Partner Support in Depression

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Abstract

This descriptive, qualitative study explored couples' experiences of giving and receiving support for depression. Nine people who were or had been depressed were interviewed jointly with their partners on two separate occasions. Partners were asked what their attempts to be supportive had entailed, what had helped or hindered them in providing support, and how they had experienced the support process. People with depression were asked how they had experienced their partner's support attempts and, in particular, what they had found helpful or unhelpful. The interview data were analysed using interpretative phenomenological analysis, the aim being to identify themes that were common across couples relating to the experience of giving and receiving support for depression in the context of an intimate relationship. Several themes emerged, which were organised within two higher-order domains. The first domain, 'Couples' experience of depression: A longitudinal perspective', was concerned with the changing context of the couples' experience and thus provided a dynamic backdrop to the second domain, 'The helping process', which focused specifically on participants' experiences of giving and receiving support for depression. Couples' accounts suggested that the challenges they faced over the course of an episode of depression were many and could vary substantially from one phase in this developmental journey to the next. This added a further layer of complexity to the already difficult circumstances in which the couples' coping and helping efforts took place.

Acknowledgements

Chapter 1: Introduction

Depression is a highly prevalent and sometimes fatal form of psychological distress. A source of considerable suffering in those affected, depression is also associated with significant incapacitation. Indeed, World Health Organisation figures indicate that depression was the predominant cause of years lived with disability throughout the developed and developing world in 1990 (Murray & Lopez, 1996). The psychological literature on depression is replete with putative examples of how depression may affect and be affected by the social environment. Surprisingly, however, very little is known about what kinds of help people with depression value from those they are close to, or indeed what happens when their significant others try to help.

In the first half of this chapter, I present data on the nature and prevalence of depressive disorders, followed by a review of research findings on psychological help-seeking patterns and preferences in the general population. I then discuss the social support and informal helping literatures, with a particular emphasis on studies that have sought to explore the process and consequences of helping interactions between intimate partners. In the second half of the chapter, I consider the interpersonal context of depression, focusing on the intimate relationships of depressed persons and their partners. Finally, I integrate the main findings from these literatures and present the rationale for the current study.

Informal Helping and Social Support

Help-seeking for psychological problems

Depression has been described as "the common cold of psychiatry" (Seligman, 1975) – a description which speaks to the prevalence of depressive disorders in the general population rather than the pain and distress that go with them. Nevertheless, prevalence figures are striking, with most estimates suggesting that about 6% of the population is affected at any

given time (Roth & Fonagy, 1996). In a Swiss prospective community survey conducted over 10 years, the lifetime prevalence of major depressive disorder to age 30 was 15% (Angst, 1992). This is broadly consistent with prevalence estimates based on retrospective reports from the US National Co-morbidity Survey (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). Most studies have found greatly elevated rates of depression in women compared to men (e.g. Kessler *et al.*, 1994; Robins & Reiger, 1991; Weissman, 1987). There is also evidence that an increasing number of young people are becoming depressed (Burke, Burke, Rae, & Reiger, 1991), and that rates of depression are increasing generally (Klerman & Weissman, 1989).

Depression is typically a recurrent, episodic disorder, with initial onset usually in a person's 20s (Coyne & Whiffen, 1995). Analyses of survey data from the US indicate that people who become depressed over the course of a year are 40 times more likely to have had past depressive episodes than those who do not become depressed (Kessler & Magee, 1994). Long-term follow-up of depressed psychiatric patients has found that very few experience only a single depressive episode (Keller, Lavori, Lewis, & Klerman, 1983). Moreover, those seeking outpatient treatment for depression are likely to spend about 20% of their lives depressed (Angst, 1986).

It is generally true that the need for mental health services far surpasses what could be met by professional therapists (Christensen & Jacobson, 1994). Indeed, while epidemiological surveys have found that about 30% of the US population will meet criteria for one or more psychiatric disorder during their lifetime, it has been estimated that only about one in five people with a diagnosable disorder currently receives treatment (Castro, 1993). Other authors have drawn similar conclusions. Thus Weissman (1987) calculated a six-month treatment rate of 19% for people meeting psychiatric criteria, while the US National Co-morbidity Survey (Kessler *et al.*, 1994) found that only around 40% of respondents with any lifetime psychiatric disorder had received professional treatment (compared with just under

60% of those with three or more lifetime diagnoses). The latter survey also revealed that only 26% of respondents had used specialist mental health services.

Such findings are not limited to the US, however: the UK National Survey of Psychiatric Morbidity found that less than 14% of people with a neurotic disorder were receiving any kind of professional treatment (Bebbington, Brugha, Meltzer, Jenkins, Ceresa, Farrell, & Lewis, 2000). These data are consistent with Goldberg and Huxley's (1992) conclusion that "episodes of disorder are fairly common in the population, but ... only a small minority will be seen by mental health professionals" (p. 5). Depression appears to be no exception to this general rule. In the Swiss study cited above (Angst, 1992), only about half of those who developed major depression also received treatment for their difficulties – supporting Weissman's (1987) claim that most cases of even major depression go untreated.

This is not simply a case of demand for mental health services outstripping their supply, however, for it appears that many people who experience psychological problems do not present to professional helpers at all. Rather, the studies reviewed below highlight the importance of ordinary network members, and particularly partners, to people facing psychological difficulties. Throughout the discussion that follows, the term 'formal helping' is used to refer to any of the various types of help provided by a trained, professional helper (e.g. psychological therapy or counselling), while 'informal helping' describes supportive exchanges "between ordinary people in everyday settings" (Barker & Pistrang, 2002, p. 362).

