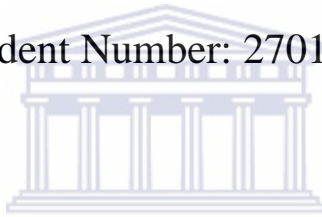


The Experiences of Spouses Living With Clinically Depressed Partners

BY

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Magister Curationis in the School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape.

Supervisor: Doctor June Jeggels

November, 2008

Declaration

I declare that; **the experiences of the spouses living with clinically depressed patients** is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Mose, Isaiah

Date 14/11/2008

Signed.....



Keywords

- Depression
- Depressed patients
- Spouse carers
- Coping strategies
- Qualitative research
- Phenomenological research
- Lived experiences
- Developing country
- Western Cape Province
- South Africa



Abbreviations

APA- American Psychiatric Association

APAM- Adaptive Potential Assessment Model

U.K. - United Kingdom

U.S.A. – United States of America

WHO- World Health Organization



Dedication

Dedicated to my wife Rosaline

My son Brian

My daughter Briana



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First and foremost, I am grateful to Almighty God for providing me with good health and the energy that has kept me going this far. I thank Him for all the provisions and blessings during the difficult times and the good times.

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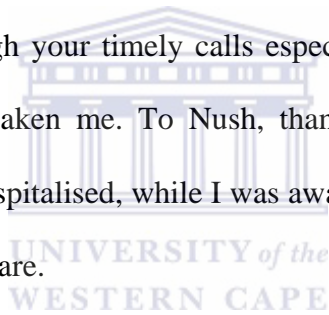
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Abstract

This study explored the lived experience of spouses living with depressed partners. A qualitative phenomenological, exploratory study design was used to explore the lived experience of the spouses, identifying the coping strategies and challenges that they face as they live with the depressed partners. A purposive sample of seven spouses living with their depressed partners who were being treated in outpatient department were recruited to participate in the study.

In-depth, face-to-face interviews were conducted, audiotaped with the participants' permission and transcribed verbatim. The data from the transcripts, field notes, and demographic questionnaires was organized ready for analysis. Thematic data analysis was used to code the data, and group the codes to form categories. The categories were further regrouped to form themes. The themes were conceptualized and contextualized to uncover the meaning that the spouse carers attached to the lived experience.

It emerged that most of the spouses described their partners and the relationship negatively due to the burden of care. The male carers as compared to the female carers expressed the negativity more and it impacted on the quality of care they were providing to the depressed partners. It was revealed that inadequate professional support was linked with the ineffective coping strategies employed by the spouse carers. Hence, most of the spouse carers presented with symptoms of depression and were at the stage of impoverishment according to the adaptive potential assessment model. A recommendation to involve spouse carers in the treatment plan and improve the support system to the spouse carers was made to the stakeholders of health service providers at the primary health level.

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CHAPTER ONE

Orientation to the Study

1.1. Introduction

The prevalence of depression seems to be increasing with the advent of many complex challenges facing modern society. This trend has not spared South Africa either, as depicted in the statistics presented in the background to the study. The nature of depression escalates a debilitated state in which an individual is unable to function socially and economically. There seems to be a relationship between the depression that patients undergo and the psychological status of the close relatives with whom they live (Nili & Coyn, 2000). Spouses and children are the most affected members of the family. Children suffer physically, socially, emotionally and psychologically because all the attention is focused on the sick parent (Riebschleger, 2004). Despite its serious effects on the society especially in the family, many researchers have not given depression the due attention to establish how it relates to the close associates in the society.

Depression results when the body's adaptive mechanism, maladapt to a real or perceived stressor (Otong, 2003). However, studies have shown that those people who closely interact with the depressed persons are at risk of either getting depressed or becoming psychologically affected. The adverse effects of depression not only affect the patients but also extend to those who live with them, especially their spouses and the children (Harris, Pistrang & Barker 2006; Jeglic, Pepper, Ryabchencko, Griffith, Miller & Johnson 2005; Mead, 2002; Nili & Coyn, 2000).

Depression in the family causes adverse effects on children. Maternal depression seems to have more effects on the children than paternal depression. Lack of early childhood attachment (Manning & Gregoire, 2006) and the unavailability of parents during adolescence (Margolese, Markiwiez, & Doyle, 2005) affect children socially, emotionally, behaviourally and cognitively. Mowbray and Mowbray (2006) observe that such children engage in drug abuse and become deviant in their later years. Among the spouses, depression negatively impacts on communication and problem solving skills. The inability to solve problems in a family leads to marital distress and conflict eventually arises causing depression in the spouse carers. Although the impact of depression extends to the children, this study will be limited to the effects of the depression on the spouses (Mead, 2002). The aim is to uncover the experiences and feelings that the spouse carers attach to living with the depressed partners. In this study I will refer to the spouses as spouse carers or male/female carers. The depressed partners will be referred as depressed partners. The study will be conducted at the Lentegour Hospital, Western Cape Province, South Africa.

1.2. Background and Rationale of the Study

South Africa is one of the countries in the African continent. It is situated to the south of the continent neighbouring Namibia and Zimbabwe among others. It is a multiracial country with 79% of its people being black, 9.6% white, 8.9% coloured and 2.5% either Asian or Indian. Its total population as per 2001 census was 44,819,778 people (South African Government information, 2006).

The official languages include Afrikaans, English, isNdebele, isiXhosa, isiZulu, Sesotho sa Leboa, Sesotho, Setswana, siSwati, Tshivenda, and Xitsonga. The majority of the people of South Africa are Christians (76%) with the rest being

Hindus, Muslims, Jews or Buddhist. Some do not belong to any of those congregations but rather refer themselves as traditionalist (South African Government information, 2006).

The country is divided into nine constitutional provinces. The current research will be based at Cape Town, the capital city of Western Cape Province. According to the 2005 mid-year estimates, the province had a population of 4,654,600 people. The area occupied by the people is 129370 (km²). The province is a cosmopolitan province with Afrikaans being the dominant language (55.3%), followed by isiXhosa (23.7%) and English speakers (19.3%). Most of its occupants are educated with 5.7% adults not educated. According to a 2005 labour force survey, the province has an unemployment rate of 17.6%. The economic activities in the province include farming especially grapes, apples, olives, oranges and wheat growing. The province is known to export horses and other animal products. Its Gross Domestic Product in 2003 was R181, 069 million (South African Government information, 2006).

Lentegeur hospital is situated in Mitchells Plain at the outskirts of Cape Town in the Western Cape Province. It admits patients with various mental disorders. Most of the admissions come from within the province.

Nightingale (2008) mentions that stigma is a heightened problem in developing countries and it is a hindrance to the development of psychiatry services. Due to the stigma and lack of finances, a large proportion of patients with mental disorders cannot access mental health services. Furthermore in some of the African countries, mental health is under-resourced with some governments allocating 1% of its budget to mental health. This could be as a result of inadequate scientific evidence to influence the allocation of resources to mental health as compared to infectious diseases (Nightingale, 2008).

According to Corrigan, Ward, Stinson, Struthers, Frantz, Lund, et al (2007) mental disorders rank second to infectious diseases as major contributors to the burden of diseases. According to a Western Cape burden of disease reduction project report, mental disorders affect all the sectors. In the health sector, mental disorders increase the vulnerability of patients to contracting the HIV virus. Economically, the patients become less productive and spend much of their time and money on seeking medical attention. In education, the disorders lead to increased school dropouts and teenage pregnancies (Corrigan, et al 2007).

According to Corrigan et al (2007) 30% of the people who live in Western Cape Province will develop a mental disorder in their lifetime. Depression is one of the common and most disabling mental disorders in the province.

South Africa has adopted a primary health system of care to provide mental health services. In this system, patients are treated at the lowest level of service delivery before they can be referred to the secondary and tertiary hospitals. This system allows patients to be nursed in an environment familiar to them. Those who require more specialised treatment are referred to the experts in the next level hospitals. Patients are admitted for acute symptoms and once they show improvement they are discharged to continue with medication at home. Despite the primary health care system's aim to provide accessible, comprehensive, appropriate, affordable and integrated services to the general population, it disadvantages the close relatives especially spouse carers, who are forced to provide care to the patient at home. This may predispose the spouse carers to intense stress due to providing care without having a choice in the matter. The system forces the carer to stay with their sick partners at home for a longer period of time than a system where patients are admitted to a hospital until they are cured before they are discharged (Thom, 2007).

The stress due to the burden of caring, coupled with poverty, stigma, social crimes such as rape, unemployment, marital conflicts, substance abuse and life style diseases all contribute to the high prevalence of depression in South Africa and more so in the Western Cape Province. A survey conducted in South Africa regarding domestic violence in relation to depression, revealed that there is a strong relationship between the two variables. Most of the survivors of domestic violence were diagnosed to be depressed (Ross, 2000; Joyner, Theunissen, De Villers, Sliman, Hardcastle & Seedat, 2007). A study conducted in Khayelitsha, a poor peri-urban settlement near Cape Town, revealed that 34.7% of women get depressed within their first two months after giving birth. The researchers attribute the high prevalence to, among other factors, poverty, lack of support from the father of the newborn and negative attitudes towards the newborn from the father (Tomlinson, Swartz, Cooper & Molteno, 2004).

Despite the high prevalence of depression in developing countries like South Africa, few studies have been done on the area of depression (Nightingale, 2008). These studies were mainly surveys that originated from research initiated by researchers from developed countries. This study will be conducted in Western Cape Province of South Africa to explore the experiences of spouses who live with clinically depressed partners.

Other than the high prevalence of depression, I became interested in conducting the study having interacted with families struggling with the grip of depression. This study will give the spouse carers an opportunity to externalise their feelings related to interacting and providing care to their depressed spouses. It will also add to existing literature that can benefit the professionals who attend to depressed patients.

1.3. Research Problem

Spouses living with depressed partners are faced with various challenges. One of the challenges is to provide care to their depressed spouses. Most of the spouse carers are taken by surprise since they might not have seen someone in an episode of depression. The spouse carers have to struggle to adapt and live with their depressed spouses. Providing care for patients experiencing depression is not easy as shown in the story of the astronaut woman (Anonymous, 2000). Trying to make the depressed spouse happy at the expense of her own health shows how difficult it is to provide care to a patient who does not even appreciate the care due to a non-functional state exacerbated by depression. Exploring the lived experiences of the spouses living with clinically depressed patients will unveil important information on how the spouse carers cope with providing care without undergoing formal training.

1.4. Purpose of the Study

Having interacted with families who struggle with depression, I noticed that during an episode of depression in the family, the spouse carer complained of persistent headache, and generalized malaise, which could not be associated with any medical disease. The children too, are left unattended especially if it is the mother who is experiencing the episode of depression. During such a time very few people visit the home because they refer to depression as madness and so the home is labelled an unsafe zone. This is because individuals associate depression with violence and often stigmatize patients suffering from depression. The current study will explore the experiences and feelings the spouses of depressed partners attach to living with depressed spouses. It will also provide insight on what the spouses undergo, the coping strategies they employ during an episode and where they get support, if any.

1.5. Research Aims and Objectives

1.5.1. Aim of the Research

The aim of the study is to explore the lived experiences and feelings of spouses who live with their depressed spouses.

1.5.2. Objectives

- To describe the experiences and feelings of spouses of depressed persons.
- To identify the challenges that the spouses face as they live and interact with their depressed partners.
- To describe the coping strategies spouses of depressed partners use to adapt to living with the depressed spouse.

1.6. Definition of Concepts

Spouse: Hornby (2005: 1426) refers spouse as husband or wife

Partner: Hornby (2005: 1036) describes partners as people involved in a marriage relationship

Spouse Carer: Husband or wife who provides care to the depressed partner (Hornby, 2005: 1426).

Depressed partner: In this study, it is the depressed partner requiring care from the spouse carer

Depression: A mental medical disorder characterised by intense feelings of sadness and anxiety coupled with physical symptoms such as sleep disturbance and psychosomatic pain (Frisch & Frisch, 2006: 262).

Developing Country: According to Hornby (2005: 400) a developing country is a state whose resources are meagre but which is working towards making it better in terms of industry and economic systems.

Experiences: An occurrence that affects you in a way and influences your way of thinking (Hornby, 2005: 513).

1.7. Research Design and process

A qualitative, phenomenological study design was used to uncover the experiences and feelings of the spouses living with depressed partners. A qualitative paradigm emphasises the study of subjects in their natural state and aims at understanding social interaction. Phenomenological design enables one to explore lived experience of people.

Triangulation during the data collection process included, face- to face interviews, collecting demographic data and writing field notes. The study was based at Lentegeur hospital because I was familiar with its functioning and the clinicians were willing to assist me especially in identifying participants. Besides, I was placed in Lentegeur hospital for my clinical modules. This made it easier to collect data alongside the gaining of clinical experience. A purposive sample of seven participants was recruited. The sample comprised of participants living together for more than two months, married, male and female, where one spouse was diagnosed with clinical depression.

During the interviews, each participant was given time to exhaustively narrate his/ her story about living together with the depressed partner. Each participant was requested to sign a consent form. The demographic data of all the participants were captured. The interviews were audio taped with every interview recorded on its own tape to

avoid confusion during transcription. A verbatim transcription was done at the earliest opportunity after the interview. Thematic analysis was used to analyse the data. Trustworthiness was ensured during the data collection and analysis process.

The ethical considerations were adhered to by obtaining permission from the University of Western Cape higher degree ethics committee and the Lentegeur research ethics committee respectively. Each participant was assigned a pseudonym to ensure that the researcher only knew his/her identity. Each participant was requested to ask any question of concern before each interview. This was to ensure that participants were comfortable before the interviews could begin. A registered psychiatric nurse was recruited to debrief participants who needed debriefing.

1.8. Chapter Outline of the Study

Chapter 1. This chapter defines the study and gives an introduction of the study to the reader. It briefly explains the background and the rationale of conducting the study at Lentegeur Hospital. Also included in the chapter is the research problem, purpose of the study, aim, objectives, definition of concepts, research design and the chapter outline.

Chapter 2. Chapter two consists of the literature review. It presents studies that have been done related to the topic. “Experiences of spouses living with depressed spouses” which is presented in this chapter. The main focus of the review was the experience of spouses who live with depressed partners. The general discussion about depression is also presented in the review so that the reader can relate its effects to the relationship and interaction between husband and wife in a family. Information about its effects on the children is presented because being eminent members of the family they may be affected by the depression in the family.

Chapter 3. In chapter three the research methodology is presented. The study design, study sample and the characteristics of the sample are described. Data collection, analysis and procedures to monitor trustworthiness are elaborated on in the chapter. The ethical considerations to ensure safety of the participants and limitations of the study are discussed. A narrative approach was used to conduct the interviews, which were audio taped and transcribed. Inductive content analysis was used to analyse the data.

Chapter 4. The demographic characteristics of the participants are discussed to contextualise the experiences of the spouses enhancing clarity of the experiences to the reader. Each emergent theme is discussed with anecdotal evidence comprising of direct quotes from the participants to ensure that the interpretations conform to what the participant intended to express. The interpretations of the findings together with the field notes are discussed in detail to unveil the experiences of the spouse cares.

Chapter 5. A summary of findings, conclusion and recommendations are presented. The research gaps are identified and recommendations made for further studies.

Chapter 6. The conclusion of the study is presented in this chapter.

1.9. Conclusion

In conclusion this chapter introduces the research study to the reader. The characteristics of the population of Western Cape Province are described and how the population is predisposed to depression. The primary health care system being implemented in South Africa worsens the situation because there is an expectation that the spouses will provide care for their depressed partners. Although the primary health care system has good benefits for the society, it might be a disadvantage to the spouses of chronically depressed patients. The appropriateness of conducting the

study in the Western Cape Province can be envisioned by critically studying the trend of increasing prevalence of depression in the province. The phenomenological study design has been used to describe the experiences of spouses living with depressed partners, identifying the challenges that they undergo and the coping strategies they put in place as they live and interact with the patients. Health professionals need this information so that they can modify the attention given to depressed patients and their spouses. This is a very current topic and has not been studied before in the Western Cape Province. The literature review is presented in the next chapter.



CHAPTER TWO

Literature Review

2.1 Introduction

The review of literature relating to the research topic is presented in this chapter. Literature was obtained from a number of different sources, for example books, journals, internet databases among others. The main focus of the literature was to access existing information related to the impact of depression on spouses living with depressed partners. Most of the literature that is available has its origin in the developed world. The aim of the literature review was to familiarise myself with the topic of study so as to establish the effects of living with depressed partners on carers in order to integrate this study with the related previous research.

The literature review will be presented as follows: A discussion about depression as a common mood disorder, the effects of depression on the family, spouse, and children.

2.2 Depression: A common Mood Disorder

According to the World Health Organisation (2004) report, depression is one of the most common mental disorders with a worldwide prevalence of 340 million people. It is known to be the leading cause of disability in the European regions and has become a prioritised mental disorder.

2.2.1 Definition of Depression

Paxton Valois, Watkins, Huebner & Drane (2007: 273) defines a depressed mood as sadness that occurs and lasts for a few minutes to hours. He describes clinical depression as sadness accompanied with other symptoms that alter normal functioning

and can last for two weeks or more. Otong (2003) describes depression as a mental disorder that is caused by the chemical imbalances in the brain mostly due to psychosocial stressors. Stuart and Laraia (2001: 346) describe depression as a pathological reaction to grief.

Frisch and Frisch (2006: 262) states that depression is divided into two broad categories, namely unipolar and bipolar depression. Unipolar depression is diagnosed when a patient's mood is always low. Bipolar depression is diagnosed when a patient's mood swings to a manic or hypomanic level thus resulting in a combination of depression and mania.

According to the Diagnostic and Statistics Manual – Text Revised (DSM IV – TR) classification, there are three types of depressive disorders. The first type is major depression and it is described as a depressed mood accompanied with loss of interest in the surroundings and no participation in the pleasurable activities, which the patient enjoyed prior to the episode. Major depression is known to cause a disruption in the social and occupational functioning of an individual. The second type of depression is dysthymic disorder, which is defined as a sad mood occurring most of the day and more often than not lasting for at least two years. The third type of depression is a depressive disorder, not otherwise specified, that does not meet the criteria of major depression or dysthymia. Among the three types of depression, major depression is the most disabling type and it has a tendency to recur (APA, 2000).

Major depression impairs the normal functioning of a patient. It is noted that the first episode has worse effects on the patient than the subsequent episodes because it requires a patient to work hard to cope with the changes associated with depression. The responsibilities resting on a patient such as being the sole breadwinner of the

family add to the burden, making the situation worse for the patient (Skarsater, Baigi & Haglund, 2006).

