305X41218
- Hedman Ahlström, B., Skärsäter, I., & Danielson, E. (2009). Living with major depression: Experiences from families' perspectives. *Scandinavian Journal of Caring Sciences*, 23(2), 309-316. doi:10.1111/j.1471-6712.2008.00624.x
- Henderson, J. (2001). 'He's not my carer—he's my husband': Personal and policy constructions of care in mental health. *Journal of Social Work Practice*, 15(2), 149-159. doi:10.1080/02650530120090601
- Highet, N., Thompson, M., & McNair, B. (2005). Identifying depression in a family member: The carer's experience. *Journal of Affective Disorders*, 87, 25-33. doi:10.1016/j.jad.2005.02.016
- Jeglic, E. L., Pepper, C. M., Ryabchenko, K. A., Griffith, J. W., Miller, A. B., & Johnson, M. D. (2005). A caregiving model of coping with a partner's depression. *Family Relations*, 54, 37-45. doi:10.1111/j.0197-6664.2005.00004.x
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology*, 3(2), 102-120. doi:10.1191/1478088706qp062oa
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. London, England: The NHS Information Centre.
- Murali, V., & Oyebode, F. (2004). Poverty, social inequality & mental health. *Advances in Psychiatric Treatment*, 10, 216-224. doi:10.1192/apt.10.3.216
- Phillips, N., & Hardy, C. (2002). *Discourse analysis: Investigating processes of social construction*. Thousand Oaks, CA: Sage.
- Rehman, U. S., Gollan, J., & Mortimer, A. R. (2008). The marital context of depression: Research, limitations, and new directions. *Clinical Psychology Review*, 28, 179-198. doi:10.1016/j.cpr.2007.04.007
- Roberts, G. A. (2000). Narrative and severe mental illness: What place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, 6, 432-441. doi:10.1192/apt.6.6.432
- Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester, United Kingdom: John Wiley & Sons.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. San Francisco, CA: W. H. Freeman.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, research*. London, United Kingdom: Sage.
- Smith, J. A., & Osborne, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology*. London, United Kingdom: Sage.

- Stjernswärd, S., & Östman, M. (2008). Whose life am I living? Relatives living in the shadow of depression. *The International Journal of Social Psychiatry*, 54(4), 358-369. doi:10.1177/0020764008090794
- Stryker, S. (1980). *Symbolic interactionism: A social structural version*. Menlo Park, CA: Benjamin Cummings.
- Trombello, J. M., Schoebi, D., & Bradbury, T. N. (2011). Relationship functioning moderates the association between depressive symptoms and life stressors. *Journal of Family Psychology*, 25(1), 58-67. doi:10.1037/a0022138
- Tsang, H. W. H., Tam, P. K. C., Chan, F., & Chang, W. M. (2003). Sources of burden on families of individuals with mental illness. *International Journal of Rehabilitation Research*, 26(2), 123-130. doi:10.1097/00004356-200306000-00007
- Wertz, F. J. (2005). Phenomenological research methods for counselling psychology. *Journal of Counseling Psychology*, 52(2), 167-177. doi:10.1037/0022-0167.52.2.167
- World Health Organization. (2012). *Depression* (Fact Sheet N° 369). Retrieved from <http://www.who.int/mediacentre/factsheets/fs369/en/index.html>