Help-seeking attitudes and behaviour in the general population

From an early coping survey of the US population, Gurin, Veroff, and Feld (1960) found that less than one fifth of people who considered themselves to have psychological difficulties had sought the help of mental health specialists. More than two-thirds of respondents in this survey reported taking their difficulties to priests or general physicians, however. Some years later, Brown (1978) conducted an epidemiological study of 1,106

adults living in Chicago. Sixty-eight percent of this sample had sought some kind of help in connection with the 26 types of life problem presented, with a four-to-one ratio of informal to formal help. In the same year, Gourash (1978) concluded that, even when respondents had used professional helpers, they tended to have first sought help from a close relation.

Veroff, Kulka, and Douvan (1981), in a replication of their earlier study, surveyed a representative sample of 2,267 adults from 48 coterminous states in the US, using a lengthy semi-structured interview with sections on subjective well-being, social networks, life events and help-seeking patterns. The findings revealed high rates of help seeking and, once again, a preference for informal helpers. In coping with major life crises, 3% of respondents only used formal help, 45% only used informal help, and 39% used a combination of both sorts (a surprising 13% reported receiving no help of any kind).

These North American surveys indicate that rates of help-seeking are high for people facing some kind of life stressor – in the region of 80 to 90% (Wills, 1992). Moreover, the ratio of informal to formal help seeking is generally about five to one or greater – the difference decreasing slightly for major life crises but still evident even for the most serious problems (Wills, 1992). It has been suggested that the data are consistent with a help-seeking chain or pathway according to which minor problems are managed within informal networks, more persistent problems taken to non-specialist helpers (e.g. priests and general practitioners) and severe difficulties referred to mental health specialists (Barker & Pistrang, 2002; Rogler & Cortes, 1993; Wade, Howell, & Wells, 1994; Wills & DePaulo, 1991).

Barker, Pistrang, Shapiro, and Shaw (1990) conducted a study of psychological coping and help-seeking attitudes in the UK. From interviews with a large, representative sample of the national adult population, they found that participants tended to say that they would make use of informal rather than formal helpers were they to experience psychological problems. The most favoured informal helpers were partners (endorsed by 68%), close relatives (54%) and friends or neighbours (43%). (The most popular formal helper, the GP, was endorsed by

41%.) This is consistent with data from the US indicating the pre-eminence of the spouse or partner in the provision of informal support (e.g. Veroff *et al.*, 1981). Individuals reporting more psychological symptoms showed a greater willingness to seek help from both informal and formal sources; and women were more likely than men to seek help from (close) relatives, friends and neighbours. Barker *et al.* (1990) suggest that their findings are "consistent with the assumption that people with psychological problems look first to those … that they are close to" (p. 282). Interestingly, however, participants in this study reporting higher levels of depressive symptoms were less inclined to seek help from their partners. This suggests that there may be something about the experience of depression that disrupts the usual process of seeking, or providing support, in the context of an intimate relationship. I return to this issue later in the chapter.

Overall, the findings reviewed above – based both on what people say they would do and on what they report actually having done – indicate a general preference for informal over formal helpers for people facing psychological difficulties. Moreover, the most popular informal helper is often reported to be the partner. Cowen (1982) suggests some reasons why people may be reluctant to bring their personal problems to mental health professionals, at least during the early stages of their distress. This may be because services are located too far away, because they are too expensive (in places where healthcare services must be paid for), or because people's attitudes or beliefs are not easily reconciled with the services on offer. In the absence of these obstacles, however, people may still prefer to talk with trusted individuals from within their natural networks – i.e. "people who are willing to listen when they are ready to talk" (Cowen, 1982, p. 385).

Who can be an effective helper?

One issue that has not been addressed in the research reviewed so far is to what extent informal helpers can be considered effective helpers. Given the difficulty of designing studies to address this question directly, an alternative approach is to consider what level of

training, if any, one might need in order to become an effective helper. This draws on Barker and Pistrang's (2002) conceptualisation of helping as a continuum based on the extent of formal training in psychological helping received. According to this model, untrained helpers (friends, partners, fellow patients) are located at the pure informal end of the continuum and trained helpers (psychotherapists, counsellors, psychiatrists) comprise the formal end. Somewhere in the middle would be a less clearly defined group of helpers with some training or experience in psychological helping – e.g. mental health paraprofessionals, priests, general practitioners, *etc* (Barker & Pistrang, 2002).

Durlak (1979) reviewed 42 studies comparing professional and paraprofessional therapists. The review included individual and group psychotherapy, crisis counselling, behaviour modification, social and vocational rehabilitation programs, and academic-adjustment services. Individuals with formal clinical training in psychology, psychiatry, social work, or psychiatric nursing were defined as professionals. Surprisingly, Durlak found that most of these studies indicated no differences in effectiveness between professional and paraprofessional therapists, and only one showed the former to be more effective. Moreover, in 12 of the studies, paraprofessionals fared better than did professionals. Although the studies reviewed offered few clues as to what lay behind the impressive performance by paraprofessionals, Durlak (1979) was to conclude that "professional mental health education, training, and experience do not appear to be necessary prerequisites for an effective helping person" (p. 80).

With the exception of a handful of investigations of self-help groups cited by Christensen and Jacobson (1994), most of the outcome studies in reviews such as these have investigated helping towards the formal end of the continuum. Consequently, we know very little about the outcome of everyday support attempts. However, as Barker and Pistrang (2002) point out, studies designed to compare helpers at the informal end of the continuum with helpers

belonging to the formal end would be neither ethical nor practicable, as they would require

that participants be barred from sources of informal support.