2.2.2 Clinical Manifestation of Depression

The symptoms of depression include among others, feelings of worthlessness, suicidal thoughts, lack of interest in pleasurable activities, agitation and sleep disturbance. Some people become socially withdrawn and fatigued. Some express a feeling of emptiness and body aches without a related cause (Frisch & Frisch, 2006).

Mustapha (2005) notes that depressed patients can sometimes complain of severe physical symptoms such as aches, general body pain, sleep disturbance, change of eating habits and sexual dysfunction. A survey conducted on depressed patients in a hospital in the United Kingdom (U. K) revealed that 43% of the patients complained of pain and general body aches (Mustapha, 2005).

2.2.3 Prevalence of Depression

Grigg (2003) states that according to a World Health Organization (W.H.O.) report, it is projected that major depression might be the second leading disease-causing burden by 2020. Major depression has the tendency to recur and 25% of patients may experience chronic depression. Solomon, Keller, Leon, Mueller, Lavori, Shea, Coryell, Warshaw, Turvey, Maser, and Endicott (2000) suggest that the average prevalence is 16.2% while (Frisch & Frisch, 2006) give a comparison in prevalence between men (7-12%) and women (20-25%). Depression is therefore more prevalent in women than in men. Stuart and Laraia (2001) note that 10 % of the general population is affected by depression in the United States of America (U.S.A).

In 2005, the prevalence of depression in South Africa was, 41.9% of women and 24.3% of men (Xoliswa, 2005). The situation is worsened by a lack of adequately

trained personnel, which results in patients having to wait for as long as 11 months to see a doctor. To make matters worse, depression could be correctly diagnosed after the fifth visit. This contributes to the high prevalence of suicide especially among adolescents (Xoliswa, 2005). According to Jarvis, Shaibes and Middleton (2002) 15% of the severely depressed patients, the majority of them being adolescents, end up committing suicide.

Jarvis, Shaibes and Middleton (2002) describe depression as the common cold of psychiatry due to its high prevalence when compared to other psychiatric conditions. For example, Oberholzer (cited in Uys, 2004) found out that 75% of psychiatric patients admitted to GaRankuwa hospital in South Africa were due to depression. They, however, note that the statistics that existed may not have captured all of the cases partly because the condition may have been misdiagnosed among the blacks in Africa. Jarvis, et al (2002) remark that out of three patients seen, two of the patients with depression were misdiagnosed. In the Western Cape, a study initiated by the Provincial Government revealed that depression ranked second as the most prevalent mental disorder with the greatest burden of disability (Kleintjes, Flisher, Fick, Railoun, Lund, Molteno & Robertson, 2006).

2.3 Family and Depression

The effects of depression on the family are discussed under three broad subtopics: The effects it has on the spouse carer, on the relationship between the spouse carer and depressed partner and the impact of depression on the children as close family members. Even though a discussion about effects of depression on children may seem to be irrelevant, the aftermath of depression among the spouses spills over to the children. In addition, children, being close members of the family may worsen the

depression or improve the well being of the parent depending on how they relate with the depressed patient at home.

2.3.1 Factors Contributing to Depression

Rejection by close associates may lead to depression. Granek (2006) discovered that a break-up of a romantic relationship often resulted in depression. She attributes this to the fact that most of the participants recruited in her study defined themselves based on a relationship; for example, they ascribed self worth to loving and being loved. Participants experienced psychosomatic pain, felt unworthy, rejected and blamed themselves for the break-up of the relationship. Consequently, isolation and loneliness set in as they craved to be in a relationship, which they were unable to initiate and sustain.

Jeglic, Pepper, Ryabchenko, Griffith, Miller and Johnson (2005) suggested that living with a depressed partner increases the risk of becoming depressed. Similar studies that were done on students sharing a room with depressed colleagues in a college revealed that they ended up getting depressed themselves (Joiner, 2002). If a casual relationship of sharing a room in a college could result in colleagues developing depressive symptoms then the spouses of depressed patients could be worse affected. This was confirmed by studies conducted by Nill and Coyne (2000); Coyn et al (1987) & Dudek, et al (2001). These studies showed that living with a depressed spouse increases the chances of the spouse carer developing symptoms of depression themselves.

2.3.2 Factors Alleviating the Depression

Lamb, Lee, and Demalis (2003) revealed that marriage acts as a booster to psychological health. They attributed this to the support that the spouses offer to one another ranging from sharing the burden of hardship to pooling resources for their

mutual benefit. They cited several studies that confirm marriage to be a booster for psychological health. Studies conducted by Brown and Moran (1997) affirm that married people are less vulnerable to depression compared to their unmarried counterparts. However, Williams and Umberson (2004) partly disagree with Lamb, et al. (2003) and argue that middle-aged men seem to get healthier after divorce or death of a spouse. William and Umberson (2004) from their longitudinal study observe that men tend to benefit more from marriage during the early years of marriage, but rate equally with the unmarried men after three years into marriage. They also note that the magnitude of stress, due to the death of a partner or loss of marriage through divorce, is perceived by middle-aged men to be mild as compared to the eminent chronic stress in their marriage. This could be true for unsatisfying relationships marred with conflicts as depicted by Coyne, Thompson and Palmer (2002).

According to Jacobson, Fruzzetti, Dobson, Whisman and Hops (2002); Harris, Pistrang and Baker (2006) the quality of a relationship affects the recovery of the depressed spouse. They concur with Papp, Goeke-Morey, and Cummings (2007) in emphasising the need for couple therapy as opposed to therapy focusing on only the patient. Jacobson et al. (2002) note that couple therapy plays a role in preventing episodes of depression.

Jeglic et al (2005), Mead (2002) and Skarsater (2006) suggest that clinicians attending to depressed patients should consider involving the spouses and other close family members who provide social support in the treatment plan. They mention that behavioural marital therapy for depression and cognitive therapy are some of the proved options that could be implemented to help alleviate the depression (Jaglic et al. 2005).

Jacobson et al (2002) suggest that a cordial relationship between the spouse carer and depressed partner enhances successful treatment. Involving both the depressed spouse and spouse carer facilitated the recovery more than when the treatment was simply geared towards the patient. They observe that mutual support between the spouses during an episode seemed to lessen the severity of the depression. Furthermore a good relationship during therapy increased the recovery rate and reduced the chances of relapse (Jacobson et al, 2002).

2.3.3 Depression and Marital Relationships

According to Sacco and Phares (2001) marital satisfaction is compromised when the spouse carer views the depressed partner negatively. Spouses of depressed patients often have negative attitudes towards the depressed partner (Benazon, 2000). The negativity exhibited by the spouse carer towards the depressed partner worsens the marital relationship leading to the breaking up of the family (Coyne, Kessler, Tal, Turnbull, Wortman, & Greden, 2004).

Papp, Goeke-Morey, and Cummings (2007) observe that the severity of depressive symptoms and inability to resolve marital conflict are directly related. They agree with Elliott, Rivera, Beny, Oswald, Adams and Grant (2006) regarding the notion that depression affects the ability of families to solve problems. Partners are therefore unable to resolve marital conflict. This is associated with exposition of negative behaviour such as withdrawal, physical distress and aggressiveness towards other members of the family. The negative behaviour exhibited by the depressed spouse leads to diminished emotional well-being of the spouse carer (Papp et al 2007).

The negativity associated with depressive symptoms from the spouse carer contributes to conflicting interactions within the family (Elliott et al, 2006). The affected family interaction can totally diminish the quality of the marriage when one spouse is

depressed, especially the wife. (Coyne et al, 2002). Depending on how well the spouse carer treats and responds to the depressed partner, the relationship may get better or worse. This is because depressed spouses get more affected by the way their significant other responds to them. Coyne and colleagues conclude by urging that professionals who provide care to the patient need to consider the spouse carer in the treatment plan since they may be equally affected (Coyne et al, 2002).

Harris et al (2006) agree with Jeglic et al. (2005) that living with a depressed spouse increase the chances of the spouse carer developing depressive symptoms which emanate due to the psychological burden of care. They note that depression in a family result in marital conflicts mainly due to communication breakdown. The marital conflict may deny the depressed spouse the emotional support he gets from the partner hence sparking an episode of depression or worsening it (Harris et al, 2006). Intense feelings of depression are associated with family dysfunction in particular during an episode of depression or even after an episode (Van Wijngaarden, Schene & Koeter, 2004).

Schmaling and Jacobson (2002) argue that depression coupled with marital distress have more severe consequences on the family than depression alone. Their study “Marital interaction and depression” compared one group of families with one partner being depressed but without marital distress to another group of families with one partner being depressed and experiencing marital distress. The study revealed that marital conflict was more prominent in those families where the spouse was depressed and experiencing marital distress. These findings are supported by findings from studies conducted by Van Wijngaarden , Schene, and Koeter 2004; Hammen (2003).

2.4 Depression and Spouses

2.4.1 Factors Affecting Spouse Carer

According to Nili and Coyne (2000); Norton (2002); Stimpson, Peek and Markiders (2006), women carers are more vulnerable, depressed and overburdened by the caring than men carers. Women are identified to be sensitive to the needs of the family and become more affected by the health of their spouses. They identify the needs of their families and work unselfishly to satisfy each family member's needs at the expense of their own health. This predisposes women to depression. However, the fact that they are known to vocalize their psychological distress puts them in a better position to cope than the men.

Attending to different people within and outside the family overwhelms the women who forget their own needs, putting them at risk of getting depressed. This is confirmed by the findings of Dudek, Zieba, Jawor, Szymaczek, Opila, and Dattilio, (2001) which reveal that depression had more of an effect on the female spouses than on the male spouses. The women spouses exhibited severe symptoms of depression, distorted thinking and perceived the relationship in the family to be worse than the men would. However, Rotermann (2007) observes that depression that results as an aftermath of family dissolution affects men more than women. Rotermann attributes this phenomenon to the loss of social support, which affects men more than women.

Brody (1998) comments that the problem is worse when it is a man taking care of a depressed spouse because he may not admit that he is also affected and needs professional help. Meighan, Davis, Mitzi, Thomas and Droppleman (1999) found that the men felt more frustrated, angry and confused because they felt helpless. This results in men blaming themselves and feeling irritated, despite them trying to show compassion towards their spouse (Mead, 2002). Men living with depressed partners are significantly impaired psychologically. Men living with depressed spouses exhibit

behaviour such as aggressiveness, anxiety, distress and fatigue (Roberts, Bushnell, Collings & Purdie, 2006).

Jeglic et al (2005) support the notion that the depressive symptoms in the spouse carer could be due to perceived stress associated with the burden of caring and not necessarily the actual care. They found that most of the carers developed the depressive symptoms due to subjective feelings of being overburdened by the caring and not the actual caring activity. Coyne et al. (2002) found that some of the spouse carers see their depressed spouses as burdensome due to their inability to function socially and attend to the activities of daily living.

Wittmund, Wilms, Mory and Angermeyer (2002) describe three aspects associated with the burden of care. The first aspect is the burden of coping with the patient's impairment, for example lack of interest in pleasurable activities and lack of energy to participate in personal care. This leaves the spouse carer with no choice other than doing everything in the house to meet the daily needs of the family. The second aspect is lack of social support. Often due to stigma, spouse carers avoid asking for assistance from their relatives and friends and subsequently work hard to meet the needs of the family without support. Thirdly, they describe the aspect of increased responsibility for the spouse carer. The depressed spouse is unable to contribute positively to the well being of the family. The spouse carer takes up all the responsibilities to keep the family in balance. This becomes overwhelming to the spouse carer and leads to depression symptoms in the spouse carer. The authors conclude that the burden of caring for the depressed spouse is directly proportional to the spouse carer developing symptoms of depression.

2.4.2 Factors Improving the Caring Experience

According to Harris, et al (2006) an appreciative response from the depressed spouse gives the spouse carer motivation to provide better care. Such a positive response from both the depressed spouse and spouse carer is linked to a satisfying relationship in marriage (Sacco & Phares, 2001). Johnson and Jacob (2000) associate the positive response to effective problem solving in the family, thus enhancing a cordial relationship. Jacobson et al (2002) add that depressed women spouses benefit more from a cordial marital interaction and intimate relationship than depressed men spouses.

Harris, et al (2006) concluded that effective spouse support was equated to open communication without judgement, trust between the depressed spouse and the spouse carer and acceptance of each other. However, they noted that the most challenging issue about support was that the spouse carer was unable to understand explicitly the feelings of the depressed spouse, because the depressed spouse could not explain his/her feelings well in words, especially during an episode of depression. This prompted the spouse carer to guess the emotional needs of the depressed partner. Sometimes the presumed emotional care was of no value to the depressed spouse.

Harris et al (2006) mention that spouse carers felt frustrated, impatient and angered at times but could not share it because it could worsen the patient's condition and therefore they did not verbalise the feelings. These feelings accumulate and lead to the spouse carer feeling overwhelmed, hence developing depressive symptoms. From their study, none of the participants mentioned that they received any support from professionals e.g. the professionals occasionally supported the depressed spouse and not the spouse carer (Harris, et al 2006). Verbalisation of feelings by the spouse carer could reduce the risk of getting depressed. By not expressing their feelings may be

beneficial to the depressed spouse but may jeopardize the carer's psychological well being.

Harris et al (2006) observes that even though spouse carers develop depression while providing care for the patients, a large percentage did not seek help. Harris et al (2006) attribute this to stigma and therefore the spouses tend to struggle on their own. They advise the spouse carers to seek help from relatives and friends as this may lessen the burden. The same sentiments are suggested by Nill and Coyne (2000) who mention that sharing responsibilities in a home may be a better strategy to reduce the burden of care. However, (Skarsater, 2006) cautions that the patient's need of a quiet environment during the recovery stage should be given due consideration when planning to seek help from relatives. Nill and Coyne (2000) further add that utilising better coping strategies may help to reduce depressive symptoms in the carer thus stabilising the emotions of the depressed partner.

2.4.3 Challenges of Spouse Carer

Denial is one of the characteristic features that manifest itself especially in depressed male spouses (Anonymous, 2000). The denial may result in a perplexing situation where the spouse carer is unable to help the depressed partner out of the mental disorder because he does not accept that he is sick and needs professional help. This confusing situation may lead the spouse carer to exhibit depressive symptoms because she lacks an alternative solution since the depressed spouse is in denial (Anonymous, 2000). For example in the story of Astronaut's wife, the spouse carer tried all ways possible to convince her husband that he required professional attention but he adamantly refused. The Astronaut's wife finally diverted her attention to the children because the husband was not getting any better and was not ready to seek professional help, an idea that she persistently suggested to him but he still denied

being depressed (Anonymous, 2000). The shifting of her attention to the children is a sign of losing hope in the husband, which could worsen the depression of the husband. The shifting of her attention to the children may be to seek recognition and appreciation, which she was not getting from her depressed spouse.

According to Newsome and Schulz (1998), care offered to the depressed spouses can elicit feelings of distress in the patients. Newsome and Schulz (1998) found that in 40% of patients who were distressed it was due to the care given to them. They attributed the distress to low self-esteem. Inability of the depressed partner to care for herself resulted in her being dependent on care from her spouse and this reduced her self esteem thus she became distressed. Marital distress may require professional intervention. Couple therapy is suggested to be a good alternative to improve marital quality (Papp, Goeke-Morey & Cummings, 2007; Schmaling & Jacobson, 2002).

2.5 The Effects of Depression on the Children

Manning and Gregoire (2006) note that parental depression affects children directly. Poor child care, coupled with the lack of early childhood attachment to the mothers affects the children socially, emotionally, behaviourally and impairs their cognitive function for their entire life. Nili and Coyne (2000) state that after a prolonged period of living with the depressed spouse, the patient may give up and the reassurance that she or he had been receiving from the spouse may not hold water any more. Mead (2002) therefore recommends that it is important to offer professional intervention to impart coping skills to both the patient and close family members.

According to Margolese, Markiewicz, and Doyle (2005), girls in the adolescence age tend to seek help from their mothers during distressing periods. Attachment to the mothers then plays a great role during the times when they require help. A strong relationship between mother and a female adolescent helps them gain autonomy as

teenagers. This means that if the mothers are unavailable to them, they also become stressed and finally they get depressed.

Mowbray and Mowbray (2006) mention that maternal depression may have more effects on children than paternal depression. Furthermore, they found that the children whose mother or father is depressed are at high risk of mental illness. They mention an example of a research study done in 1997, which revealed that after 10 years, children of depressed parents ended up being mentally ill. They conclude that a child whose parent is depressed needs to be reassured that the parent will get well and will continue to attend to them.

Children of mothers who are victims of chronic depression or bipolar mental illness were observed to engage in alcohol abuse and develop behaviour problems including breaking the law in their adult years. However, research shows that their behaviour could improve when somebody that they trust provided care on behalf of the sick mother. Explaining to children about the parent's mental illness could improve their understanding to avoid blaming themselves when their mother is in an episode and not ready to play with them (Mowbray & Mowbray, 2006).

2.6 Conclusion

According to the literature, depression is one of the most disabling and common mental illnesses that people present with in the primary health services. However, it is often misdiagnosed especially at its initial stages. Having a close interaction with the depressed person increases the risk of getting depressed. The risks increase in a case of intimate relationship. Depression in a family affects all the family members. This could be as a result of inappropriate behaviour exhibited by the depressed partner such as social withdrawal and inability to participate in meeting expected family responsibilities. As a result, the spouse carer may develop a negative attitude towards

the depressed partner. Due to the negativity associated with the relationship, communication between them and problem solving skills are affected, hence leading to marital conflict. The marital conflict may get better or worse depending on how the spouse carer may approach it. Sometimes, the marital conflict results in marriage dissolution, but with intervention of professional care, it may be saved.



CHAPTER THREE

Research Methodology

3.1 Introduction

In this chapter the research methodology used for the study will be described in detail.

The methodology chosen involves a qualitative paradigm and phenomenological research design. A qualitative paradigm was chosen as the most appropriate because it entails the exploration of the lived experience of a person. The lived experience being the focus of this research, a phenomenological design was chosen because the researcher is interested in understanding the phenomenon, which is the experience of living with a depressed partner. A detailed explanation of recruitment of the participants, data collection and analysis is presented systematically. The trustworthiness of the study as well as the ethical consideration is discussed. An explicit conclusion that summarises the pertinent component of methodology marks the end of the chapter.

3.2 Research Design

This study adopted the qualitative paradigm and phenomenological design to explore the feelings and experiences of the spouses living with depressed partners. The theory about the origin of the qualitative research and the phenomenological study design including the suitability to the study is discussed below (Creswell, 2003).

3.2.1 Qualitative Research

Qualitative research originated from the “American sociology” used in studies involving “cultural anthropology”. Its main aim is to seek to understand a specific social interaction. It enables a researcher to explore a phenomenon that has not been exhaustively explored in its natural environment (Creswell, 2003:198).