Barker and Pistrang (2002) argue that "both formal and informal helping have their proper

roles" (p. 364), but not that they are the same thing. Thus, while the most effective informal

helping may have many qualities in common with the help provided by trained therapists

(e.g. Cowen, 1982), this is not to say that anyone can do therapy, nor is it to deny that, in

practice, informal support attempts may often not be very helpful at all (Barker & Pistrang,

2002). In the sections that follow, I review some of the studies that have sought to explore

what actually happens in informal helping interactions, and consider the potential

consequences of such encounters for both helper and helpee. Much of this research been

conducted within, or has grown out of the social support field, which will therefore be the

starting point for this discussion.

Social support and informal helping

In the late 1970s, Cassel (1976) and Cobb (1976) published highly influential reviews of

research evidence concerned with the impact of social relationships on physical and

psychological well-being. Theory and research on 'social support' subsequently proliferated.

Indeed, some 20 years later, Cutrona (1996) estimated that more than 4000 papers had been

published on the subject since 1980. The benefits claimed for social support have been

diverse. It has been widely argued that social support acts as a 'buffer' against the harmful

effects of stress (e.g. Cassel, 1976; Dean & Lin, 1977), for example, and also that social

support is beneficial to well-being even when stress levels are low (e.g. Henderson, 1980;

Lin, Simeone, Ensel, & Kuo, 1979; Williams, Ware, & Donald, 1981). Social support has

been presented as facilitating adjustment to adverse experiences ranging from asthma

(DeAraujo, van Arsdel, Holmes, & Dudley, 1973) to widowhood (Vachon, Lyall, Rogers,

Freedman-Letofsky, & Freeman, 1980). There is also a well-known association between

social support and a range of physical health outcomes (reviewed in Sarason, Sarason, &

Gurung, 2001), the most striking being reduced mortality (Berkman & Syme, 1979; Burman

& Margolin, 1992). However, while numerous studies have found an association between

social support and measures of well-being, the predominantly correlational nature of this

data means that the direction of the (putative) causality remains uncertain (Dooley, 1985;

Wortman & Dunkel-Schetter, 1987). Moreover, there is no consensus within the field on

how social support should be conceptualised (Cutrona, 1996).

Despite the divergence of opinion over what is being measured, there has been considerable

uniformity of method in studies of social support. Thus most researchers have relied on

(retrospective) self-report as a means of assessing the qualities of a person's social

relationships (Barker & Pistrang, 2002). This approach has been criticised for its subjectivity

and the possibility of influence by variables unconnected with the support received – e.g. the

mood or personality of the recipient (Procidano & Heller, 1983). These difficulties have

been downplayed by authors who claim that it is the belief that others will provide support in

times of crisis which is beneficial, even when this is unfounded or erroneous (Thoits, 1992;

Turner, Frankel, & Levin, 1983). This has been described as 'perceived social support'

(Dunkel-Schetter & Bennett, 1990).

Other researchers have sought to be more objective by asking for estimates of some concrete

aspect of the support received – e.g. the frequency of supportive behaviours from others

during a specified period (Barrera & Ainley, 1983). The construct in this case has been

labelled 'received social support'. This approach has been criticised by authors who point

out that the number of support-intended acts does not in itself indicate the quality of the

support received (Turner *et al.*, 1983). Indeed, as I discuss below, attempts to provide

support are not always perceived as helpful by the person on the receiving end. Another

problem with received social support is that the number of supportive acts provided may

reflect the seriousness of the helpee's difficulties or distress – i.e. more support may be

provided by others when an individual appears to need it – making it difficult to interpret a

positive correlation between frequency of support and level of distress (Coyne & Bolger, 1990; Cutrona, 1996).

These methodological and conceptual problems notwithstanding, a consistent finding has been that people who report better social support also tend to report greater psychological well-being. Although it has frequently been argued that the former causes the latter, most of this research has little to say about how social support might have this supposed effect. Moreover, because investigators have tended to use broad categories to describe support attempts (Barker & Pistrang, 2002) – e.g. 'emotional', 'informational', 'instrumental' – these studies tell us little about what actually goes on in helping interactions (Pistrang, Barker, & Rutter, 1997).

During the 1990s, a number of authors called for a move towards research methods better suited to capturing the interactive nature of social support (Burleson, Albrecht, & Sarason, 1994; Coyne & Bolger, 1990; Fincham & Bradbury, 1990; Pistrang *et al.*, 1997; Sarason, Sarason, & Pierce, 1994). This appeal was apparently heard, as a growing number of studies have since begun to explore what happens when one person reveals a source of concern or distress to another. Given the obvious practical difficulties associated with researching informal helping as it happens *in vivo*, a viable alternative has been to examine actual or simulated helping interactions in the laboratory (e.g. Barker & Lemle, 1984; Cutrona & Suhr, 1994; Pasch & Bradbury, 1998; Pistrang & Barker, 1998; Pistrang *et al.*, 1997). Observational coding schedules have also been used to describe what people say and do in trying to be helpful (e.g. Barker & Lemle, 1984; Cutrona, Suhr, & MacFarlane, 1990). Yet another approach to investigating the helping process has involved asking people who have experienced a stressful event (e.g. bereavement, serious illness) about others' attempts to be supportive. As well as providing some clues as to the kinds of support that are most welcomed by such individuals, these studies have indicated some of the ways in which attempts to help may be misguided or otherwise go awry.

The views of support recipients on what is helpful and unhelpful

Lehman, Ellard, and Wortman (1986) asked people who had suffered a bereavement to describe helpful and unhelpful support attempts by others. They compared these reports with responses from control participants who had been asked what they would do or say in trying to help a bereaved person to cope. In this study, 73% of the bereaved participants reported that other people had been helpful in coping with their loss. In terms of what was considered helpful, contact with a similar other was the most frequent response. Expressions of concern, opportunity to talk about feelings, involvement in social activities, and presence of another person were also helpful and, moreover, never cited as unhelpful. While uninformative about the relative frequency of helpful and unhelpful support attempts, Lehman *et al.*'s findings on the latter are nevertheless striking. Thus 62% of the bereaved participants reported that others had said or done unhelpful things. The most common unhelpful support tactics were giving advice, encouragement of recovery, minimisation / forced cheerfulness, and identification with feelings (e.g. "I know how you feel").

Interestingly, control participants tended to say that, in trying to help a bereaved person, they would "be there", express concern, and provide opportunities to talk about feelings. They rarely mentioned unhelpful support tactics; indeed, only 14% of control responses fell into the bereaved respondents' 'unhelpful' categories. Moreover, control participants' estimates of their bereaved target's recovery were consistent with the latter's self-reports of their actual recovery. This study suggests that, hypothetically, people can identify appropriate strategies for supporting a bereaved person, and can make accurate estimates about the duration of the person's emotional distress, yet it nevertheless appears that, in practice, people do and say unhelpful things. In trying to account for their findings, Lehman *et al.* argue that encounters with people who have suffered adverse life events may often be too anxiety-provoking for delivery of effective support strategies. Of potential relevance to this discussion, the authors suggest that supporter anxiety may increase where the recipient is

unable or unwilling to indicate that a support attempt has been helpful, and that some types of distress (e.g. anger) may be more likely to disrupt the delivery of helpful support.

Other investigators have taken a similar approach in exploring perceptions of the help provided to people coping with a serious illness, such as cancer (Dakof & Taylor, 1990) or multiple sclerosis (Lehman & Hemphill, 1990). Overall, these studies suggest that expressions of concern, love, and understanding are generally regarded as helpful, while responses that serve to minimise or maximise symptoms are considered particularly unhelpful (Lehman & Hemphill, 1990).

The impact of unhelpful social encounters

More quantitatively-oriented investigations of social support have also highlighted potentially unhelpful aspects of social relationships. For example, Fiore, Becker, and Coppel (1983) found that the extent to which participants rated network members as upsetting was a better predictor of depression than ratings of their helpfulness; while a study by Rook (1984) revealed that negative interpersonal experiences were "more consistently and more strongly related to well-being" in a sample of widowed women than were positive social encounters (p. 1097). Similarly, from a longitudinal study of people caring for a spouse with Alzheimer's disease, Pagel, Erdly, and Becker (1987) found that the extent of carers' upset with their networks was strongly correlated with lower network satisfaction at initial interview and at follow-up 10 months later. By contrast, helpful aspects of carers' networks had little or no relationship with depression or network satisfaction.

Thus there is a fair amount of empirical evidence to suggest that social interactions, including attempts to be supportive, may sometimes feel unhelpful to and, moreover, have a detrimental impact on people facing difficulties of various kinds (see also Davidowitz & Myrick, 1984; DiMatteo & Hays, 1981; House, 1981; Thoits, 1982; Wortman, 1984). The issue of how and why attempts to be supportive may go awry in close relationships is considered in more detail below. Before turning to the issue of helping in close relationships,

I briefly review some research findings on the potential emotional consequences of trying to relieve another person's distress.

The emotional consequences of trying to provide comfort

Perrine (1993) has argued that, relative to the recipients of support, support providers have been neglected in the social support literature and that, consequently, little is known about the emotional consequences of providing support in informal situations. There is some evidence to suggest that providing social support can have adverse consequences for the health of the helper and, as will be discussed in more detail later in this chapter, that exposure to another's distress may be particularly stressful (e.g. Coyne, Kessler, Tal, Turnbull, Wortman, & Greden, 1987; Kessler, McLeod, & Wethington, 1985). Studies by Notarius and Herrick (1988) and Perrine (1993) have sought to explore whether certain helper response styles confer greater protection against adverse emotional consequences.

In Notarius and Herrick's (1988) study of the relationship between listener response style and listener emotional response, 30 female participants engaged in a 15-minute conversation with a confederate enacting a depressed role. Observational codings indicated that just over half of the listeners tried to manoeuvre away from the speaker's low mood with problem-solving strategies or irrelevant small-talk. The remaining participants employed supportive listening techniques to demonstrate attention to and acceptance of the other's distress. Listeners who relied most heavily on problem solving reported higher levels of depressed mood following the interaction and were less willing to have future contact with their 'depressed' partners than participants who drew on a supportive listening strategy.

Notarius and Herrick (1988) speculate that, aware that their advice and attempts at levity were being ignored, listeners who took a predominantly problem-solving approach may have experienced a sense of failure in the task of being a good person to talk to. They suggest that an internalised sense of helplessness may have explained these listeners' increase in depressive feelings, while their unwillingness to have further contact with their

conversational partner perhaps reflected the desire to avoid a situation in which they felt inept, rather than rejection of the 'depressed' person *per se.* Notarius and Herrick acknowledge, however, that the study's correlational design makes it impossible to determine whether there was a causal relationship between listener response strategy and listener affective reaction.

Perrine (1993) conducted a similar study, which extended Notarius and Herrick's (1988) paradigm by including a condition in which the helpee did not respond to the supporter's efforts. In Perrine's study, student participants engaged in helping interactions with a confederate role-playing someone who had recently broken up with a partner. Regardless of their predominant helping strategy (i.e. 'active' vs. 'supportive'), participants tended to feel better when the person they were trying to help appeared to become less distressed. When attempts to help seemed to have no beneficial effect, however, those who relied on supportive strategies (i.e. sympathetic listening, commiserating, offering encouragement) reported a greater increase in their feelings of sadness and anger. Perrine explains the discrepancy with Notarius and Herrick's (1988) findings with reference to the differing contexts (i.e. cover stories) for providing support in each of the two studies, suggesting that participants' different motives (i.e. to 'be there' vs. to 'help') may have influenced the response strategy-emotion relationship in each case. Perrine (1993) concludes, "To the extent that emotions are reactions to motive relevant events, it is important to know the motive of the supporter before predictions about emotional consequences can be made" (p. 382).