The qualitative paradigm seeks in-depth understanding and “knowledge about a specific phenomenon” in its natural environment (Myburgh & Poggenpoel, 2007; Marshal & Rossman, 2006; Maxwell, 1996). According to Richards (2003), the qualitative paradigm is person centred. This means that each individual participant’s experience is taken into consideration as an unique entity. It seeks to explore how the participants interact with their social world. That is why Creswell (2003) recommends that a qualitative researcher needs to meet participants in their natural setting to be able to contextualise the experience of the participants.

Richards (2003: 9) explains that in a qualitative inquiry, the researcher is actively involved in the whole process and becomes part of the research. The prolonged engagement especially during data collection requires that the researcher gets involved in the participant’s world to be able to understand what a phenomenon means to the participant. It is because of this reason that Creswell (1998: 52) emphasises that qualitative researchers bracket their own preconceptions of the phenomenon being investigated to avoid influencing the experiences of the participants. This is especially true of the phenomenological study design as depicted by Creswell, 1998: 52).

Neuman (2003:145) remarks that qualitative research entails in-depth face-to-face interviewing to collect data. The data collected is in the form of words, observations and transcripts. The data analysis requires that the researcher get immersed in the data to be able to understand the phenomenon from the participant’s point of view. This is achieved by organising the data to form themes, which then are contextualized and conceptualized to understand the meaning attached to the phenomenon. The researcher getting absorbed in the data collected, and interpreting it to make sense of the phenomenon ensures a clear understanding of the participant’s view of a

phenomenon. The phenomenological study design, its origin and its suitability are discussed next.

3.2.2 Phenomenological Study Design

According to Heidegger (1977) cited in Creswell (1998: 51) phenomenon means “to bring to light” It also refers to clarifying information about which there is little known or enlightens that which is not known. According to Creswell (1998: 51) phenomenological studies involve more than one individual subject and describe the meaning of their lived experience. The origin of phenomenology dates back to between 1859 and 1938 and it was developed by a German mathematician called Edmund Husserl as a philosophy. Heidegger later introduced it as a research design and a philosophy. Since then it has been used in social sciences, psychology, nursing and other health sciences (Creswell, 1998: 52).

According to Giorgi and Giorgi (2008: 168) a phenomenological study entails the interpretations of the lived experience of a person. The experience is assumed to have some meaning to the person. A phenomenologist therefore seeks to understand what the experience means to the subject. The researcher then describes the meaning as it unfolds from the participants` narratives. Therefore the phenomenological study design is both descriptive and interpretive in nature. The descriptive aspect “allows things to speak for themselves” and ensures that the researcher describes things that emerge without influencing them. It is also interpretive because the researcher interprets the issues from data to construct meaning about the phenomenon (Giorgi & Giorgi, 2008: 168).

The fact that qualitative research requires a phenomenon to be holistically explored, gives the spouse carers an opportunity to share their experiences about living with the depressed partner. Creswell (2003: 198) mentions that the more interactive the

process, the better because it yields rich data that also enhances the credibility of the study.

3.2.3 The Design of Choice

The phenomenological approach was selected as the most appropriate study design for this study because it provides the participants the opportunity to give a detailed account of “lived experience” from the participants’ perspective (Lichtman, 2006; Marshal & Rossman, 2006). Creswell (2003) states that a phenomenological study seeks to uncover the meaning of experiences of a person with a given phenomenon. The participants’ experiences were explored concerning living and caring for their depressed spouses. According to Creswell (1998) the phenomenologist assumes that an experience makes sense to those people who live in it. The researcher then seeks to understand and describe the meaning of the experience from the participants’ point of view (Boor & Wood, 2006: 128). In the current study the researcher explored the experiences of the spouses who live with depressed spouses.

It is against this background that the researcher chose to use the qualitative paradigm and phenomenological study design to explore the experiences of living with depressed partner. Since the nature of qualitative study requires that the researcher meets the participants in their natural environment, participants suggested a place familiar to them. Some of them chose to be interviewed in the hospital premises to avoid distraction from other family members while others felt that their home was the most ideal place for the interview. A narrative approach was used to enable the participants to tell their story about the experience.

According to Neuman (2006: 474), a narrative is a story told to explain an event. Boor and Wood (2006: 119) describe narrative as a continuous story that can give an account of an experience. Each participant was given adequate time to narrate his or

her experiences related to living with and providing care to the depressed spouse. Narratives can be one way of gathering data and can be either oral or written. The question “share with me as much as possible about your feelings and experiences while living with a depressed spouse” elicited an oral narrative. Participants in the current study were given time to exhaustively narrate their stories with minimal probing to redirect the narrative. However, occasionally the researcher had to ask probing questions especially in the case of participants whose responses were too brief. The narratives were read several times to identify themes, which were then conceptualized to uncover the meaning attached to the experience.

3.3 Recruitment of Participants

A purposive sample composed of seven participants was recruited. According to Boor and Wood (2006) a purposive sample entails the selection of participants most suitable to provide information that is of interest to the researcher. Since an in-depth understanding of each participant’s experiences was sought, a small sample was recruited (Maxwell, 1996: 70). Creswell (2003: 15) suggests that a small number of participants is suitable for a qualitative phenomenological study because it requires prolonged engagement between researcher and participants. In order to recruit the most suitable participants to the study, I drafted the following inclusion criteria:

- Spouses whose partners are diagnosed as suffering from clinical depression as described in APA (2000).
- Male and female partners living together for at least three months
- Those who are 18 years or older
- Those who are willing to participate in the study

After getting permission from the hospital ethics committee, I visited the hospital's outpatient department to introduce myself to the staff. I discussed the study with the clinical consultant of the outpatient department who was in charge of the department to seek his assistance in identifying participants. He introduced me to the sister in-charge of the unit. I wrote an information sheet comprising a brief description of the study and inclusion criteria. I provided a copy of the information sheet to each clinician so that they might assist in identifying suitable participants. I requested them to forward the names and cell-phone numbers of potential recruits to the sister in-charge from whom I collected the contact details.

I contacted the potential participants by phone and those who accepted the invitation to participate were interviewed at a date convenient to the researcher and them. Some of the participants who were recruited were those that were accompanying their depressed partners for a follow-up visit or psychotherapy in the outpatient department. Some of the participants were comfortable to be interviewed in the hospital after the first contact session after being briefed about the research by the researcher. Those whose spouse carers did not accompany their partners to hospital for therapy were contacted on their cell-phones. I introduced myself telephonically to the potential participants and most of those that I contacted accepted to participate in the study. After contacting them, some of them chose to come to the hospital for interviews to avoid distraction from other family members. Some suggested that they were comfortable being interviewed at home. After recruiting appropriate participants, the interviews were scheduled and the process of data collection commenced.

3.4 Data Collection

According to Marshall and Rossman (2006: 97), data collection is the procedure researchers utilise to implement the research design. It is described as an accurate,

organized method of gathering information pertinent to a study. Patton (1990: 283) suggests that a qualitative researcher is required to get close to the participants and the phenomenon being investigated to be able to understand the phenomenon better during data collection. This allows the researcher to capture data comprising of what the people actually said. The data collected by the researcher consists of descriptions of situations, activities and settings under which the phenomenon took place (Patton, 1990).

The data collection process started when I introduced myself and the aims of the research to the participants. I then allowed the participants to introduce themselves before commencing the interview. The interview started after filling in the consent forms, and capturing the demographic data.

The in-depth interview was the main technique used to collect data. Richards (2003:50-54) suggests that for a researcher to be able to conduct an interview, good listening skills must be mastered and used properly. Richards (2003: 50-54) goes on to say that such skills can be learned and perfected as the researcher conducts more interviews. Caution is however given that without creating a good rapport with the participant, little of the experience will be revealed in the interview. Richards (2003) adds that prompting is equally important to ensure that rich data is obtained while conducting interviews. Probing questions were used to extract as much information as possible, so that details about their experiences might surface (Richards, 2003:50-54). Good listening skills helped me to gather data, as it eventually emerged that most of those who participated really needed someone to listen to them.

The following data collection instruments and techniques were used to collect data: a demographic questionnaire, face-to-face interviews and unstructured observation that was captured in the field notes.

3.4.1 Data Collection Instruments

In depth face to face interviewing is one of the important approaches used by qualitative researchers to collect data. Marshall and Rossman (2006: 101) describe such an interview as “a conversation with a purpose”. The interview guide comprised of one major question with five open-ended questions that was used for probing. The main reason for using these questions was to direct the conversation and to assist in organising the data to make it easy for analysis (Gerson & Horowitz, 2002: 210). In the current study, the researcher used one broad question “Share with me as much information as you can concerning your experience and feelings about living with a depressed spouse” and asked probing questions to seek more information where necessary (Appendix C, part B).

Face-to-face interview was the primary data collection instrument used. Gerson and Horowitz (2002: 210) mention that early interviews can be used to inform on anything that may be altered to improve the subsequent interviews. The first two explorative interviews were transcribed and analysed before continuing with the process of data collection. They were used by the researcher to identify gaps in the data collection process and for the researcher to refine his interviewing skills before conducting subsequent interviews. The data collected in the two interviews was included in the analysis because they were considered to be equally important to the study.

The demographic questionnaire was used to capture the characteristics of the participants recruited to participate in the study. Information included the age of the participant; the period she/he had lived together with the depressed spouse; the employment status; the source of emotional support and whether they had children. All this information was used to contextualize the experience of the spouse carers.

Marshall and Rossman (2006) suggest that field notes provided additional information and should contain a description of the social setting and objects in the environment of the interview. Unstructured observations were used to obtain data and the participants' non-verbal communication was captured in the field notes. This included body language such as mannerisms, facial expressions and sign language used by the participant to add meaning to narratives.

3.4.2 Data Collection Process

Data collection was done between August and September 2008. After recruiting participants, the venues and time for interviews were jointly planned by the researcher and participants. The venues that were convenient to both were booked. I employed specific techniques to build rapport and to make the participant comfortable and ready to start the interview. These techniques included a brief introduction of myself to the participant who was then invited to ask questions about the research before the interview commenced. Creswell (2003:181) mentions that since a qualitative study requires more extensive involvement of the participants in the data collection it is important for the researcher to build a good rapport, before commencing with the interviews.

The researcher explained to the participants about the aim of the research and the expected benefits for both the researcher and the participant. Besides the researcher developing skills in research and participants contributing to the world of research, the research findings may be of use for academic and professional purposes.

Face-to-face interviews were conducted which made provision for the researcher to observe the participants' body language while they told their story. The interviews, the field notes and the prolonged engagement between researcher and respondent yielded rich data. Creswell (2003) recommends that multiple data collection

techniques result in the collection of more meaningful data, which adds to the rigour of the study. The interviews were audio taped with the permission of the participants. I also recorded field notes comprising of the observations made during the interview (Maxwell, 1996). The observations included participants' body language as this may portray the deeper feelings expressed by the participants (Lankshear & Knobel, 2004: 229; Maxwell, 1996: 76). Some of the field notes were written during the interview session but the bulk of it was written immediately after the interview session. To avoid any confusion during transcribing, each interview was audio taped on a separate audiotape.

Participants were allocated pseudonyms to ensure that any other person could not identify them. Confidentiality is one of the ethical issues that was taken into consideration during the data collection process. Participant names were assigned codes to make it easy for the researcher to identify the data during transcription. Along with the codes, the dates and times of the interviews were recorded on each transcript.

According to Gerson and Horowitz (2002) a careful and detailed data collection process results in reliable and believable data. Rich data may be realised by ensuring that data saturation is achieved by conducting adequate data collection sessions until no new information emerges (Neuman, 2006). In the current study each interview session lasted for 40 to 60 minutes and saturation reached after seven interviews. The interviews were conducted in English.

The audiotaped data was transcribed verbatim as soon as possible after the interview. After transcribing, I met some of the participants to confirm if the transcripts were true to what they had said during interview. The audiotapes and the field notes were

kept under lock and key during the data analysis phase and will be destroyed after completion of the research study.

3.5 Data Analysis

According to Creswell (2003: 191) data analysis for a phenomenological study entails the analysis of important statements made by participants concerning their experiences. The statements are classified into meaningful units, which are then described to uncover the experience related to the phenomenon. Neuman (2006) notes that data analysis entails looking for patterns of recurrent phrases, behaviours and ideas in the raw data. The identified pattern is then interpreted in relation to the setting where data was collected to uncover the meaning it holds for the participants. Merriam (2002:14) observes that data analysis is done concurrently with data collection. This is meant to guide the researcher to make adjustments accordingly as the process of data collection continues. The first two interviews were analysed to identify gaps that were attended to in the subsequent interviews.

The raw data was organised by ensuring that each transcript had a code, time and place where the interview was conducted. Field notes were also organised by matching them with the respective transcripts to avoid confusion during the analysis. Lichtman (2006) mentions that data should be well organised before the researcher starts the process of data analysis.

The researcher started the actual data analysis with careful reading through the transcripts while reflecting on the research question. The researcher focused on statements related to the research question. The statements were given a code that was written in the margin next to the paragraph. Neuman (2006) refers to this as open coding which helps to reduce the voluminous data into smaller manageable piles and makes it easy to retrieve relevant parts of the data.

In the subsequent reading of the same transcript, the researcher focused on the codes. Codes emerged as I read through the sentences in the transcripts. In most cases, sentences were coded depending on the information contained in them and if they were related to the focus of the study. In some instances when the sentences did not provide meaning, paragraphs were used to code the transcripts. After coding, all the codes were listed and cross-examined to identify the common, similar and different codes. This process was done for all the transcripts. Similar codes were grouped together to form categories. The similar categories were then grouped together into themes. The process of identifying codes was done more than once. Occasionally, new codes were identified during subsequent readings. The field notes formed an integral part of the data analysis process. The non-verbal communications of the participants were captured in reflective notes and added context to the analysis. For example, cross examining the transcripts reveals that those respondents who used less of the negative connotations to describe their partners provided stronger support to their depressed partners as compared to those who used more negative expressions. It is also revealed that those spouse carers who used fewer negative connotations were receiving professional support (see 4.3.4.2) besides family and friend support. Even during the interview day, the spouse carers who were receiving attention from professionals seemed more relaxed as compared to those spouse carers who were not receiving any professional intervention and who displayed perturbed expressions. The field notes were incorporated in the reflective notes.

In the current study, four themes emerged from the data. The themes were then conceptualised to unveil the meaning that the spouse carers attach to their lived experience while living with the depressed partner. Further more the demographic data contextualised the findings, and added meaning to the concepts that emerged

from the analysis to the participants. Lichtman (2006) refers to this process as inductive analysis where researchers immerse themselves in the raw data to identify patterns, codes, categories and themes in the transcripts. Neuman (2006) explains that themes can be generated from the research question, concepts in the literature, terms frequently used by friends and thoughts that come as one reads through the transcripts. The concepts that were generated during the data analysis will be described in chapter four.

3.6 Trustworthiness of the Study

According to Myburgh and Poggenpoel (2007) trustworthiness refers to the extent to which the data collected reflects the perceptions and experience of the participants.

Creswell (1998) explains that trustworthiness and authenticity of a study refers to the credibility of the study.

Credibility of the study was ensured by prolonged engagement between researcher and participants. Creswell (2003) argues that prolonged engagement with the participants results in a detailed description of the experience of the participant and the natural environment. The detailed description adds to the accuracy of the study.

Probing questions were asked to uncover more information during the interview sessions. This was done until no new information was obtained from the participants.

Creswell (2003) mentions that saturation of data is one of the ways to ensure credibility of a study. Saturation was reached after the seventh interview.

Triangulation in data collection involved capturing demographic data, conducting face-to-face interviews, and writing field notes. The verbatim transcription added to the credibility of the study.

The transcribed data was taken to the participants to confirm that what was typed was what they said during the interview. Data analysis was also checked with my research

supervisor. Creswell (1998: 203) notes that member checks are one of the important techniques that can be used to ensure that findings and conclusions are accurate.

In-depth interview to collect data and the detailed descriptions of the participants was used to ensure transferability. Creswell (1998: 203) suggests that in depth interview coupled with prolonged interaction with the participant will provide a detailed account of the participant and the setting. The detailed description of the study setting allows the reader to assess the extent to which the results of the study can be transferable to their own settings.

Neutrality of the researcher was achieved by identifying information already known about the topic. I bracketed my experience and attitude concerning the research before commencing the interviews to avoid influencing the research findings. Creswell (1998) asserts that the researcher should identify the sources of bias so that the reader understands the researcher's opinion regarding the topic in question. This will ensure that the researcher remains neutral and does not influence interpretations of the study (Myburgh & Poggenpoel, 2007).

Creswell (1998) also recommends that a qualitative researcher should use at least two procedures to monitor the trustworthiness of the findings of a study. I used member checks and transferability, neutrality and prolonged engagement to ensure that findings are credible and applicable.

3.7 Ethical Consideration

To conduct the research, I applied for ethical approval from the Higher Degrees Committee of the University of Western Cape and the ethics committee of Lentegeur Hospital, Western Cape Province. The aims, benefits and risks involved in participating in the study were explained to the participants before they signed the

consent forms. Confidentiality was guaranteed and the participants were allocated pseudonyms.

The data collected was kept under lock and key as we had agreed with participants. The researcher alone listened to the audiotapes. I allocated pseudonyms to the participants to avoid anybody identifying them. It was explained to them that participation was voluntary and that they were allowed to withdraw from the study without giving any reason. I ensured that the participants were not subjected to harm by recruiting one of the psychiatric nurses at Lentegeur Hospital to debrief and comfort the participants whenever they felt distressed during and after the interview.

3.8 *Permission to Conduct Research*

Permission to conduct the research was granted by the Higher Degree committee of the University of Western Cape. Using the letter given, I made an application to Lentegeur Hospital to allow me to collect my data in May 2008. Permission was granted three months later in mid August 2008. The participants gave consent by signing the consent forms at the beginning of every interview session.

3.9 *Delimitation of the Study*

The study was conducted in Cape Town, Western Cape Province South Africa. The study was not limited to any race, culture or language. Despite the fact that Western Cape Province is a multiracial province, the majority of the participants were coloureds with one participant being black. All the participants understand and spoke English. The study aimed to explore the experiences of spouses living with a depressed partner. Despite the fact that depression is a common mental illness, few people with depression could qualify to participate in the study because most people with depression were already either separated or divorced. Besides, some of them,

especially the men, were still in denial and did not accept that their partners were being treated for depression.

3.10 Conclusion

This chapter described the methodology used by the researcher to uncover the meaning the participants attach to the experience of living with a depressed partner. A qualitative paradigm, phenomenological study design was used to explore the lived experience of spouse carers living with depressed partners. A purposive sample of seven participants was recruited and interviewed at a convenient date and place. The interviews were audio taped and transcribed verbatim ready for analysis. The study was conducted in Cape Town based at Lentegeur Hospital. Research ethics were adhered to in respect of each participant's rights especially during data collection. The research outcomes will be presented in the next chapter.