Social support in close relationships

The literature on helping and coping is replete with examples of the benefits associated with having close personal relationships (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder 1982). Indeed, Cutrona (1996) argues that intimate relationships constitute the principal domain for the provision of social support. As discussed above, numerous studies have

found that, for people facing adversity, the spouse is frequently the first person turned to. Moreover, support from elsewhere appears not to make up for the absence of an intimate supportive relationship (Brown & Harris, 1978; Coyne & DeLongis, 1986; Lieberman, 1982). In this section, I consider some of the support-related aspects of close relationships and then review a selection of studies that have explored the helping process in couples.

'Communal' relationship norms

Clark and Mills (1979; Mills & Clark, 1982) have argued that close relationships (i.e. between family members, friends, and romantic partners) may be influenced by different norms to those operating in other relationships. They describe the former as 'communal' relationships. People in communal relationships feel a heightened sense of mutual obligation, and generally a desire, to be responsive to each other's needs. (For people in 'exchange' relationships, there is no special pull towards mutual responsivity; thus resources, including help, tend to be given in the expectation of receiving something of comparable value in return.) Consistent with this notion, laboratory studies of helping have found that persons in communal relationships do not keep track of joint inputs to a task (Clark, 1984) but do keep track of the other's needs, even when there is no potential to help or reciprocate (Clark, Mills, & Powell, 1986). It is unclear how far these findings generalise to helping in ongoing personal relationships, however (Wills, 1992).

Intimacy

Reis and Shaver (1988) suggest that intimacy is an interactive process involving not only the disclosure of feelings by one partner but also a supportive or empathic response from the other, so that the discloser comes to feel understood and accepted. According to Wills (1992), field studies of helping point to a prominent role for intimacy in determining the supportiveness of relationships. Measures of confidant relationships and emotional support have emerged as key in buffering the effects of life stressors (Cohen & Wills, 1985; Wills, 1991); and there is evidence that the buffering effect of the marital relationship is largely

determined by intimacy and quality of communication (Huisaini, Neff, Newbrough, & Moore, 1982; Stemp, Turner, & Noh, 1986). Wills (1992) comments that the literature is largely uninformative on the issue of how intimacy shapes coping and adaptation, however. He speculates that intimacy may make it easier to raise problems and concerns so that potential support providers are made aware of them; moreover, a history of self-disclosure may facilitate partners' accurate perception of each other's needs, enabling helping efforts to be more appropriately tailored.

Empathy

There has been a considerable amount of theoretical work on the function of empathy in psychological helping (Bohart & Greenberg, 1997). Rogers (1957) famously proposed that empathy, along with positive regard and genuineness, was one of the necessary and sufficient conditions for therapeutic change. Empathy has subsequently remained of great interest to psychotherapy researchers, who nowadays cite it as a defining feature of the 'therapeutic alliance' (Horvath & Luborsky, 1993). It has been formulated in different ways by different authors, though there is a consensus that it entails both an emotional connection and the cognitive capacity to put oneself in the other's place (Duan & Hill, 1996; Warner, 1997). According to Barker and Pistrang (2002), "being understood or not seems to be a central factor in how people evaluate their social interactions" (p. 368); they note, however, that little research has so far been conducted on how empathy is communicated by informal helpers. There is some evidence to suggest that empathy between partners may be communicated by a wider range of responses than the reflections or interpretations offered by psychotherapists to their clients (Barker & Pistrang, 2002). For example, in a study of couples expecting a first baby, responses that offered solutions or conveyed a sense of mutuality were also experienced as empathic (Pistrang, Picciotto, & Barker, 2001). Other studies, drawing on self-report and observer ratings of helping interactions, suggest that helpful partner responses tend to be high in empathy (Barker & Lemle, 1984; Pistrang & Barker, 1995, 1998; Pistrang *et al.*, 2001). However, partners have also been rated by

observers as less empathic than other informal helpers (Barker & Lemle, 1987; Pistrang &

Barker, 1998), and there is evidence that partners' personal involvement in a problem can at

times make it harder for them to put aside their own feelings or attitudes sufficiently to be

empathic (Pistrang & Barker, 1997; Pistrang, Clare, & Barker, 1999).

Responsiveness

Cutrona (1996) proposes that responsiveness is of key importance in understanding how

social support operates between partners. She draws on the argument that trust in close

relationships is built on each person's expectations about the other's responsiveness to his or

her needs in times of adversity (Holmes & Rempel, 1989). According to Cutrona (1996),

more than simply easing a person's current distress, behaviours that communicate concern

may also help to shape the recipient's picture of the relationship with the support provider.

That is, repeated experience of interactions in which another person behaves supportively

may help to build a picture or schema of the relationship according to which support is

provided when needed (e.g. Baldwin, 1992; Planalp, 1987).

Social support and the marital relationship

A wealth of research findings suggest that people who are married tend to be happier,

healthier (physically and psychologically), and less likely to die within a 10-year period than

those who are not married (Burman & Margolin, 1992; Gove, Hughes, & Style, 1983).

These differences seem to apply for people regardless of age, race and socio-economic level

(Cutrona, 1996). There is, however, evidence to suggest that the effects of marriage are

different for men and women. Thus happiness, satisfaction with one's home life, and

psychological health seem to be more strongly predicted by marriage for men than women

(Gove *et al.*, 1983).

Research by Antonucci and Akiyama (1987) found that men tended to be more satisfied with

their marriages and depended on them more for happiness than did women. Marital status

appears not to be so important for the adjustment of women. It would appear that, for

women, the quality of the marital relationship is of more significance than the simple fact of being married (Cutrona, 1996). Indeed for women, the correlation between marital satisfaction and a whole range of indices of psychological health is strong and stronger than it is for men (Gove *et al.*, 1983).

It is known that men are more heavily dependent on their partners for social support than are women. Women access support from a variety of sources including friends, relatives and neighbours (e.g. Antonucci & Akiyama, 1987; Veroff *et al.*, 1981) and are more likely to have a close, confiding relationship with people outside the marital relationship than are men (Lowenthal & Haven, 1968). Although women may have more choice in terms of available support, it appears that support outside of the marital relationship does not compensate for the difficulties associated with an unsatisfactory marriage. A study by Julien and Markman (1991), for example, found that looking for external support in the context of a troubled marital relationship was associated with poorer psychological outcomes.

Belle (1982) has identified a support gap in male-female relationships whereby women receive less support from a male partner than vice versa. Thus Antonucci and Akiyama (1987) report that confiding, reassuring, and various forms of support in times of illness and distress were supplied more abundantly by wives than husbands. Similarly, in Vinokur and Vinokur-Kaplan's (1990) study of couples in which the female partner had breast cancer, both spouses agreed that wives gave more support than they received from their husbands.

Obtaining support from a partner

Barbee, Druen, Gulley, Yankeelov, and Cunningham (1993, cited in Cutrona, 1996) offer the term 'support activation strategies' to describe attempts to obtain support from another person. Such strategies may be direct or indirect, verbal or non-verbal. In terms of Barbee *et al.*'s categories, a direct verbal strategy is a straightforward request for support; indirect verbal strategies would include hinting at difficulties or complaining. The non-verbal

category contains direct expressions of distress, such as crying, as well as indirect ones, such as sulking or fidgeting.

Barbee *et al.* suggest various factors that may influence the types of support activation strategies people use, including gender, level of social skill, and personality. In relation to gender, it is known that women are more likely to look for social support in difficult circumstances than are men (Rosario, Shinn, Morch, & Huckabee, 1988); while findings from a study by Belle (1987) support the idea that women are more likely than men explicitly to voice their need for support.

Barbee *et al.* (1993, cited in Cutrona, 1996) suggest potential problems in using indirect support activation strategies. Indirect strategies obviously carry a greater risk of misinterpretation and what unfolds will be dependent on the partner's attributions for the behaviour he or she observes. Where an indirect strategy is understood as an indication that the partner wants or needs support, it may still be unclear what type of support is required. Indirect support activation strategies (e.g. crying) may also be viewed as manipulative or experienced as aversive by the potential support provider, provoking withdrawal or criticism rather than offers of support.

Responding to requests for support

Cutrona and Suhr's (1992) observational studies of married couples found that spouses were generally quick to provide support on learning that the partner was facing a stressor. There are circumstances, however, in which support may not be provided by a spouse even when he or she knows that it is wanted. The problem may not be considered legitimate or sufficiently serious to warrant support from the spouse; or, if the family is facing other problems, the distressed person's problem may not be prioritised (Pearlin & McCall, 1990).

There is some evidence that people are more likely to provide effective support when in a positive rather than negative mood. Studies by Barbee and her colleagues found that,

following induction of a sad mood, participants did not recognise the need to provide

support, or lacked sufficient energy to help (Barbee, 1991, cited in Cutrona, 1996;

Yankeelov, Barbee, Cunningham, & Druen, 1991, cited in Cutrona, 1996). Moreover,

Barbee *et al.* (1993, cited in Cutrona, 1996) suggest there may be particular difficulties

associated with depression in a distressed partner. The non-depressed partner may lose

patience, unable to understand why the depressed person does not 'snap out of it', or else be

distressed by the depressed person's low mood, unresponsiveness, and withdrawal from

family life. Moreover, unsuccessful attempts to lift a partner's mood may engender a sense

of helplessness in the non-depressed partner (Coyne, Wortman, & Lehman, 1988).

Other relationship issues may have a bearing on whether one partner responds to the other's

need for support. Dunkel-Schetter and Bennett (1990) found that where partners perceived

inequality in the support provided this was associated with a reduction in helping activity.

Also, a negative correlation has been reported between conflict and perceived supportiveness

in close relationships; thus partners who are angry with each other are less likely to provide

support (Abbey, Abramis, & Caplan, 1985).

Disappointed expectations for support

Little research has been conducted on the consequences of disappointed expectations for

support (Cutrona, 1996). In Ruble's (1988) study of the transition to parenthood it emerged

that discrepancies between the amount of childcare assistance women expected to receive

from their husbands before the birth and the amount they actually received strongly

predicted post-partum distress and was a better predictor than absolute level of childcare

assistance provided by the spouse. Cutrona, Cohen, and Igram (1990) found that support is

less favourably received when different from that desired – e.g. when comfort was desired

but practical assistance provided this was judged much more negatively than when comfort

was both wanted and provided. Interestingly, this study also revealed that when tangible

assistance was desired, emotional support was judged almost as positively as the practical help actually wanted.