CHAPTER FOUR

Research Outcomes

4.1. Introduction

In this chapter the details of the data analysis is presented. The data that was collected was analyzed through the inductive process by organizing the data into codes, categories and themes. The themes were then conceptualized to provide information about the experiences of spouse carers living with depressed partners.

The data collected was mainly collected through face-to-face interviews as discussed in the methodology. The field notes and demographic information were incorporated into the respective interview transcripts. The demographic data will be presented in section A of this chapter and the data obtained through face-to-face interviews and field notes in section B.

4.2. Section A: Demographic Data

Table 4.1: Presentation of the Demographic Data

	Age	Years of living together	Employment status	Source of emotional support	No. of children	No. of Years of providing care
CLY2	21-30	3- 4	Employed	Relatives	1- 2	0- 5
LWX2	21-30	5- 6	Employed	Relatives	1- 2	0- 5
SBY1	31-40	3- 4	Employed	Mosque	1- 2	0- 5
CWX3	21-30	7- 8	Not employed	Church, friend & relatives	1- 2	6- 10
GX1	51-60	10 & >	Not employed	Relatives, church	5-6	21 & above
APY4	41-50	10 & >	Employed	Relatives	3-4	21& above
ABY3	61-70	10 & >years	Employed	Relatives	3-4	21 & above

The sample consisted of seven (N= 7) spouses living with depressed partners in Cape Town, Western Cape Province. In the research study, seven participants were recruited. The seven participants were interviewed and the data analysed as presented in this chapter. Four (N=4) of the spouses who participated in the study were male while three (N=3) were female. Therefore, there were more male spouse carers than female carers.

The age of the spouses who participated in the study ranged between 21 and 60 years. The majority age group of the participants ranged between 21-30 years (N=3) followed by 51-60 years (N=2), 31-40 years (N=1) and 41-50 years (N=1). It seems that the vulnerable group for depression is 21-30 years. This could be because of the many challenges they may be facing such as getting to understand more about their partners and trying to adjust to marriage life. Out of the three in the age group of 21-30 years, two were female carers and one was a male carer.

The numbers of years the participants have lived together with the depressed partners ranged between 3- 10 years & more. The majority of the participants indicated that they had lived together for more than 10 years and more (N=3) followed by 3-4 years (N=2), 4-5 years (N=1) and 6-7 years (N=1)

The findings about employment status indicated that most of the participants were employed (N=5) and those who were not employed were (N=2). All the male carer participants who participated in the study were employed. Two of the employed carers were sales representatives of the companies that they were working for. Two were working as accountants and one as a mechanic.

Most of the participants indicated that they received emotional support from relatives (N=6). One of the participants did not get emotional support from any relative. Only

one indicated getting emotional support from a friend (N=1). Only two indicated getting emotional support from professionals (N=2) One of the two mentioned that the psychiatrist provided emotional support to him while the other participant received support from a marriage counsellor. Two of the participants indicated getting emotional support from religion (N=2). None of them indicated getting emotional support from community, support groups and government-established institutions.

All the participants indicated that they have children. The number of children to each spouse who participated in the study ranged between 1- 6 children. The majority of the spouses had between 1-2 children (N= 3) followed by 3-4 children (N=2) and one between 5-6 children (N=1).

The number of years that the spouses had provided care to the depressed partners ranged between 1-21 years &more. Some of the participants indicated that they had provided care to their depressed partners for 21 years and more (N=3). Some indicated providing care for between 1-5 years (N=3) while the remaining one indicated providing care to the depressed partner between 6-10 years

4.3. Section B: Qualitative Data

During the data analysis, each transcript was analyzed in totality before cross analysis was commenced. During the cross analysis of the findings from each transcript, four themes emerged from the data. The themes included spouse carer expresses opinion, spouse carer dealing with partner's behaviour, challenges experienced by the spouse carer and support provided to the spouse carer. The themes are discussed below in that order.

Themes and categories identified

4.3.1. Spouse carer expresses opinion

- Carer expresses opinion towards depressed partner
- Carer expresses opinion towards their relationship

4.3.2. Spouse carer deals with partner's behaviour.

- Caring approach
- Alternative approaches
- Insensitive approach

4.3.3. Challenges experienced by spouse carer

- Disjointed social responsibilities
- Employer expectations
- Lack of skills of caring partner

4.3.4. Support provided to the spouse carer

- Psychosocial support
- Professional support

4.3.1. Spouse Carer Expresses Opinions

In this theme, the spouse carer expressed his/ her opinion about the depressed partner and relationship by describing the partner and their relationship. The spouse carer's opinion towards the partner and relationship was expressed spontaneously and voluntarily even without the researcher asking questions related to the partner. Opinions are revealed in the descriptions made by the spouse carers in regard to their depressed partners and their relationship. In this study, using negative connotations to describe partner and relationship will be interpreted as negative opinion while using

positive connotations to describe partner and relationship will be interpreted as positive opinion towards partner and their relationship. The spouse carer's opinion about the depressed partner seems to be influenced by, his/her perceptions, feelings, the challenges posed as a result of living together and the support systems available to the spouse carer. A spouse carer with negative perceptions, whose partner is demanding and who has a weak support system, will eventually use negative connotations to describe the partner and relationship thus portraying a negative opinion towards the partner and relationship. Most of the spouse carers expressed negative opinions by describing depressed partners and relationships negatively as will be discussed below. The theme "Spouse carer expresses opinion" is discussed in two categories: Spouse carer expresses opinion about partner and spouse carer expresses opinion about their relationship. In the presentation of the research findings the codes will be in italics.

4.3.1.1. Spouse Carer expresses opinion about partner

The spouse carer's opinion about the depressed partner emerged from the descriptions the spouse carers made to describe their partners. The descriptions were based on the perceptions and feelings of the spouse carer towards the depressed partners. The behaviour and mood of the depressed partner while living together with the spouse carer impacted on the perceptions and feelings expressed by the spouse carer to describe their depressed partners. It emerged from the data that the opinion of the spouse carer towards the depressed partner was expressed depending on how the spouse carer described the depressed partners. It also emerged that the descriptions expressed by the spouse carer towards the depressed partner had some influence on the way they described the relationship (see 4.3.1.2), the way they could handle them and the quality of care they provided to the depressed partner (see 4.3.2.1). The

dimensions of the descriptions ranged from amiable to indifferent and arduous as is presented below.

Some of the spouse carers described their partners positively as *amiable* people. They used words such as *pleasant*, *cheery* and *selfless*, to express a positive opinion about their depressed partners. It was mainly the female carers who expressed positive descriptions about their partners. The male carers only described their partners positively if their partners were cooperative in meeting the family responsibilities. This may mean that female spouse carers were more caring and tolerant than the male carers. It emerged that the positive connotations in describing the depressed partners were used to indicate a time of happiness for both the spouse carer and the depressed partner. It seems that when the depressed partner went through the bouts of depression, the spouse carer described them negatively because they could not perform as expected by the spouse carer. This means that the opinion of the spouse carers changed with the mood of the depressed partner.

Resp. GX1 *...is a very nice person, he can be very nice... he is very jovial, very caring*

Resp. GX1 *... when he goes through the bouts of depression he becomes nasty and cattish*

Some of the respondents described their partners as *selfless* and hard working in serving the family. This portrays a positive opinion about the depressed partner. Respondent APY4 mentions that because of the depressed partner's dedication in making them comfortable, he finds her to be pleasant.

Resp. APY4: *She is always there for me and my children, she is not selfish, she doesn't think about herself, she always thinks about us. She always thinks about me and our children*

Reflection: The spouse carer seems to be enjoying the fact that the depressed partner is selflessly thinking about him and the children. Despite portraying a picture of tolerance to the partner, during the

interview he appeared to be discontented in this partnership. However, the fact that the depressed partner was always working hard both in the house and at a job, risks worsening the partner's depression because she does not get adequate time to rest.

Some of the respondents used the positive connotations to describe the partner before they got depressed. This implies that they cannot use the same descriptions currently because the partner has changed from the pleasant person he used to be to an unpleasant person. According to the previous descriptions, the spouse carer seems to have enjoyed the company of the depressed partner before he became depressed. But currently, she does not seem to be enjoying the partner's company. This could be due to the burden of care and the inappropriate behaviour of the depressed partner.

Resp. LWX2 ...have known him for the last fifteen years of my life, he is one of those nice persons I have ever met. He was very friendly person, outspoken ...

Resp LWX2 You see like today am off and I have been busy since Monday in a training session sitting from 8-5pm and this is the day am supposed to be relaxing, but you see am in the hospital, you know what am saying, tomorrow I have to go to work and it is a Friday the busiest day of the week. Sunday is my next day off, so am preparing myself am not worried about the amount of work I will have on Monday or Saturday, am worried about Sunday

The negative opinions towards partner were expressed by describing the depressed partner negatively. Many of the spouse carers described their partners as *indifferent* denoting that the depressed partners were unresponsive to the feelings of the spouse carer because they were socially withdrawn, unwelcoming and unconcerned. These kind of descriptions emerged because the depressed partners did not bother to participate in meeting family responsibilities (see 4.3.3.1). Some of these descriptions emerged from the male carers who were judgemental and blamed their depressed partners for being unwelcoming, and unconcerned about the welfare of the spouse carer.

Resp. CLY2 ...I come home and she gives me a face that I did not expect, ... I come home I greet her and she shout at me, iabo she will not see me again

Resp. SHY1...sometimes I come home and an argument comes up and I can't always say yeah it is the depression.

The description of the partner as unresponsive emerges in some of the transcripts. Some of the respondents say that their depressed partners are uncaring and pass negative remarks against the spouse carer sometimes. These descriptions emerged from the female spouse carers.

Resp. GX1 ... goes into silent mood, cattish or withdrawn, passing unkind remarks, keeps to himself ... sometimes he is nasty and cattish...

Resp CX3 ...the shouting, the anger, and in the past he could abuse me so I couldn't take it any more.

Some of the spouse carers described their partners as *arduous* persons implying that they were demanding and difficult to live with. Most of the spouse carers described their partners as burdensome due to the physical and emotional care they provided for them. (See 4.3.2.1) The expression of burdensome strongly emerges especially in those respondents who were expected to be productive by their employers and at the same time provide care for the family including the depressed spouse. It gets worse if it is a male partner who is depressed and the female partner is employed.

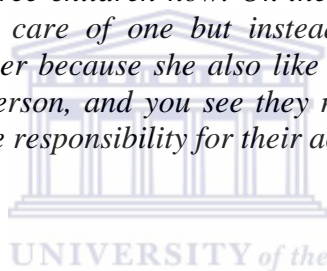
Resp. LWX2I wake up about 7.30- 8.00 prepare breakfast, I clean the house see to the children, cleaning them preparing them what they eat. then I prepare lunch at about 2 o'clock then he wakes up eats and goes back to sleep. So from 4 o'clock am busy preparing food and he wakes up to go shower then comes and sits to eat and he goes back to be ... I left it in the morning and he is still sleeping. He hasn't moved or anything... basically it feels like am doing everything for him

Reflection- It seems that the male depressed partners are more dependent on spouse carers than the female depressed partners.

Reflection: It seems that the situation gets better if the depressed male is involved in doing something that contributes positively to the welfare of the family. This is because, comparing the way respondent LWX2 and respondent CX3 described their partners, respondent LWX2 seems to be going through a worse experience than respondent CX3 whose partner is busy working during the day. This is because she looked so disturbed throughout the interview session. Respondent LWX2 whose partner sleeps most of the time was furious throughout the interview despite saying that she felt better after the interview. It seems that being recognized as contributing positively to the family improves the mood of the male partners.

Respondent CLY2 expresses a negative opinion about his partner by describing her as burdensome because he has to care for her, as he would have to care for a child.

Resp. CLY2...relieve in brackets yeah because now I don't have to take care of three children now. Ok the one doesn't live with us, so I will only take care of one but instead of taking care of both the children and her because she also like a child. It is difficult thinking for a grown person, and you see they make decision in life and they don't want take responsibility for their actions.



Many of the spouse carers described their partners as difficult to live with because of their unpredictable mood and behaviour. They mentioned that the mood of their partners changed suddenly and so did their behaviour. The depressed partner's mood changed from happy to sad and his/her behaviour from cooperative to uncooperative depending on factors which were not clear to the spouse carer. This affects the family members because the depressed partner is not able to explain what could be stressing him or her. Then each member of the family becomes concerned about what has prompted the depressed partner to change his/her mood. This then leads to stress among the members.

Resp: APY4 ... into this depression and it affects the whole family and my daughter will come and ask me what is wrong with mum today. Then I will ask her what is wrong today and she will tell me nothing wrong , just leave her the way she is and I do get stressed ...

Resp. GX1... everyday you start watching and looking at the moods swings. You are so aware of the persons (silence trying to look for an appropriate word to use) through your life that you are able to tell what is going to come next

Reflection: Cross-examining the transcripts reveals that those respondents who used less of the negative connotations to describe their partners provided stronger support to their depressed partners as compared to those who used more negative expressions.

It was also revealed that those spouse carers who used fewer negative connotations were receiving professional support (see 4.3.4.2) besides family and friend support. Even during the interview day, the spouse carers who were receiving attention from professionals seemed more relaxed as compared to those spouse carers who were not receiving any professional intervention and who displayed perturbed expressions.

4.3.1.2. Spouse Carer expresses opinions about relationship

In this category, the spouse carer expressed opinions about his/her relationship with the depressed partner. The opinions were expressed by describing the feelings about the relationship. Describing feelings using positive remarks implies a positive opinion and negative connotations imply negative opinions. The dimensions of feelings described by the spouse carers ranged from cordial and tolerable to dejection and discontent. Respondents expressed different feelings during different stages of their interactions with the depressed partners. Spouse carers who were involved in a longstanding relationship with their partners and those who felt the need to reciprocate, expressed the positive feelings.

Resp CX3 ... I do love my husband because he supported me before we were married we had known each other for three years so that totals to 10 years now with the 7 years that we are married. So it is my time to support him because he supported me in the past before were marriage

Resp APY4 ... I don't think I will find another lady like her. She is always there for me and my children, she is not selfish, she doesn't think about herself, she always thinks about us. She always thinks about me and our children and that to me keeps the bond between us very strongly. I don't think I will find another like her. That is what keeps us going ...

One spouse carer expressed tolerance in adapting to the relationship

Resp ABY3*I just had to take step by step, I just had to live with it and afterwards I overcame*

While another displayed intolerance

Resp. CLY2..... *but then I will just tell her, Hey she just get out of it man. Am straight forward and harsh so you will not get any TLC from me if I feel it is not necessary. That is my thing man. So I will tell her to get out of it. Am not going to sit there then I start telling her, how are you, (smiles)ah . That is crap man.....*

However, most spouse carers expressed negative opinions towards their relationship by describing feelings about it negatively. The negative feelings ranged from *ambivalence, to dejection and discontent*. Many spouse carers expressed that they were emotionally drained as a result of providing physical care, hence experiencing emotional strain.

Resp GX1 ... *You know because it just drains you and as I said we are married for 43 years and for most part of the marriage I had to live with a depressed person that it is only when you are in it that one will feel what am going through hold back tears .*

Some spouse carers get emotionally affected because despite them seeing their partner going through the experience, they feel *helpless* because they can't help them out of the depression

`Resp. APY4...emotionally yeah it is eating me up but just because I just don't want to see her like that`.

Many of the participants expressed a feeling that living with a depressed partner was physically exhausting. This was common especially with spouse carers who were working at the same time caring for the depressed partner. They would work for a whole day then come home to also provide support to the depressed partner.

Resp: LX2 ... *It is exhausting process it is tiring, it pulls all your energy`. ... I leave in the morning and I leave him sleeping, I will be there to dress two children see to it what I can do before I go to work. And rush and drop the children on foot because I can't drive again. By the time I get home at six o'clock, I walk into the house and the house is still in the state I left it...*

Many of the spouse carers expressed feelings of *ambivalence* in that they weren't sure about the precipitating factors for the depression.

Resp. APY4: I ask her if I am actually the one that could be contributing to the depression but she could say no.

The majority of the spouse carers do not know how they should behave in the presence of the depressed partner and so they decide to be sad just like the depressed partner. This may mean that they may not be necessarily sad but they may kind of mask their mood so that they may identify with the depressed partner.

Resp: LX2 said, *because he is sad and down most of the time and so it doesn't feel right for me to be all happy, and outspoken or whatever*
...
WESTERN CAPE

The feelings of *dejection* emerged from most of the transcripts. Some of the spouse carers expressed that they got disappointed with some of the behaviours of the depressed partners. Some said that the depressed partners could not respond to their questions and this made them feel disappointed.

Resp: CX3: *...I feel frustrated when he doesn't communicate with me, when I ask him and he doesn't answer me back.*

Resp: GX1 ... *When he is not in the episode life is easy for me and when he is depressed, I become stressed too... I promise you only when you have experienced it is when you can understand what am going through.*

Respondent LXW2 seemed to be undergoing a similar experience to GX1

Resp. LXW2 ... *it is difficult when I say to you because what is coming to you are just words. But once you are in that confrontation, it is worse.....*

Respondents express the feelings of *discontent* in different ways. Some find themselves shouting as a compensatory mechanism because they are discontented in the relationship while others will get involved in arguments or confrontations. Respondent APY4 expresses his anger by shouting because he doesn't get enough attention from his depressed partner.

Resp. APY4 ... *It gets to me sometimes it boils over to me and I start shouting in the kitchen because I can not get satisfaction from her now*

Some respondents mentioned that when they try to ask for clarification of something in the house from the depressed partner, an argument crops up. This then results into an argument, sometimes a confrontation and eventually the carer becomes angry.

Resp SHY1 ...*I can't fix things right when I can't correct her. You can't say come lets do this together for example going out because we will argue then I feel angry*

Feelings of *hopelessness* in the marriage have emerged in some respondents. They expressed the feelings that they have tried to help their partners in the marriage and feel that they are exhausted. Spouses whose partners had been on treatment for a long time and had not shown improvement expressed the feelings of hopelessness. It also emerged that the male participants who had been in the marriage for less than ten years expressed feelings of hopelessness towards their marriage.

Resp GX1*yet I understand it in the sense that I am not critical, very supportive, but I have reached a stage that I cannot take any more*

Resp CLY2 *Look here, I don't get fed up quickly, nor get angry quickly, but am fed up now in this whole issue Because from day one I*

am the only one who has been caring for her but I also want to start living my own life..... So basically I don't give any crap any more about her. I don't know if those feelings will ever come back, may it might, but currently am tired`

Reflection: It is clear that most of the respondents who described their partners negatively, expressed similar feelings towards their relationship. They described it as a stressful experience. Some described it as difficult to live and work with.