Studies of helping in couples coping with serious physical illness

Studies of couples have consistently found that helping behaviour is an important determinant of overall relationship satisfaction (e.g. Barker & Lemle, 1984; Burke & Weir, 1977; Nye, 1976; Pasch & Bradbury, 1998). Research indicates that feeling emotionally supported is one of the fundamental expectations of an intimate relationship (e.g. Baxter, 1986; Braiker & Kelley, 1979). Indeed, disappointed support expectations have been cited by former partners as the main reason for the failure of their relationship (Baxter, 1986). Thus the exchange of supportive behaviours between partners appears to be a fundamental aspect of close relationships (e.g. Stafford & Canary, 1991) and of central importance in their maintenance (e.g. Barbee, 1990; Leatham & Duck, 1990; Pasch & Bradbury, 1998). Nevertheless, it is also known that helping within couples does not always run smoothly (Pistrang & Barker, 1992). I now review a selection of studies from the growing literature on the helping process in couples in which one partner has a serious physical illness. This research points to particular difficulties associated with giving and receiving support in relation to a stressor with potentially serious implications for both partners.

Coyne, Ellard, and Smith (1990) report a study of coping in 56 couples in which the husband had suffered a heart attack around six months earlier. The data confirmed the importance of the spouse and the marital relationship for the patient's adjustment. Also consistent with previous findings (e.g. Stern & Pascale, 1979), spouses were as likely as patients to experience psychological distress. It emerged that spouses' use of a 'buffering' coping style (i.e. concealing worries, giving in to avoid conflict) was beneficial to patients' well-being and self-efficacy but detrimental to their own well-being. Spouses' over-protectiveness, on the other hand, was detrimental to the patient's well-being and was correlated with spouses feeling distressed and burdened, and perceiving the husband as lacking in efficacy. A source

of conflict for these couples related to patients' and spouses' attempts to manage the other's distress, as well as differences of opinion over the extent to which the spouse was responsible for the patient's well-being. Thus couples argued about patients taking what their wives viewed as unnecessary risks or not making appropriate lifestyle changes. Spouses attempts to cajole the patient into doing or nor doing something would sometimes have the desired effect but could also damage the patient's well-being and sense of efficacy.

Coyne, Ellard *et al.* (1990) note that these couples found different ways of coping, though, in each case, what was needed and what helped depended on the behaviour of the other partner. Moreover, there was not always a correspondence between what was good for the patient and what was good for the relationship or the spouse. The authors summarise what appeared to be happening in these couples as follows:

> Both the patients and their spouses were faced with having to make changes in their lifestyle, perform certain instrumental tasks, manage their own distress, and, in complex ways, come to terms with the presence of the other (Coyne, Ellard *et al.*, 1990, p. 133).

Coyne, Ellard *et al.* (1990) therefore emphasise the need to consider the interdependence of recipient and provider when thinking about the support process in close relationships. Thus, a particular action by one partner may appear helpful, until it is put in context and the negative implications for the recipient become apparent. They propose the term "dilemmas of helping" to describe the conflict of interests that may arise between the needs of support provider and recipient.

A series of studies by Pistrang and Barker and their colleagues have investigated the informal helping process in couples coping with breast cancer (Pistrang & Barker, 1992, 1998; Pistrang & Barker, 1995; Pistrang *et al.*, 1997) and, in a single case study, recovery from heart attack (Pistrang *et al.*, 1999). These studies have again underlined the importance

of partners as informal helpers. For example, Pistrang and Barker (1995) found that satisfaction with the partner helping relationship was associated with psychological well-being; and importantly, even when good helping relationships were available elsewhere, these did not compensate for inadequate support from the partner. These studies have also demonstrated that communication between partners may be fraught with misunderstanding (Pistrang & Barker, 1992) and failures of empathy (Pistrang *et al.*, 1997).

In a study drawing on both observational and self-report methods, Pistrang *et al.* (1997) investigated the process of social support in three couples in which the husband was trying to be helpful to his wife in relation to her concerns about having breast cancer. The study used a 'tape-assisted recall' paradigm (Elliott, 1986), whereby sections of the helping interaction were played back to both partners to allow detailed exploration of their views of the process. This approach provided important insights into the personal meanings of these interactions, which were necessary for understanding why support attempts succeeded or failed. Some of the unhelpful responses conveyed a lack of empathy or a redirection of the conversation on the part of the helper, while helpful interactions involved the helper's close attention to his partner's concern.

Pistrang and Barker (1998) investigated the helping process when 26 breast cancer patients discussed illness-related concerns with their partners and, in a separate conversation, with fellow patients. Trained observers rated the volunteer helpers as more helpful, empathic and supportive, less critical, and as using more self disclosure than the partners. Partners' criticism in this study often seemed to be conveyed through inappropriate advice. Pistrang and Barker suggest that it may have been difficult for these partners to disentangle their own needs from those of the patient – i.e. they were caught in one of Coyne, Ellard *et al.*'s (1990) 'dilemmas of helping' – so that their advice was received as undermining or critical.

Informal helping and social support: Conclusions

It appears that attempts to be helpful can go awry in various ways and for various reasons, though often, it would seem, because it is hard for helpers sufficiently to put aside their own feelings about the situation. There is evidence that this is particularly the case in close relationships, where the needs of 'helper' and 'helpee' may at times interact in ways inimical to providing effective support. This is important because partners' provision of support in times of need appears to be a major determinant of the health and sustainability of a relationship, while its absence may not be compensated by support from other sources. The discussion so far suggests that it may at times be difficult to provide effective support to a distressed partner; moreover, providing such support may itself be distressing. This idea is explored further in the second half of this chapter in which I discuss the interpersonal context of depression, including its impact on intimate relationships.

The Interpersonal Context of Depression

The importance of interpersonal factors in understanding depression has become increasingly well recognised in the last two decades, with numerous studies investigating the interactions of depressed persons and others across a range of social contexts. In this latter half of the chapter, I describe an influential interactional model of depression and review the empirical literature on the social encounters and more intimate relationships of people with depression.