4.3.2. Spouse Carer Deals with Partner's Behaviour

The approach the spouse carer adopted to deal with the behaviour of the depressed partner depended on a number of factors. Some of the factors that emerged from the data included; the support system available for the spouse carer (see 4.3.4), the way the spouse carer perceives the depressed partner (see 4.3.1.1), the feelings expressed by the spouse carer towards their relationship and the period it has lasted (see 4.3.1.2), the mood of the spouse carer and whether the spouse carer is female or male. The approach of dealing with the behaviour of the depressed spouse ranged from a caring approach to an alternative and insensitive approach. It is important to note that the approach used by the spouse carer to deal with the partner's behaviour could suggest the carer's coping mechanism.

4.3.2.1. Caring approach

The caring approaches include handling the depressed partners compassionately, trying to be accommodative to them, being supportive to them and being cautious in the way they communicate with them. The caring approach has emerged from spouses who described their spouses positively (see 4.3.1.1.) and are hopeful that their partners will get well. The female respondents mostly expressed this

Resp. LWX2 ... am hoping that somehow he will get back for the children so that they can see that is how dad is l... I want to help him get back to his feet

Most of the female carers modify their programs to *accommodate* the depressed partners. Some of them abandon their own feelings for the sake of accommodating the depressed partners. This is unique to the female carers. For instance (Resp GX1) changes her usual program to give the depressed partner company when the partner is depressed because he doesn't want to interact with many people during that time.

Resp. GX1...when he is depressed he just prefers staying indoor... So because of his situation I will not go out because I accommodate him

Resp LX2 ... because he is sad and down most of the time and so it doesn't feel right for me to be all happy, and outspoken or whatever ... So am sort of trying to accommodate him and so it has...

Resp CX3 ... when they are down you also become down and when they are ok you also ok. Because it feels like if they are depressed and you are happy they feel like you are ignoring him although you are not ignoring them. You are for them and you need to show that you are there for them`...because at work there is a lot of pressure and when he comes home, he is not happy. So it means that I also must not be happy...

Many of the respondents are *supportive* to their depressed partners, a finding common amongst female carers. Some of them said that they support their partners because of the number of years they have known each other. It is clear that having known each other for a long time and an established prior relationship, gave them the motivation to support their depressed partners. Some also say that they have to support their partners because they have hope that they will get well so that they can have a happy marriage again while some spouse carers could be supportive to their depressed partners because of the support they received from them before they got sick.

Resp. LWX2 ... I have known him for the last fifteen years of my life.... and because I was around when his mother died and I saw the process that put him into this situation, ... am hoping that somehow he will get back for the children so that they can see that is how dad is like because now he spends most of the time sleeping.

Resp. CX3 ... *I will say I support him in everything that he does I support him. I just don't have mixed feelings about him. love my husband because he supported me before we were married we had known each other for three years so that totals to 10 years now with the 7 years that we are married. So it is my time to support him because he supported me in the past before were marriage.*

The *supportive* attitude in male carers was exhibited in those whose marriage has lasted for more than 10 years. They support their partners because they love them and appreciate them despite the depression.

Resp.APY4.... *that is why I don't let her go through this alone. In fact I will rather be comfortable for both of us going through it together...I am trying to be more supportive and what I do is do in the evening, if she starts going into the depression, then she takes the machine to start washing or she will start cleaning the house then I will stop her there and tell her to go and relax a bit... I do support her in whichever way I can.*

Spouse carers mention that they have to be *cautious* in the words they use to communicate in the house. This is because they don't want to hurt their partners' feelings since they are not sure how their partners will interpret whatever statements they make. This is commonly observed in the female carers and one male carer.

Resp: CX3 ... *I must think twice before I talk to him because I fear that I might tell him something may be it may put him off...*

Resp: LWX2... *You can't just say something because you don't know how he will react so you have sort of hold back all the time and be careful what you say because he will then say "ooh you are just going on with your life and you are not worried about me.*

Resp: SHY1 *I get scared of saying something or implement something because she is going to step in and say this is wrong, then she cant talk she don't greet in the morning*

4.3.2.2. Alternative approaches

The alternative approaches utilized by the spouse carers included approaches that appeared to be more considerate than the insensitive approach. The approaches under this category seem to be moderate as compared to insensitive approaches. The approaches, although not very caring, showed some aspect of being considerate by being within the reach of the depressed partners. These approaches range from getting used to the depressed partner's condition (Resp. CLY2) to engaging in alternative activities either with the depressed partners or by themselves. The activities included watching television together with the partners, smoking cigarettes and keeping to themselves.

Resp. CLY2 I couldn't sleep, but now I am used to because the thing is I let myself get used to a certain thing quickly. Because I know it is all about me and I am not going to let things to happen to me, to protect myself is to get used to the thing. Because I cant make myself ill because of other peoples` behaviours

Resp. LWX2 ...I will just hold it in. ...I will just smoke a cigarette or I don't know I just deal with it.

Resp. CLY2 ... I come home and you give me a face that I did not expect, then I turn around and leave you with your stress... I turn around and go to Watch TV or rugby or whatever

Resp. GX1 I will also do something like reading or watching television or he will go and fetch movies and we shall watch together.

Resp. CX3 ...There is nothing actually I can do because if he gets angry, really gets angry. So I keep to myself to be out of his way.

4.3.2.3. Insensitive approach

Carers who have been married for a short period of time display the insensitive approach. The approach is displayed more by the male carers than female carers. This ranged from using inconsiderate utterances against the depressed partners to distancing themselves physically. Although the female respondents could also distance themselves, the male carers distanced themselves by going away from the

house while most of the female carers were involved in doing something else but within the reach of the depressed partners.

Resp. CLY2 ... I told her look here, I thought to myself ... am not going to make myself sick of because of your illness. So I told her... if you want to go, just go if you want to take your own life, take your own life. Why are you doing it to seek for a bitty or what,

Although it was a common treatment by the male respondents, it also emerged in one female respondent that she could sometimes treat her partner harshly depending on her mood.

Resp. GX1...and am in an aggressive mood ... then I give him back what he gives to me, if he is nasty and cattish, then I retaliate but not all the time because sometimes he is nasty and cattish but then I tell myself, just keep the peace, just let it go but sometimes I cant do that because I feel that this just enough now,

The physical *distancing* emerged as a coping mechanism adopted mostly by male spouse carers and one female carer (GX1). The activities involved in distancing included going to play rugby, drinking alcohol, meeting friends, taking a walk and leaving the depressed partner for a couple of days as mentioned by one female respondent.

Resp. GX1 I would leave and stay away for a couple of days just to get away from the situation, until he asks me to come back,.I look after my daughter's children and I attend to the little daughter and I am away from him only when I come at night that I will have to handle him. So the granddaughter gives me the sanity

Resp. APY4.... I take the dog for a walk to get that stress level off me, or sometimes I just do some work what I normally do is I go sit by a friend socialize with him...

Resp. CLY2 ... you realize am a social drinker so when am stressed, I go and take a short..... I go play rugby

Reflection: It is noted from the data that, as the method of approach, changes along the continuum from a caring approach to an insensitive approach, the male carers' approaches tend towards the insensitive approaches while the opposite is true for the female carers. In the caring approach, very few male carers displayed the caring approach.

The male carers who displayed the caring approaches were either getting professional support (see 4.3.4.2.) or had learned to tolerate living with the depressed partner due to a strong support network from family and friends (see 4.3.4.1). It is also important to note that the male carers who expressed losing hope in the marriage, displayed insensitive approaches to the depressed partners (see 4.3.2.2).

From the data, the coping mechanisms utilized can be broadly categorized into two psychological and social coping. Psychological coping involved cognitive behaviour such as keeping to self, behavioural coping such as distancing, emotional behaviour such as crying and shouting. The social coping involved visiting friends to socialize.

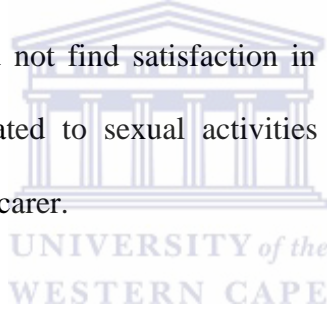
4.3.3. Challenges Experienced by Spouse Carers

The challenges experienced by the spouse carers emerged as they interacted and provided care to the depressed partners. Most of the challenges that emerged seem to be closely linked with the approaches the spouse carers used to deal with the depressed partner. For instance the insensitive approaches adopted by some of the respondents may have prompted the depressed partners to be more rebellious or more depressed hence becoming more dependent on the spouse carer for care (Resp CLY2). The inappropriate behaviour that might arise due to insensitive approaches of dealing with depressed partners may be difficult to deal with hence the spouse carer resorts to describing the depressed partner using negative connotations (see 4.3.1). The

challenges experienced by spouse carer seems to be triggered by displaying negative opinion towards the depressed partner, psychological unpreparedness to provide care to the partner, providing care to the partner for a long period, financial implications in caring for the partner, the approach employed by spouse carers to deal with the depressed partner's behaviour and lack of adequate support to the spouse carer (see 4.3.3.).

4.3.3.1. Disjointed social responsibilities

The category challenges related to disjointed social responsibilities include marital, family and social challenges. The male carers openly expressed the *disjointed marital responsibilities*. Most of them complained that they were dissatisfied with the relationship because they did not find satisfaction in the partners (see 4.3.1.2) The dissatisfaction especially related to sexual activities were expressed by the male spouse carers and one female carer.



Resp. SHY1 *Sexual intimacy is not even there, the last one and half years that she is depressed, our sexual intimacy is not too good.*

Resp. APY4 ... *I would say sexually we don't converse or indulge in intercourse like we used to do and I will say that from a personal point of view it has affected me.*

Resp. CX3..... *Even sexually it is not right and I wonder if there is medication for that.*

Some respondents said that it is difficult living with depressed partners because they do not fulfil their expectations.

Resp. SHY1*said in the house but it is difficult living with her because she doesn't handle situations so that all parties can benefit. ... It is difficult for me because where I come from although am not so strict with religion; the wife doesn't say everything in the house.it is difficult to have a relationship especially when she is depressed*

Most of the spouse carers expressed the challenge of meeting *family needs* without much help from the depressed partners. The female carers seem to be more affected especially if they are the breadwinners and providing care to the depressed partners because they end up doing everything in the house. The spouse carers mentioned that seeking for help from the depressed male partners results in arguments, which finally lead to marital conflicts.

Resp LWX2 *`I walk into the house and the house is still in the state I left it in the morning and he is still sleeping. He hasn't moved or anything.....if I ask him ... then we start arguing and he will not see any fault in what am trying to say to him lift yourself and do something. Then he gets aggressive, its fighting, get verbal with one another and my children are in affected by this kind story`*

Some of the spouse carers could not comprehend why the depressed partners could not perform what they are expected to perform in the family.

Resp. GX1 ... *And so I wasn't always just understanding about because he did not know his work then*

Resp. SHY1 ... *We don't greet one another, we are always arguing, She wants to go and shop when she gets paid and I don't want to stop her but there are plans that we have ...*

Some of the spouse carers expressed that the depressed partners did not assist them in training the children to grow up holding the cultural values in which they were brought up. This could be attributed to the fact that other than the partner suffering from depression, having a different cultural and religious background and having children from a previous marriage worsened the situation. The spouse carer becomes angry because he is not able to dispense his role as the head of the house because the partner favours the child from the previous marriage.

Resp. SHY1 ... *she wants to reprimand the kids and she doesn't want me to reprimand. But she has a child from a previous marriage and I*

also have got. So now the more am interacting with the kids and when it comes to her elder child she wants to step in and have her say like if I wanted to reprimand her the child is already looking up to the mother to say something. So she like overrules me ... and ... the moment I want to reprimand the child, she will not listen to me

The same respondent continues to say

...she can take a position of being a child instead of being an adult and it is difficult especially if she is not your own child it is hard to love her because she is also stubborn and she knows that I am not her father it is difficult and you as her father, she listens to and at the same time she is not listening to you

Some respondents expressed a concern that despite their religious expectations to have more say in the house, this is overruled by the depressed partner who subscribes to a different religion. This also affects the upbringing of children because the spouse carer who is also the man of the house feels that his values are not being practised in the family and therefore may not be passed on to children.

Resp. SHY1 ... Where I come from, we greet each other at night and in the morning and I want to implement that in our children, but it is difficult to implement those kind of things. So living with her results me not implement those small things and they leave you questioning your values although am trying to steer the family towards the right direction because where you come from you have values.

It seems that those respondents who had stayed together for more than 10 years were able to tolerate their responsibilities better than those who had lived together for less than 10 years as depicted by respondent ABY3 as above. He explains that despite it being a tough experience, he struggled on and coped well.

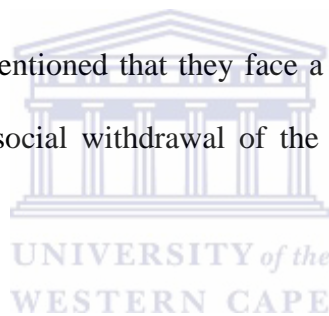
Resp ABY3 said I just used to come home and make something to eat because she was not feeling well. ...She was in hospital and I had to be here, so I just had to keep the children together and we were all worried about her

Some spouse carers experienced financial challenges in meeting *family needs* because in one way or the other, they spent money on the depressed partners. The spouse carers complained that their partners bought items on credit and the spouse carers ended up paying for those items.

Resp. CLY2 ... *So economically it's been from day one, you check so she has been buying stuff and I have always been footing the bill for it and am tired of that. Am actually glad that she is in hospital because she can not buy stuff now*

Resp. LWX2 ... *he has been on drugs for 3 years before (substance abuse) and financially, it takes a lot out of you because, he is making debts all over, you know what I'm saying!! So I am still covering some of those debts,*

Some of the spouse carers mentioned that they face a *social challenge* because they lost company either due to social withdrawal of the partner (see 4.3.2.1), hospital admission and stigma.



Resp. CLY2 ... *Basically now am living alone, now and despite the fact that I was prepared for anything, now am living alone and there is no home again because am living alone.*

Others mentioned that they would not discuss their wives with friends. This becomes a challenge because then the respondent avoids seeking for assistance from friends and may avoid socializing. One respondent mentioned that the friends indicated to him that if the wife is seeking a psychiatrist attention, he should move on with his life. This may imply that, he should get a different woman because the depressed partner is sick and life must continue. Stigma emerged in one transcript.

Resp. ABY3 ...*as soon as you tell somebody that your wife is admitted at the clinic and she is seeing a psychiatrist, the first thing that came to anybody's mind was, there is something wrong up here (points to the head)because you get some people ... say that if your wife is like*

that they say no you can stay there, life must go on, social life must go on ..

4.3.3.2. Employer expectations

Most of the respondents who were working to earn a living mentioned job responsibilities as one of the challenges that they face each day. Spouse carers mentioned that having a job and a caring responsibility resulted in physical exhaustion (see 4.3.1.2) and yet their employer expected them to perform despite what they are going through at home. This though was more complicated for the female respondents who basically had to do everything for depressed partners.

Resp. LWX2 ... I have been busy since Monday in a training session sitting from 8-5pm... I described it to you, you are at work the whole day, I'm a cosmetics consultant... I stand whole day... tomorrow I have to go to work and it is a Friday the busiest day of the week.

Resp. GX1 ... I was a manageress and I brought in my share economically and you know it was a challenge because I had to go and work and come home I was a mother and I had sit with my kids and being as a wife it was a challenge

Other carers were concerned that due to the situation at home, their supervisors may single them out and they may lose their jobs because they look exhausted due to inadequate time to rest. They resorted to taking nutritional supplements such as vitamins for energy.

Resp. LWX2 ... half of the time am so tired at work, I take energizer, vitamins...away am a bit afraid obviously we have got managers and wherever so you are not sleeping well and you know am selling cosmetics, and you have to make your hair nice and make-ups and if I look so exhausted then I know it may get me down at some point, then I have got no job, I have two children to look after and then I also get into depression.

Resp. SHY1*you are tired most of the time; you have to take vitamins in order to pump yourself up to be competitive in your work.....*

Some of the male carers mentioned that they had to block out the thoughts about the partner so that they were able to concentrate on the jobs. Some mentioned that it was challenging to concentrate at their work totally and explained that they could try to balance although it was difficult.

Resp. ABY3...*you cant in the job that I was in, you cant think of your wife 100%. May be 50% 50%. So the 50% is worrying about her and the other 50% is to do my work, because I have a house that I have to look after, twins*

While for female spouse carers it was even more difficult to concentrate at work because they were totally pre-occupied by the condition of their partners.

Resp. LWX2 *Obviously at work because am constantly worried of him, is he all right, did he take the children to school, did he do all those things so I keep phoning and phoning to hear how he is doing. So it affects me professionally as well.*

4.3.3.3. Spouse carer skills

The skills of caring for the depressed partner emerged from various spouse carers. The factors that the researcher used to identify the skills included the way the spouse carers described the partners and the way they dealt with the depressed partner's behaviour. Mostly, the negative descriptions (see 4.3.1.1.) were associated with lack of knowledge and skills about depression. Likewise, the insensitive approach in dealing with the depressed partner's behaviour indicated inadequate skills. The knowledge and skills of dealing with depressed partners is revealed from the way the

spouse carer interacts with the depressed partner. Ineffectual interactions emerged from some of the transcripts

Resp. CLY2.....she will not take the tablets for a while and then take everything at once. So I told her look here if you want to go, just go if you want to take your own life, take your own life. Why are you doing it to seek for a pity or what, so I told her look here if you want to do it, do it.

The lack of knowledge about depression is evidenced in the approach they used to deal with the depressed partner's behaviour. The kind of care (Resp CLY2) provided to the partner when she presented with suicidal thoughts is a clear indication that they lacked skills in caring for depressed partners.

Resp. CLY2 I knew she was suicidal but to a certain extent but then by just being there it takes off that feeling of committing suicide, because she feels I cant do this and that because... I don't know or she cannot do it because there are people.

Reflection: If the spouse carers had the knowledge about how to deal with a depressed partner, more of them could have considered being more caring. Blaming could have been minimized as they would have understood that the depression is not of their making but that the patient needed care and support for them to get well.

4.3.4. Support Provided to the Spouse Carer

The theme of support has emerged in most of the transcripts. The support network available to provide support to the spouse carer impacted on the way the carer perceived the partner, the relationship, the approach the carer used to deal with the behaviour of the partner and the challenges that come with caring for the depressed partner. The source of the support has also shown some significance because it seems that those carers who received support from professionals, coped better than those who were not receiving professional support. Those who were receiving professional

support seemed to provide quality support to the depressed partners. The source of the support to the carer ranges from psychosocial to professional support.

4.3.4.1. Psychosocial support

The psychosocial support includes support from religious literature, family and friends. Almost all the spouse carers mentioned that they received support from relatives. This information was confirmed from the information captured in the demographic data (see section A. of this chapter). It is apparent that most of the respondents obtained emotional support from close relatives such as a mother or sister and one mentioned a brother in-law etc.

Resp. CLY2 my emotional support, I don't know where I get from; I just get it from somewhere (laughs). Look here I talk to my mother and if I don't talk to my mother and if not I just keep quiet with it.

Resp. GX1 ... I also have one daughter she is the one that I a speak to... I requested my mother to come and stay by me until he comes home on Friday ... I have stressful moments I ask my mother to come and stay in a couple of days so that I can rather take my mind off.

Resp. LWX2... Well I depend a lot on my mother because my children are in a day care crèche so she washes them she sees that they eat and it sorts of makes my load a little bit lighter ...My sister also helps me sometimes because like if I have bills to pay I can send her to go and pay because I work six days in a week.

Resp. APY4 ... I will say I discuss it with my sister and mother because those are the only persons I can think of. Then the other personal friend is actually my brother in-law and he also gives her sisters and me a little bit of support and stuff like that also.

Resp CX3.... There is that lady that was seated here is my support. She is the only person I talk to, no friends that I can talk to about my situation.... So I will keep it to myself but when I want to talk, I don't know where to go

It emerged that the male spouse carers did not seek support from friends and relatives while female carers requested help from close family friends.

Resp. GX1 *` so instead of me wallowing in sympathy while he is here (hospital) I have asked my mother to come by me so that I can give her quality time*

Reflection: Most respondents have mentioned their mothers in the support system. None of them mentioned their fathers and even the male respondents whom I thought could have mentioned their fathers mentioned the mother as the sole supporter. It is also vital to note that very few respondents mentioned brothers in the support system. Mostly sisters and mothers were the preferred members of a family to provide both physical and emotional support to the spouse carers. It will be important to establish why fathers are totally not mentioned in the support system.

Support based on religious beliefs and literature emerged in a few of the transcripts. Support from religion was minimal. Despite the fact that most of the people of Cape Town belong to a religious congregation, very few of the carers get emotional support from the church members. The few who mentioned religion as a source of emotional support seem to prefer to consult religious literature to sharing information through interactions and discussions with members of the religious institution. This could be due to lack of trust in the people the spouse carers attend with since even friends were seldom mentioned to provide emotional support. Another reason that could support that notion is the stigma, which emerged in one of the transcripts (Resp.ABY3).

Resp. GX1 *...I often read the bible, how God wants us to live as husband and wife.*

Resp. ABY3 *... I would say am not religious but I do believe in the Man above, and I think it is the Man above that gave me strength and you must thank must thank your Creator for that.*

4.3.4.2. Professional support

Professional support does not emerge as a source of support to the spouse carers in most of the transcripts. Despite some respondents mentioning that they would have

wished to get attention from professionals, the health system does not provide guidelines to access professional services. The few respondents who were getting professional support seem to be coping well and providing support to their depressed partners.

Resp. CX3.... I will say I support him in everything that he does I support him. I just don't have mixed feelings about him. Because we go for counselling and that is basically how we are out.

A psychiatrist and nurses were attending to respondent ABY3 and he attributes his coping to their support. He also thinks the professional support he obtained enabled him to support his partner until now that she is mentally healthy.

Resp. ABY3.... I had to see a psychiatrist like once a month and he will also ask me, are you coping, how are you feeling etc and that was it ...day the psychiatrist asked me if I can make an appointment. I must see him and he spoke to me about my wife now. What he said to me was my wife underwent hysterectomy and he said that it could be that... There was a time when nurses used to ask me questions like you are asking me now, how am I coping at home you know... I went to the hospital to see the psychiatrist at hospital and he asked me questions whether am I getting support from my family.....

The same respondent mentioned that

Resp. ABY3 ... now she is fine and she has not gone to the hospital for sometime now. She looks the same now, she is now stronger than me

Reflection: During the interview, the spouse carer looked more relaxed and happy and proud of how he managed to support his wife while in the hospital and now she seems to be doing fine. The spouse carer mentioned that he visited hospital frequently especially in the evening to visit his wife and most of the time could talk to the nurses and psychiatrist. In his concluding remarks, he said those who are going through this same experience should seek help from professionals.

The findings of this research study will be presented in a diagrammatic format in the next chapter to facilitate the discussion of the findings at a conceptual level. The

diagram illustrates the interrelatedness of the four themes identified during data analysis.

4.4. Conclusion

In this chapter, the research outcomes have been presented. The chapter is divided into two sections. In section A, the demographic data is presented and Section B consists of the qualitative data. The demographic data contains the age range of the respondents, the number of years they have lived together, sources of emotional support, the number of children if any and the number of years the spouse has provided care to the depressed partner.

The qualitative data is presented in four themes. From the data, it emerged that most of the spouse carers perceived their depressed partners negatively and therefore portrayed a negative opinion towards them. This influenced the descriptions of their relationship because the carers expressed the relationship negatively as well. It also emerged that the way the spouse carers described the partner and the relationship, impacted on the approach they used to deal with the behaviour of the depressed partner. From the data, the approaches adopted in dealing with the depressed partner were used as the coping mechanism for the spouse carer. The physical and emotional distancing and doing alternative activities were the common approaches that were displayed by the spouse carer. It was revealed that the challenges experienced by the spouse carers centred on adopting ineffective coping mechanisms, inadequate support system for the spouse carer and lack of knowledge and skills about depression. These findings will be discussed in the next chapter to compare them with the findings of other researchers.

CHAPTER FIVE

Discussion and Recommendations

5.1 *Introduction*

In this chapter, a discussion of the findings is presented. It links the research outcomes with other studies related to the experiences of living with a depressed partner. The research findings will be discussed according to the themes which were reported in the previous chapter. The discussion will be presented in two parts: Part one (5.2.1) and part two (5.2.2). In part one, a diagrammatic presentation of the interrelatedness of the themes will be presented. Part two will consist of the comparisons of research findings from the current study to the findings of other related research to determine the contribution to the existing literature. By comparing the findings, gaps will be identified and recommendations suggested to fill the identified gaps.

5.2 *Discussion*

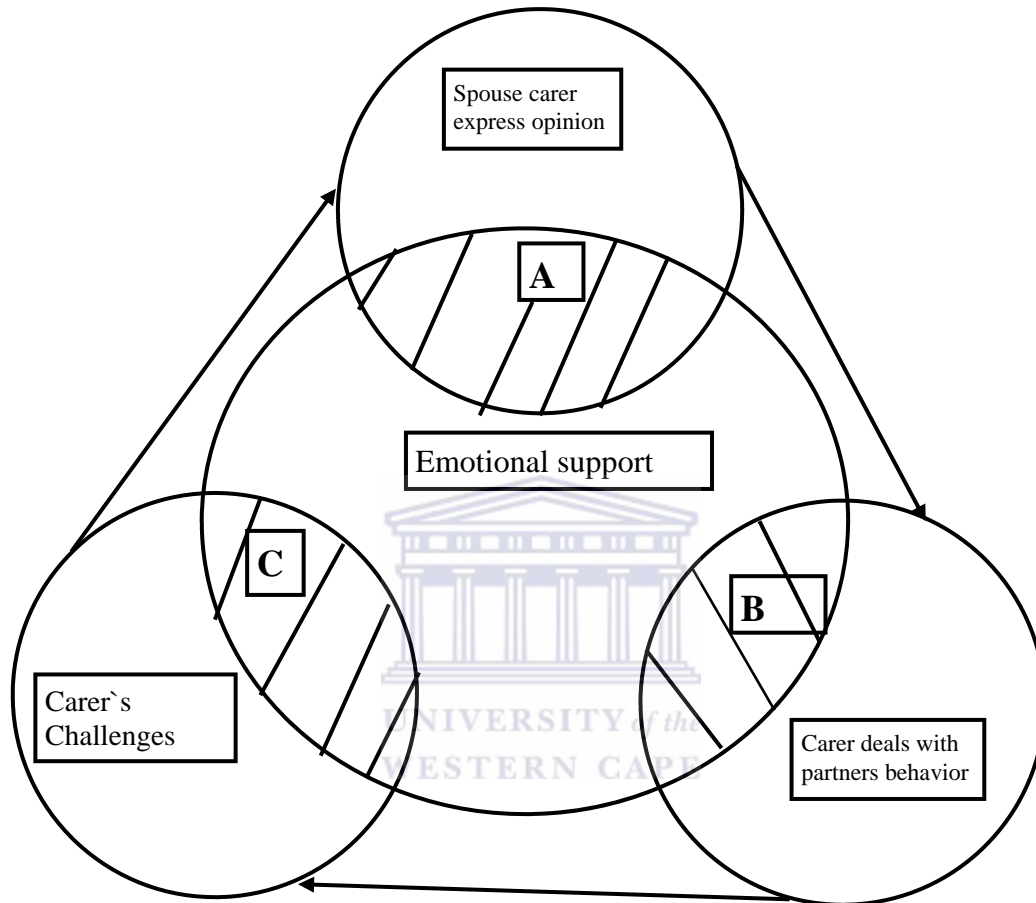
The four themes that emerged in the analysis are closely related and impact on each other as presented in the diagram below.

5.2.1 Diagrammatic Presentation of Interrelatedness of the Themes

The diagram below is used to explain the interrelatedness of the four themes that emerged during data analysis. It illustrates that the spouse carer's opinion about the depressed partner, as depicted in the descriptions used, influences the approach used by the carer to deal with the behavior of the partner. For instance if the spouse carer has a negative opinion towards the depressed partner (see 4.3.1.1 Resp. CLY2), the

insensitive approach is commonly adopted by the spouse carer to deal with the depressed partner's behavior (see 4.3.2.3 Resp CLY2).

Figure 5.2.1: Diagram of the lived experience of the spouse carers



According to the diagram, the approach employed by the spouse carers to deal or cope with the depressed partner's behavior may impact on their perception of the nature of the challenges. For instance insensitive approaches by the spouse carer (see 4.3.2.3), may negatively influence the depressed partners' behavior to be more rebellious hence increasing the severity of the challenge of meeting marital responsibilities (see 4.3.3.1).

The challenges in turn may influence the spouse carer's opinion about their relationship with the depressed partner. For example, if the challenges posed by the

depressed partner are many and difficult to deal with, (see 4.3.3), the carer may use negative descriptions (see 4.3.1) such as *burdensome* to describe their partner and *dejection* to describe their relationship.

The theme of spouse carer support is strategically placed in the centre of the diagram because it overrides the other three themes. Quality support, especially the emotional support from professionals and psychosocial support (see 4.3.4) may impact on the dimensions of the other themes. The shaded points (**A**, **B**, **C**) on the figure (5.2.2) indicate how each theme's dimensions may change with adequate support. For instance, with quality emotional support available for spouse carers at point A, the spouse carer may have a positive opinion about their depressed partners and their relationship and thus use more positive connotations to describe the partner and relationship. Likewise, support may have some influence on the approaches used by spouse carers to deal with the partner's behavior. The shaded point **B** on the diagram may represent more of caring approaches. Point **C** may represent fewer challenges due to the support provided to the spouse carer.

5.2.2 Discussion of Research Findings According to Emergent Themes

The above diagram has presented an overview of how the themes are related to one another. Discussion of the findings will be according to the themes that emerged during data analysis and will occasionally make reference to the diagram presented and described above.

5.2.2.1 Spouse carer expresses opinion about depressed partner and their relationship

The way the spouse carer described the depressed partner revealed his/her opinion about the depressed partner. The findings from this study reveal that the spouse carer's opinion about the depressed partner had an impact on the relationship between

them. Negative descriptions by the spouse carer about the depressed partner outweighed the positive descriptions. The negative connotations describing the depressed partners included *indifference* and *arduousness*. The negative connotations describing the feelings towards the relationship included *ambivalence*, *discontent* and *dejection*. The negativity towards the partner may have impacted on the family interactions because most spouse carers mentioned that they engage in arguments and some even end up fighting. Hence, most of the spouse carers expressed dissatisfaction in the marriage. These findings are similar to Sacco and Phares (2001) who found that marital satisfaction is compromised by the negative attitude towards the depressed partner.

The positive opinions towards the partner and relationship as depicted in the positive descriptions were scanty (see 4.3.1). It is clear from the findings that the *tolerance* displayed by some spouse carers was equated to the services they received in the past or now from the depressed partners. It also emerged that the relationships which were described with positive connotations were those where the depressed partners were the bread winners to their families, depressed partners participated actively in the familial responsibilities and where a marriage relationship had lasted longer than 10 years. Lamb et al (2003) mention that marriage acts as a booster to psychological health due to the support the spouses offer to one another. This could be the reason as to why spouses who lived together for more than ten years were tolerant to each other.

It is also important to observe that some spouse carers took advantage of the depressed partners because the spouse carers allowed the partners to work so hard to provide for the needs of the family which could be worsening the depression. For instance, one respondent (APY4) said that he likes his partner because she works unselfishly to serve him and the children (see 4.3.1.2). Allowing the depressed

partner to work hard to satisfy family needs risked worsening the partner's depression. Dudek et al (2001) specifies that women are more vulnerable to a worse form of depression if they are overworked. This is contrary to what I expected because it is the spouse carer who is supposed to work more than the depressed partner.

Negative opinion towards the relationship is depicted in the descriptions made by spouse carers about the feelings associated with the marital relationship. It is apparent from the findings that the feelings of *dejection* were expressed more by male spouse carers than the female carers. These negative feelings influenced the way the spouse carers dealt with the behaviour of the depressed partners (see 4.3.2.2) as illustrated in the diagram 5.2.1. The negative feelings expressed by the spouse carer portrayed a negative attitude towards the depressed partner. Benazon (2000) found similar findings that revealed that spouses of depressed partners exhibited a negative attitude towards them. The negative attitude is exhibited more by male than female participants and it contributed to conflicting interactions. Elliott et al (2006) affirmed in their study that negative attitude contributes much to interactions of the depressed partner and the spouse carer.

Some of the spouse carers expressed discontent in their relationships especially in fulfilling the responsibilities in the relationship. Physical and emotional exhaustion resulted due to the inability of the depressed partner to assist in executing family responsibilities (see 4.3.1.2). This leaves the spouse carer with no option other than taking every responsibility to keep the relationship going. These findings are similar to findings of Wittmund, Wilms, Mory and Angermeyer (2002) which revealed that the disjointed efforts to fulfil family responsibilities exhausted the spouse carer. This is even worse if the spouse carer is a female caring for a male partner because from the literature female carers are keen to meet the needs of the family and will therefore

work tirelessly to satisfy the needs of their families at the expense of their psychological health. This predisposes the women to depression more than men as affirmed in findings of Nili and Coyne (2000). Besides women working unselfishly to satisfy their family member's needs, findings from this study indicate that depressed male partners were more dependent on the spouse carer than the female depressed partners.

The depressed male partners are reported to sleep most of the time (Resp LWX2) while the depressed females were able to participate in doing some work either in the house or having a job (Resp APY4). This could be due to the fact that women cope better with depression than men because they are known to vocalize their stresses and they have more social support from friends than men. Norton (2002) mentions that women vocalize their psychological distress to close friends and relatives. This enables them to cope better than men.

The negativity towards depressed partners was more pronounced in male carers whose partnership was less than ten years. Although the negativity was also expressed by the female carers, it was accompanied by support from spouse carers. The negativity expressed by female carers was situational depending on factors such as the mood of spouse carer and behaviour of depressed partner. The negativity of male carers was more generalized covering most of the period that they had been living together. The male carers seem to have lost hope in the relationships and are not sure about the future in the partnership (Resp CLY2 and SHY1 see 4.31.2). The negativity could be as a result of the intense psychological distress due to living and providing care for the depressed partner. Roberts, Bushnell, Collins & Purdie (2006) reveals that living with a depressed spouse causes more psychological turmoil to male partners than the female partners in a marriage. This has affected even the quality of care that they have

provided to their depressed partners. The female carers could get irritated and feel like retaliating to the depressed partner's irrational behaviour, but on reflection, were able to be more caring and supportive, a behaviour which male spouse carers seldom exhibited (Resp. GX1).

Losing hope in the relationship expressed by male carers (Resp CLY2 and Resp SHY1) may not be surprising because Williams and Umberson (2004) found similar findings which revealed that middle aged men enjoy marriage in early years but may not get so worried if they lose their marriage later especially if it is dominated by the stress of providing care to the depressed spouse.

5.2.2.2 Spouse carer deals with depressed partner's behaviour

The depressed partner's behaviour evoked some reaction from the spouse carers. It is observed that the spouse carer adopted an approach to deal with the depressed partner's behaviour. The approaches adopted by the spouse carer seem to be implemented as a strategy to try to solve a problem that may arise due to the behaviour of the depressed partner. In the second round of literature review more information concerning coping mechanisms was sought. This was avoided in the first round of literature review because it could have somehow influenced the researcher to ask leading questions while conducting the interviews.

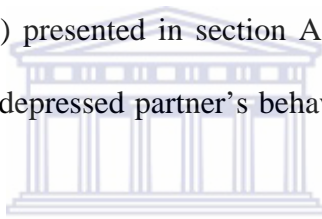
According to Stuart and Laraia (2001: 282), coping mechanisms can be classified into: task oriented behaviours and ego-oriented reactions. They explain that task oriented behaviours aim at resolving stress by utilizing realistic approaches to solve a problem. The "ego-oriented reactions" also referred to as "ego defence mechanisms" are described as unconscious, deceptive and do not help a person to realistically solve an impending problem. Although they are known to be the first line approaches used to cope with a stressful situation, some of them distort reality (Stuart & Laraia, 2001).

Therefore in the current study, the researcher focussed attention more to the task-oriented behaviours since they emerged spontaneously as approaches used by spouse carers to deal with depressed partner's behaviour.

The approaches that were identified as being utilised by the spouse carer to deal with the depressed partner's behaviour included being accommodative, supportive and being cautious not to hurt the partner's feelings (see 4.3.2.1). According to Stuart and Laraia (2001: 282) such approaches are grouped under the "compromise coping mechanisms". They explain that such coping mechanisms usually come as a sacrifice after other coping mechanisms such as attack behaviour and withdrawal have failed to work. They are thought to be constructive and may help to solve a problem. Elliot et al (2006) mentions that the positive responses which are characteristic of the approaches under this category of coping mechanisms, help in solving a problem. The research findings from the current study indicate that these kinds of approaches were adopted by female carers and a few male carers. The male carers who used this approach as a coping mechanism in solving a problem were those who had stayed in a marriage relationship for more than ten years.

Another category of coping mechanism identified by Stuart and Laraia (2001) is the "withdraw behaviour". This is the psychological or physical avoidance of a stressor by moving away from it. In the current study, such coping mechanisms as distancing, alcohol drinking, going to socialise with friends etc (see 4.3.2.3) can be grouped under this category of coping behaviour. Psychologically, admitting a mistake and apologising to avoid further arguments as expressed by some of the female carers, may be an effective way of solving an imminent crisis (Resp. LWX2). However, "withdraw behaviour" is exhibited more commonly by male carers as compared to the female carers. The female carers who utilised coping mechanisms from this group just

distanced themselves but still remained in the proximity of the depressed partner. The female carers who were forced by circumstances such as work to be far from the depressed partners were preoccupied by the condition of the partner and kept calling the partners to monitor their condition (Resp. LWX2). Norton (2002) reveals that female carers get more affected by the ill health of their spouses as compared to male carers. This was different from the male carers who expressed that while they were at work, they tried to forget about their partner's condition in order to concentrate on their work. These may be effective coping mechanisms if they help to solve the problem as explained by Stuart and Laraia (2001). However, the coping mechanisms under this group, may worsen the challenges faced by the spouse carers if not used carefully. The diagram (5.2.1) presented in section A of this chapter, indicates that approaches of dealing with a depressed partner's behaviour impact on the challenges experienced by spouse carers.



According to Stuart and Laraia (2001) the attack behaviour coping mechanism confronts the problem or the behaviour so that it is solved before it can cause more harm. However, the mechanisms under this category, if not utilised carefully, may result in arguments which eventually may result in anger and family conflicts. In many cases it might be misunderstood by the depressed partner leading to war as depicted by (Resp. LWX2).

Stress theory developed by Selye and described in Frisch and Frisch (2006: 166) mention that every individual has an approach that he/ she may use to counter stress. The approaches are the coping mechanisms identified above. According to the theory, a major illness in a family is listed as one of the sources of stress. Therefore, depression in a family equally causes stress to the spouse carers and the rest of the close family members. In response to stress, Erickson cited in Frisch and Frisch

(2006) developed an adaptation theory that defines health as a balance between physical, psychological and social aspects. This implies that anything that threatens the balance calls on coping mechanisms to be able to adapt. They developed an Adaptive Potential Assessment Model (APAM) to assess the effectiveness of coping mechanisms employed to achieve equilibrium. .

The Adaptive Potential Assessment Model (APAM) was used to assess the effectiveness of the coping strategies used by the spouse carers in the current study. The APAM model consists of three states; arousal, equilibrium and impoverishment. Arousal and impoverishment are both stress states. In arousal, the person has the potential to cope because he/she has coping strategies to be used. The impoverishment state is when one has exhausted all the coping strategies and is overwhelmed. Equilibrium is when the person is able to cope and maintain balance in his functioning (Frisch & Frisch, 2006: 176).

According to the adaptive potential assessment model, some of the respondents managed to effectively cope at the arousal stage and maintained equilibrium. This could be attributed to a good support system provided by family members, friends and professionals (see 4.3.4.2). This is clearly illustrated on the diagram above and such a group of carers may fall in the shaded part on the diagram (**B**) (see Figure 5.2.1).

Many of the spouse carers were in the impoverished state because they mentioned that the experience of living with and caring for the depressed was exhausting. Many of the spouse carers expressed feelings of sadness and depression and had lost hope for the future in the partnership. Those are some of the characteristics of people whose coping mechanisms are exhausted as explained by (Frisch & Frisch 2006: 176).

Some of the spouse carers were at the point of marriage break-up if the depressed partners did not accept professional help. Van Wijngaarden, Schene, & Koeter (2004) mention that family dysfunction is associated with intense feelings of depression which emanates from the burden of caring for a depressed partner. This may mean that they would be patient in the marriage hoping to see their partners improve. Without such improvement, they could be on their way out of the marriage due to the unsatisfying relationship. This concurs with the findings of Coyne, Thompson and Palmer (2002). Some of the respondents were at the stage of impoverishment and had lost hope in the marriage because they had tried to cope with the partner but they felt overwhelmed. This was especially expressed by spouses who had been in a marriage for a long time and the depressed partner seemed not to be improving despite being on treatment (Resp GX1).

The challenges the spouse carers experienced may have been exacerbated by the approach they adopted in response to the depressed partner's behaviour and the way they described the depressed partners as revealed in the diagram presented (see Figure 5.2.1). For instance, a negative opinion towards the depressed partner as depicted in the descriptions made about the depressed partner and an insensitive approach in dealing with them could prompt the depressed partner to exhibit severe symptoms of depression. This may make the depressed partner more dependent on the spouse carer, hence worsening the burden of care (Resp CLY2). Coyne et al (2002) found that depressed partners are sensitive to how the spouse carer and significant other respond to them. The challenges identified are discussed within the other themes since in every theme, there were challenges identified.

The approach that the spouse carer used to handle the depressed partner depended on their opinion about the depressed partner, how much information about depression

they have, prior experience and the type of support system available for them. This was revealed in the type of care that the spouse carer provided to the depressed partners. The spouse carers who had positive opinions, had some experience in dealing with depressed partners, and had quality emotional support reciprocated by providing quality care and support to their depressed partners. For instance, one spouse carer mentioned that it was because they were being attended to by a marriage counsellor that they managed to resolve their marital conflicts. Before they had consulted a marital counsellor and a psychiatrist, the spouse carer had considered quitting the marriage. This may mean that professional counselling played a major role in saving the marriage. This is why Papp et al (2007) emphasize couple therapy as the best approach that professionals can use to attend to depression in a family. If many of those who have dissolved their marriage could have been given information about such services, many more marriages might have been saved.

5.2.2.3 Challenges experienced and support required by spouse carers

Most of the male spouse carers had limited sources of support as compared to female carers. One of the reasons that could have prompted them to limit their support system could be their perception that there was stigma attached to mental illness. One spouse carer mentioned that he could not discuss his wife's illness elsewhere because the moment he mentioned that his wife was seeking help from a psychiatrist, there was a perception that his wife was crazy and could not be assisted to recover from the illness (see 4.3.3.1.). Some of the friends advised him that he needed to move on with his life. If he had not been receiving emotional support from a psychiatrist, he might have heeded the advice of friends. Wittmund et al (2002) found that stigma associated with mental illness made the spouse carers avoid seeking assistance from friends and relatives. Therefore, the burden of providing care to the depressed partner is entirely

vested on the spouse carer which increases the risk of getting depressed (Skarster, Baigi & Haglund, 2006). Mead (2002) advises the spouse carers to seek assistance from relatives and professionals because it may lessen the burden of caring, thus reducing the risk of getting overworked and depressed.

It is important that health workers of whatever rank should join hands to disseminate information to enlighten the entire population of Cape Town that mental illness is just an illness like any other and that with compliance to treatment, the patient can function normally. Besides being afraid of the stigma of mental illness, male carers may also deny the fact that they are getting overwhelmed with the responsibility of caring and may not seek help (Anonymous, 2000). It emerged from the study that the men had only the mothers as supporters. This was typical of the male whose marriage had lasted for about four years. It is apparent that this is the same group of male carers who expressed hopelessness and uncertainty about their future in the marriage (see 4.3.1.3). As a result of weak support systems, spouse carers engaged their depressed partners in arguments and blamed them for a dysfunctional relationship. Similar findings surfaced from the study conducted by Brody (1998) which revealed that male carers may not admit that they are equally affected and need professional attention.

Most of the spouse carers said that they were glad that their depressed partners accepted medical help. Some of them expressed contentment with their partners being admitted to hospital instead of having them at home. This was expressed more by the male carers than the female carers, despite the loneliness they experienced as a result of their partners being hospitalized. It illustrates the extent to which they had exhausted their coping strategies and that they were at the stage of impoverishment according to the APAM model of assessment.

Many of the carers mentioned that despite their depressed partners getting medical attention, the spouse carers were not given attention. Those who participated in the study did so because they felt it would give them a chance to discuss their feelings and hoped that they would be given professional attention in future. These findings conform to those of Harris et al (2006) which revealed that among all the participants who participated in their study, none of the spouse carers had received professional attention.

Most of the female respondents expressed an eagerness to see their depressed partners recover from the depression, especially those who had recently started seeking medical attention. They appeared to be very supportive because they were optimistic that the depressed partner would get better. However, if the depressed partners do not improve as expected by the spouse carers, the support that spouse carers are currently providing may eventually be compromised. This is evidenced by the way some of the carers deal with their partners especially the spouse carers who have provided care for a long period (Resp. GX1). This has resulted in their dealing with the depressed partners in an insensitive manner .e.g. retaliating with a negative response to the depressed partners, distancing when they are in a depressed mood and expressing anger etc (see 4.3.2.2). Involving both the spouse carer and the depressed partner in professional care could have ensured a consistent supportive attitude towards the depressed partner. This could be the main reason that Papp et al (2007) emphasize couple therapy as opposed to directing all the attention only to the patient.

Clinicians attending to the depressed partners should realize that by involving the spouse carer in the treatment plan, they could be promoting a cordial relationship between the spouse carer and depressed partner. From the literature, it is evidenced that a good relationship between the depressed partner and the spouse carer is a

boosting factor towards recovery (Harris et al, 2006). Some of the clinicians argue that the depression could be due to the partner but do not take time to contemplate how much the depressed partner will benefit if they are both involved in the treatment. It is also important to note that the depressed partner spends a short time with clinicians and most of the time with the spouse carer and therefore they should not be treated in isolation.

5.3 Recommendations

The data reveals that most of the challenges that the spouse carers are facing are as a result of a weak support system. Reflecting on (Figure 5.2.1) it can be deduced that most of the spouse carers who participated in the study, fit into the unshaded regions. This could be attributed to a weak support system as revealed in the data analysis. The male carers whose marriages had lasted between three and four years were the most affected because they had limited sources of emotional support. The female carers seem to be transitory between the two dimensions. This may mean that whatever support the spouse carers were receiving was not adequate to maintain them in the shaded regions. Hence, a need for quality emotional support that involves a good network between professionals and psychosocial familial support may be required to be able to keep the spouse carers in the shaded regions. The recommendations therefore will focus on strengthening support systems for the spouse carer.

Firstly, to strengthen the support system for spouse carers, they should be involved in the treatment plan. This is because depression of one member of the family affects all the members of the family in one way or another. The findings revealed that close family members were affected when their loved one experienced an episode of depression. The researcher is aware that the spouse carer could be one of the

precipitating factors to the depression but it may benefit the depressed partner more if both are involved in the treatment. This may be a better way to approach the depression because then the spouse carer will need to modify his/her perceptions and attitudes to be more supportive. Coyne et al (2002) recommends couple therapy because the carer is equally affected by providing care to the depressed partner.

Secondly, an open pathway for spouse carers to seek professional support should be provided in the current health care system. Professional support is important as revealed in the research findings. The two spouse carers who were receiving professional support seemed to be more tolerant, supportive and caring to their spouses. This represents a very small percentage of carers receiving professional support while caring for their depressed partners. Professional support in terms of health education about depression and how to live with depressed partners will be of benefit to the spouse carer. It is therefore important that the health system provides a clear referral system for the spouse carer to access professional support. An open pathway for spouse carers to seek professional help seems to have been neglected in the current health system. Harris et al (2006) recommends professional help for both spouse carer and depressed partner.

Thirdly, it is recommended that support groups for spouse carers should be initiated to help them cope with the burden of care. It will be important for clinicians to consider initiating support groups for carers in every health facility. Support groups provide opportunities of sharing information pertinent to handling situations and effective problem solving strategies. Sharing experience could also be helpful especially for those who do not have experience in living with a depressed partner. Support groups may also increase the support network especially for the male carers who have limited support system due to stigma. It therefore provides an easy approach to making

friends with whom to identify and can provide emotional support when needed. Such avenues could be used to enlighten the spouse carers about the available services such as marriage counselling.

Finally, further research needs to be conducted to test the effectiveness of emotional support by ruling out other factors that could be playing a role in these findings. The findings of this research reveal that quality emotional support to the spouse carers is the backbone of keeping them psychologically healthy i.e. the shaded regions on the diagram (see Figure 5.2.1). A good network between professional and psychosocial support systems is the main way that carers can be maintained in the shaded parts of the diagram above. Uchino (2006) found that spouse carers who receive quality emotional support remained psychologically and physiologically healthy.

5.4 Conclusion

A discussion of the research findings was presented in this chapter. It emerged that most of the findings were similar to the findings of other researchers. Negative descriptions towards partners and the relationship between carers outweighed the positive descriptions and this was attributed to inadequate support services to the spouse carers. The APAM model of assessing the effectiveness of coping mechanisms denoted that most of the spouse carers were at the impoverishment state and needed help to effectively cope with stress due to the caring. A deficit in support services to the spouse carer, and, more importantly, the inadequate professional support, was singled out as one of the main challenges which may need intervention. Finally, recommendations regarding improving the support system for the carer were made.

CHAPTER SIX

Conclusion

In this chapter the conclusion to the study is presented. The study explored the lived experience of spouses living with depressed partners. The background information about the people of Cape Town was discussed in chapter one to provide the context to the study. It was revealed that Western Cape Province is a cosmopolitan province with the majority of the people being Afrikaans speaking and that most of the occupants affiliate themselves with a religious movement.

The literature search involved reviewing the existing information related to experiences of living together with a depressed partner. In the literature, a discussion on depression as mood disorder is presented. The clinical manifestation and the prevalence of the disorder is presented. It is revealed from the literature that major depression is a common mood disorder and may be the most disabling mental disorder by 2020. The effects of depression to the family especially close family members is discussed. It is apparent from the literature that living with or interacting closely with a depressed partner may result in the spouse carer to experience depression. It also emerged that women are more vulnerable to depression than men.

In the research methodology, a qualitative, exploratory phenomenological research design was used to guide the implementation of the study. Its applicability to the study was discussed in Chapter Three. In the research design, qualitative paradigm, phenomenology as a study design and its suitability to the study are discussed. The instruments used in data collection and the process of data collection are presented. In data analysis, the process of analysing the important statements made by the participants was described in details. Prolonged engagement between researcher and

participants, the verbatim transcription of data, transferability and neutrality are some of the procedures utilised to monitor for trustworthiness. Finally, the ethical considerations are discussed.

In Chapter Four, the research outcomes were presented. Four themes emerged centred around the spouse carer's opinions as depicted in their descriptions about depressed partner and the feeling related to their relationship, the approach of dealing with the behaviour exhibited by the depressed partner which included the coping, the challenges the spouse carers faced and the support system available for the spouse carer.

In Chapter 5 the discussion of the research findings were presented. A literature search was once again conducted to relate the findings to the findings from other research conducted elsewhere. It is apparent from the findings to this study that living with a depressed partner increased the risks of the spouse carers getting depressed as revealed by other researchers too. An adequate support system has shown that it can be a better solution to help the spouse carers to cope with the stress due to providing care to the depressed partner. The research findings were presented and gaps noted. For instance, it emerged that despite support to the spouse carers being a valuable aspect, professional support is lacking. Support from family members was the most common resource available to the respondents but the respondents commonly mentioned the mother as the sole source of emotional support. Recommendations to improve support have been made by the researcher because it emerged that emotional support play a major role in maintaining the spouse carer healthy psychologically.

References

- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*. Washington: American Psychiatric Association.
- Anonymous (2000). The astronaut's wife. *Journal of Psychosocial Nursing & Mental Health Services*, 38(10), 20-26.
- Benazon, N. R. (2000). Predicting negative spousal attitudes toward depressed persons: a test of Coyne's interpersonal. *Journal of abnormal psychology*, 109(3), 550-555.
- Benson, P.R. (2006). The impact of child symptom severity and depressed mood among patients of children with ASD. The mediating role of stress proliferation. *Journal of Autism and Development Disorders*, 36(5), 685-695.
- Boor, M. & Wood, F. (2006). *Keywords in Qualitative Methods: A vocabulary of Research Concepts*. London: Sage Publications.
- Brody, J. E. (1998). *Personal health; trying to cope when a partner or a loved one is chronically depressed*. Retrieved March 20, 2008 from <http://query.nytimes.com/gst/fullpage.html?res=9B00EEDD1530F935A35752C0A96E958260&sec=health&spon=&pagewanted=1>
- Brown, G.W & Moran, P.M. (1997). Single Mothers Poverty and Depression. *Journal Of Psychology Medicine*, 27, 21-33
- Corrigall, J., Ward, C., Stinson, K., Struthers, P., Frantz, J., Lund, C., Flisher, A.J & Joska, J. (2007). *Decreasing the burden of mental illness. Western Cape burden of disease reduction project final report (vol. 4 of 7)*. Western Cape Province Government Publishing service
- Coyne, J.C., Thompson, R. & Palmer, S.C. (2002). Marital quality, coping with conflict, marital complaints, and affection in couples with a depressed wife. *Journal of Family Psychology*, 16 (1).
- Creswell, J.W. (2003). *Research design: qualitative, quantitative, and mixed methods approaches*. London: Sage Publications.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. London: Sage Publications.
- Dudek, D., Zieba, A., Jawor, M., Szymaczek, K., Opila, J., & Dattilio, F.M. (2001). The impact of depressive illness on spouses of depressed patients. *Journal of Cognitive Psychotherapy*, 15, 49-57.
- Elliott, T.R., Rivera, P., Beny, J., Oswald, K., Adams, D. & Grant, J. (2006). Problem solving abilities and caregiver adjustment. *Journal of Head Trauma Rehabilitation*, 21(5), 426-427.

- Frisch, N.C. & Frisch, L.E. (2006). *Psychiatric Mental Health Nursing*. Ohio: Delmar Learning.
- Gerson, K. & Horowitz, R. (2002). Observation and interviewing: options and choices in qualitative research. In May, T. *Qualitative Research in Action*. London: Sage Publications.
- Giorgi, A.P. & Giorgi, B. (2008). Phenomenological psychology. in c. willing & w. stainton- rogers. *The Sage Handbook of Qualitative Research in Psychology*. London: Sage Publications.
- Grigg, M. (2003). Working at the world health organization: an international perspective on mental health nursing. *International Journal of Mental Health Nursing*, 12(4), 235-236.
- Granek, L. (2006). What's love got to do with it? the relational nature of depressive experiences. *Journal of Humanistic Psychology*, 46(2), 191-208.
- Hammen, C. (2003). Interpersonal stress and depression in women. *Journal of Affect Disorder*, 74, 49-57.
- 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
- Hornby, A.S. (2005). *Oxford advanced learner's dictionary*. Cape Town: Oxford University Press.
- Jacobson, N.S., Fruzzetti, A.E., Dobson, K., Whisman, M. & Hops, H (2002). Couple therapy a treatment for depression: ii. the effects of relationship quality and therapy on depressive relapse. *Journal of Consulting and Clinical Psychology*, 68(4), 516-519.
- Jarvis, M., Shaibes, P. & Middleton, L. (2004). Nursing the patient with a mood disorder. in L. Uys and L. Middleton (Eds.), *Mental Health Nursing: A South African Perspective* (pp.325-368). Cape Town: Juta & CO.
- Jeglic, E.L., Pepper, C.M., Ryabchenko, K.A., Griffith, J.W., Miller, A.B. & Johnson, M.D. (2005). A care giving model of coping with a partner's depression. *Journal of Family Relations*, 54, 37-45.
- Johnson, S. & Jacob, T. (2000). Sequential interactions in the marital communication of depressed men and women. *Journal of Consulting and Clinical Psychology*, 68(1), 412-431.
- Joiner, T.E. (1994). Contagious depression: existence, specificity to depressed symptoms and the role of reassurance seeking. *Journal of Personality and Social Psychology*, 67(2), 287-296.

- Joyner, K., Theunissen, L., De Villiers, L., Sliman, S., Hardcastle, T. & Seedat, S. (2007). emergency care provision for, and psychological distress In, Survivors of Domestic Violence. *South African Family Practice*: 49(3), 15a-15d.
- Kleintjes, S., Flisher, A.J., Fick, M., Railoun, A., Lund, C., Molteno, C. & Robertson, B.A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa: original article. *South African Psychiatry Review*, 9(3), 157-160.
- Lamb, K.A., Lee, G.R. & Demaris, A. (2003). Union formation and depression: selection and relationship effects. *Journal of Marriage and Family*, 65(4), 953- 956.
- Lankshear, C. and Knobel, M (2004). *Teacher Research: From Design to Implementation*. London, Bell & Bain.
- Lichtman, M (2006). *Qualitative Research in Education: a User's guide*. London: Sage Publications.
- Luxton, D.D., Ingram, R.E. & Wenzalaff, R.M. (2006). Uncertain self-esteem and future thinking in depression vulnerability. *Journal of Social and Clinical Psychology*, 25(8), 840-854.
- Manning, C., and Gregoire, A. (2006) Effects of Parental Mental Illness on Children. *Journal of psychiatry*, 5, 1.
- Margolese, S.K., Markiewicz, D. & Doyle, A.B. (2005). Attachment to parents, best friend, and romantic partner: predicting different pathways to depression in adolescence. *Journal of Youth and Adolescence*, 34(6), 637- 638.
- Marshall, C. & Rossman, G.B. (2006). *Designing Qualitative Research*. London: Sage Publication
- Maxwell, J.A. (1996). *Qualitative Research Design an Interactive Approach*. London: Sage Publications
- Mead, D. E. (2002) Marital distress, co-occurring depression, and marital therapy: A Review. *Journal of Marital and Family Therapy*, 28(3), 299-315.
- Meighan, M., Davis, M., Mitzi, W., Thomas, S. P. & Droppleman, P. G. (1999) living with postpartum depression: the father's experience. *American Journal of Maternal Child Nursing*, 24(4), 202-208.
- Merriam, S.B. (2002). Introduction to qualitative research. In S.B. Merriam and Associates (Eds). *Qualitative research in practice: examples for discussion and Analysis* (pp. 3- 15). San Francisco: Jossey Bass.
- Mowbray, C.T & Mowbray, O.P (2006). Psychosocial outcomes of adult children of mothers with depression and bipolar disorder. *Journal of Emotional and Behavioural Disorders*, 14(3) 130- 142.

- Mustapha, A. (2005). Depression can cause severe physical symptoms. *British Journal of Nursing*, 14(9), 482.
- Myburgh, C. & Poggenpoel, M. (2007). Qualitative methods: a research approach worth considering. *South Africa Psychiatry Review*, 10, 66-67.
- Neuman, W.L. (2003). *Social research methods: qualitative and quantitative Approaches*. Boston: Pearson Education.
- Neuman, W. L. (2006). *Social research methods: qualitative and quantitative Approaches*. Boston: Pearson Education.
- Newsome, J.T. & Schulz, R. (1998). Care giving from the recipient's perspective: negative reaction to being helped. *Health Psychology*, 17, 172-181.
- Nightingale, K. (2008). Mental health research: falling through the Gaps. *News, Health Systems Trust*. Retrieved April 10, 2008, from <http://www.hst.org.za/news/20041756>
- Nili, B. R. & Coyne, J. C. (2000). Living with a depressed spouse. *Journal of Family Psychology*, 14(1), 71-79.
- Norton, M (2002). Does having a depressed spouse increase an older adult's risk for developing depression? *The Gerontologist*, 42(1), 119.
- Otong, D. A. (2003). *Psychiatric nursing. biological & behavioural concepts*. Australia: Thomson.
- Papp, L.M., Goeke-Morey, M.C. & Cummings, E.M. (2007). Linkages between spouses' psychological distress and marital conflict in the home. *Journal of Family Psychology*, 21(3), 533-537.
- Patton, M.Q. (1990). *Qualitative evaluation and research method*. London: Sage Publications.
- Paxton, R.J., Valois, F.R., Watkins, K. W., Huebner, E.S. & Drane, J. W. (2007). Associations between depressed mood and clusters of health risk behaviours. *American Journal of Health behaviour*, 13(3), 272-284.
- Richards, K. (2003). *Qualitative Inquiry in TESOL*. New York: Palgrave Macmillan
- Riebschleger, J. (2004). Good Days and Bad Days: The Experiences of Children of a Parent with a Psychiatric Disability. *Psychiatric Rehabilitation Journal*, 28, 25-30
- Roberts, S. L., Bushnell, J. A., Collings, S. C. & Purdie, G. L. (2006). Psychological health of men with partners who have post-partum depression. *Australian and New Zealand Journal of Psychiatry*, 40, 704-711.

- Ross, C.E. (2000). Neighbourhood disadvantage and adult depression. *Journal of Health and Social Behaviour*, 41(2), 177-187.
- Rotermann, M. (2007). Marital breakdown and subsequent depression. *Journal of Health Report*, 18(2), 33-44.
- Sacco, W.P. & Phares, V. (2001). Partner appraisal and marital satisfaction: The role of self-esteem and depression. *Journal of Marriage and Family*, 63, 504-513.
- Schmaling, K.B. & Jacobson, N.S. (2002). Marital interaction and depression. *Journal of Abnormal Psychology*, 99(5), 129-134.
- Skarsater, I., Baigi, A. & Haglund, L. (2006). Functional status and quality of life in patients with first episode major depression. *Journal of Psychiatric and Mental Health Nursing*, 13, 205-213.
- Skarsater, I. (2006). Parents with first time major depression: perceptions of social support for themselves and their children. *Scandinavian Journal of Caring Sciences*, 20(3), 308-314.
- Solomon D., Keller M.B., Leon A., Mueller T., Lavori P., Shea, M.T., Coryell W., Warshaw M., Turvey C., Maser J. & Endicott J. (2000). Multiple recurrences of major depression. *American Journal of Psychiatry*, 157, 229-233.
- South African Government Information (2006). The land and its people. Pretoria: South African Government Publishing Service. Retrieved January 30, 2008, from www.info.gov.za/aboutsa/landpeople.htm
- Stimpson, J.P., Peek, M.K., & Markides, K.S. (2006). Depression and mental health among older Mexican American spouses. *Journal of Aging and Mental Health*, 10(4), 386-393.
- Stuart, G.W. & Laraia, M. T. (2001). Principles and practice of psychiatric nursing. London: Mosby
- Tomlinson, M., Swartz, L., Cooper, P.J. & Molteno, C. (2004). Social Factors and Postpartum Depression in Khayelitsha, Cape Town. *South African Journal of Psychology*, 34(3), 409-420.
- Thom, R. (2007). Psychiatry at Primary Healthcare Level. In S.E. Baumann (Ed), *Primary Health Care Psychiatry: A practical guide for Southern Africa* (pp. 2-9). Cape Town: Juta.
- Uchino, B.N. (2006). Social support and health: A review of physiological processes potentially underlying links to disease outcomes. *Journal of Behavioural Medicine*, 29, 377-387.

- Van Wijngaarden B., Schene, A.H & Koeter, M.W. (2004). Family care giving in depression: impact on caregivers' daily life, distress, and help seeking. *Journal of Affect Disorders*, 81, 11–22.
- Williams, K & Umberson, D. (2004). Marital Status, Marital Transition and Health: a gendered life course perspective. *Journal of Health and Social Behaviour*, 45, 81-98.
- Wittmund, B., Wilms, H. U., Mory, C. & Angermeyer, M. C., (2002). depressive disorders in spouses of mentally ill patients. *Journal of Psychiatric Epidemiology*, 37, 177–182.
- World Health Organisation (2004). *Prevention of Mental Disorders: Effective interventions and policy options*. World Health Organisation. Retrieved October 15, 2007, from [http://who.int/mental_health/evidence/en/prevention_of_mental_disorders sr](http://who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr).
- Xoliswa, Z. (2005). Mental Illness on the Rise in South Africa. *Health Systems Trust News*. Retrieved February 28, 2008, from <http://www.hst.org.za/news/20040998>



Appendix

Appendix A: Challenges I Faced as I carried the research process

The Political mayhem that made it totally impossible to collect data in Kenya necessitated a request to change the data collection site to Cape Town, Western Cape Province, South Africa. Permission was granted by the Higher Degree Committee to collect data in Cape Town.

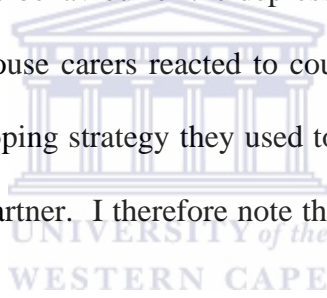
The Lentegeur Hospital Research Ethics Committee took longer than three months to approval my request to collect data at the hospital's outpatient department. After getting permission from the Higher Degree to collect data in Cape Town I applied for permission to collect data at Lentegeur Hospital. It took approximately three months before I could be given permission to collect data at Lentegeur Hospital.

Recruiting of participants was challenging because some of the potential participants refused to participate in the study because they were still in denial that their partners were suffering from depression especially the male partners. However, the excuse they gave was that they are busy and could not get time to participate in the study. I also realized that despite the fact that many people are being treated for depression, most of them are divorced or separated and could not qualify to participate in the study.

In the data collection process, I realized that most of the respondents were very guarded and could not open up easily to give information. This prompted me to ask more questions to probe for more information although my plan was to limit the number of questions so that participants can talk more.

Appendix B: Realization of the Research Aims and Objectives

The research aim was to explore the lived experiences and feelings of spouses who lived with their depressed spouse. This aim was achieved by exploring the lived experience of seven participants. The experiences and feelings that emerged were presented in chapter 4 and it revealed that most of the respondents expressed negative feeling towards living together with a depressed partner. Most of them described it as a sad an exhausting and stressful experience. The challenges that they undergo as they provide the care were sort and it emerged that the spouse carers experience many challenges some of which predispose them to depression. The coping mechanisms the spouse carers used to cope the behaviour of the depressed partner was described. It is apparent that the way the spouse carers reacted to counteract the behaviour of their depressed partners was the coping strategy they used to solve problems that emerged due to the behaviour of the partner. I therefore note that I achieved all the objectives as stipulated in my proposal.



Appendix C: Interview Protocol

Title: The experiences of spouses living with clinically depressed patients.

Name of the Health Facility.....

Interview Number

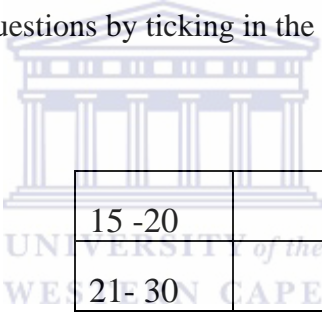
Date of the Interview

SECTION A

Demographic Data

Please answer the following questions by ticking in the appropriate box.

1. Age



15 -20	
21- 30	
31- 40	
41- 50	
51- 60	
61- 70	
71- 80	
81and above	

2. For how long have you lived together?

1- 6 Months	
7- 12 Months	
1- 2 years	
3-4 years	
5- 6 years	
7-8 years	
9-10 years	
11-12 years	
13 -14 years	
15 years and above	

3. Are you employed?

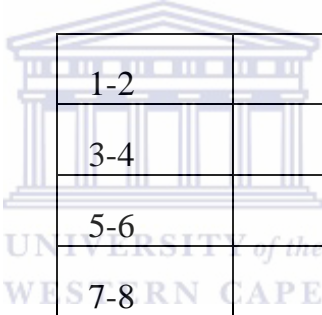
Yes	
No	

4. Where do you get emotional support from?

Relatives	
Support group	
Government	
Church/Mosque	
Community/ Friends	
Other	

5. Do you have children?

If yes how many?



1-2	
3-4	
5-6	
7-8	
9 and above	

6. For how long have you been providing care to your spouse?

0- 5 year	
6- 10	
11- 15	
16-20	
21 and above	

SECTION B

Interview question

The participants will be asked the following one question and be allowed to narrate their story. “Share with me as much information as you can concern your experiences about living with a depressed spouse.”

Probing will be used to redirect the interview and to ascertain the coping strategies used by the spouses. Some of the questions asked to probe the participants’ responses included:

What does it feel like living with a depressed partner?

Share with me about your typical day.

Share with me about your good days and bad days while living with him/ her.

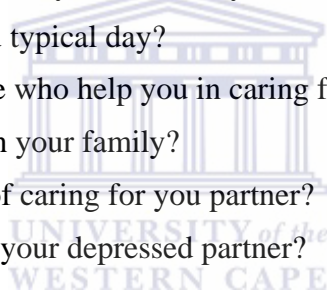
What events characterises you typical day?

Tell me about the other people who help you in caring for your depressed partner.

How do you solve problems in your family?

How do you perceive the art of caring for you partner?

What is your attitude towards your depressed partner?



Appendix D: Consent Form



University of the Western Cape

SCHOOL OF NURSING

Private Bag X17 Bellville 7535 South Africa
Telephone: (021) 959 2277 Fax: (021) 959 2845
Email: 2701509@uwc.ac.za

Research Title: The experiences of spouses living with clinically depressed patients

I..... agree to participate in the interview conducted by Mr. Mose, a post- graduate student in the department of nursing at University of Western Cape. He has explained to me in detailed and I understand that:

- Participation is voluntary and I can withdraw any time without giving any reason.
- Information will be kept under lock and key and will be destroyed after finishing writing the research.
- I am at liberty to answer only those questions that am comfortable with.
- The data collected will only be used for the research purpose and will be audio taped.
- The researcher may call me or come back in person for clarification of any point or statement that may no be clear.
- There are no direct benefits to the participation but the findings will be used by professionals to improve services to the patients and care givers.

He has explained to me that each interview will take approximately 40 minutes and I am allowed to ask questions during the session.

The contact of researcher: Cell 0742292453, email 2701509@uwc.ac.za

Signature of participant..... Date.....

Signature of researcher..... Date.....

Supervisor
Dr June Jeggels (PhD)
Clinical Program Coordinator
School of Nursing
University of the Western Cape
Private Bag X17
Bellville 7537
Tel: +27 21 959 2278
Fax: +27 21 9592679
E-mail: jjeggels@uwc.ac.za

Appendix E: Higher Degree Ethics Clearance Letter

**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT**

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

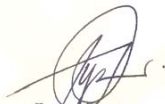
31 October 2007

To Whom It May Concern

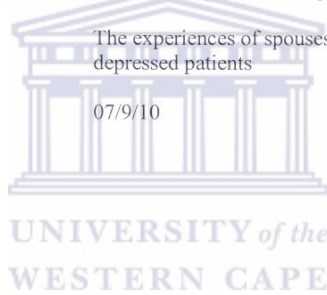
I hereby certify that the Senate Research Committee together with the relevant Ethics Committee of the University of the Western Cape has approved the methodology and the ethics of the following project by: Mr. I Mose (Dept. of Nursing)

Research Project: The experiences of spouses living with clinically depressed patients

Registration no: 07/9/10



Peter Syster
Research Development
University of the Western Cape



**UNIVERSITY of the
WESTERN CAPE**

A place of quality, a place to grow, from hope to action through knowledge

Appendix F: Application Letter to Lentegeur Hospital for Data collection

Mose, Isaiah
School of Nursing
University of Western Cape
Private bag X79, Bellville
7535.
Cell: 0745339352
19th May, 2008

Through: Mrs B. Swartz (Director of Nursing)
To The Chairperson
Research Ethics Committee
Lentegeur Psychiatric Hospital

Dear sir/ Madam

Re: Application for Permission to Conduct Research at Lentegeur Psychiatric Hospital

I am a postgraduate student at the University of Western Cape, pursuing master of nursing degree (MCUR).

As a requirement of the degree, I am required to conduct a research. The title of my research, **“Experiences of the Spouses Living with their Clinically Depressed Partners”**. The aim of the study is to explore the experiences and feelings of the spouses of the depressed patients. This will uncover the meanings that the spouses attach to the lived experiences, to describe the impact depression has had in their lives and the coping strategies they employ as they interact and live with their sick partners. I humbly request for permission to conduct my research in your Hospital. I intend to recruit seven participants whose spouses are seen at the outpatient department. A report of the findings will be presented to your office after completion of the study. Attached please find letters of ethical clearance from the Research Ethics Committee and School of Nursing of the University of Western Cape.

Thank you in advance

Yours Sincerely

Mose, I

Appendix G: Approval of Data Collection at Lentegeur Hospital

CONFIDENTIAL

Enquiries : Prof Denise White

Reference :

Telephone : 021- 3701180

Date : 26 August 2008

Provincial Administration : Western Cape
Department of Health



Provinsiale Administrasie : Wes-Kaap
Departement van Gesondheid

Ulawulo Lwephondo : Intshona Koloni
Isebe Lezempilo

Dear Mr Mose

Re: RESEARCH PROPOSAL

This is to inform you that your research proposal was approved in principle by the Lentegeur Hospital Research and Ethics Committee with the proviso that the research be carried out in an outpatient setting, and not in the neuroclinic setting, for the reasons explained to you at the protocol meeting.

The patients to be interviewed by yourself must be selected and approved of initially by the psychiatrist or psychologist in the outpatient department at Lentegeur Hospital.

Informed consent of the patient must be obtained prior to interviewing the respective spouses of patients.

The committee wishes you well in your research endeavour.

Yours sincerely

Prof White
Chair Ethics and Research Committee
Lentegeur Hospital

**UNIVERSITY of the
WESTERN CAPE**

Lentegeur Hospitaal	Lentegeur Hospital
P.K. MITCHELLS PLAIN	P.O. MITCHELLS PLAIN
7785	7785
Tel. (021) 370 1111	Fax (021) 31 7359

Address all correspondence to the Senior Medical Superintendent.
Rig alle korrespondensie aan die Senior Mediese Superintendent.