Intrapsychic models of depression

Theoretical models of depression have been abundant in the psychological literature of the 20th century. The vast majority of these have stressed the aetiological significance of intrapsychic factors, though most also carry implications for interpersonal functioning (Coyne, 1976a). Early psychoanalytic accounts of depression (Abraham, 1911; Freud, 1917) emphasised the importance of aggression, proposing that hostility directed towards others

came to be turned inwards on the self. More recently, cognitive theories of depression have become popular. According to Beck's influential model (1967; 1976), dysfunctional assumptions bias an individual's information-processing and thus negatively distort his perception of himself and the world around him. While Beck's cognitive theory developed from his clinical experience of working with depressed patients, Seligman's (1975) 'learned helplessness' model was derived from studies of animal learning. Seligman proposed that helplessness in laboratory animals previously exposed to unavoidable painful stimuli was similar to depression in humans, the latter also associated with passivity and a reduction in goal-directed behaviour. Criticisms of the original helplessness model (Abramson & Sackheim, 1977) led to a reformulation emphasising attributional style. In this light, an individual who attributes the negative events in his life to internal, global, and stable causes would be conceptualised as possessing a depressogenic attributional style (Abramson, Seligman, & Teasdale, 1978).

Coyne has been prominent amongst authors to argue that cognitive theories of depression confuse symptom with cause (Coyne & Gotlib, 1983; see also Lewinsohn, Hoberman, Teri, & Hautzinger, 1985). According to Coyne, given that hopelessness, helplessness, and self-devaluation are symptoms of depression, attributing them with causal significance is akin to saying that a person has a cold because he sneezes. Coyne has argued that cognitive models of depression fail to provide an adequate picture of the depressed person's ongoing relationship with his social environment (Coyne, Burchill, & Stiles, 1990). Thus, "rather than being a matter of cognitive distortion … depressed persons' complaints of rejection and social ineffectiveness may reflect the feedback available to them in social interactions" (Strack & Coyne, 1983; p. 799). Coyne argues instead for an interactional perspective on depression, predicated on an understanding of the difficulties encountered by people with depression in their everyday lives and how these difficulties are influenced by their own and others' attempts to cope (Coyne, Burchill *et al.*, 1990).

An interactional perspective on depression

According to Coyne (1976a), through their expressions of helplessness and hopelessness and other symptomatic behaviour, people with depression seek reassurance from others to counter their concerns about their own worth and to determine whether they are genuinely cared for. These expressions of distress and despair are initially likely to elicit a supportive response from others in the environment. However, the reassurance provided is liable to be greeted with suspicion by the depressed person, who may attribute it to a sense of pity or duty on the part of the other – thus rendering it ineffective.

The depressed person is then caught in a dilemma between both needing and doubting reassurance. The need for reassurance proves compelling, however, leading the depressed person to seek further feedback from others. The reassurance provided is again doubted, and so the cycle continues. Although this repetitive process sooner or later evokes frustration and irritation in other people, the depressed person's distress simultaneously arouses guilt, which inhibits direct expressions of antipathy. The depressed person is nevertheless likely to detect "a growing discrepancy between the verbal content and the affective quality of [others' reassurances]", thus reinforcing his sense that he is not genuinely cared for and increasing his manifest distress (Coyne, 1976a, p. 34). In this way, others interact with people with depression in ways that maintain or exacerbate their difficulties, leading to what Coyne describes as "an interactional stalemate" (Coyne, Burchill *et al.*, 1990). Thus other people discover that they can reduce the depressed person's aversive behaviour through displays of non-genuine concern and support, while the depressed person finds that he is able to elicit sympathy and concern from others yet is increasingly aware that they actually hold critical and rejecting attitudes towards him. Rejection – implicit or explicit – has a deleterious effect on the depressed person's interpersonal environment and thus plays a role in maintaining or intensifying his low mood and associated difficulties (Coyne, 1976a; Joiner, Coyne, & Blalock, 1999; see also Coates & Wortman, 1980, for a similar interactional account).

Interactional research on depression

In a study devised as a partial test of his theory, Coyne (1976b) had college students speak on the telephone with depressed psychiatric patients, non-depressed psychiatric patients, or healthy 'normals'. From self-report measures completed after the interaction, it emerged that participants who had interacted with a depressed person themselves reported significantly higher levels of depressive symptoms, anxiety, and hostility than did those in the control conditions. Coyne also investigated his participants' willingness to interact with their conversational partners again in the future; he found that participants were more rejecting of depressed patients than they were of non-depressed persons.

Numerous investigators subsequently conducted similar studies. Howes and Hokanson (1979), for example, investigated the responses of college students following interaction with a confederate enacting a depressed role, a non-depressed role, or a physically ill role. They found that participants who conversed with a 'depressive' confederate responded with higher rates of silence and negative comments and fewer verbal responses overall than those in other conditions. Despite offering a similar level of direct support to 'depressive' as to 'physically ill' confederates, participants were more rejecting of their depressive conversational partners and described them more negatively (e.g. as less agreeable and affiliative, more inhibited, submissive, hostile, and detached). Strack and Coyne (1983) sought to investigate whether dysphoric female undergraduates would evoke a negative emotional response and rejection in other female students following a 15-minute conversation. They found that dysphoric participants induced hostility, depression, and anxiety in their conversational partners and were indeed rejected in terms of the latter's willingness to engage in further interactions. While dysphoric persons did not indicate negative views of those with whom they interacted, they were nevertheless also rejecting of their conversational partners. On the basis of these findings, Strack and Coyne (1983) argued that negative mood induction is not limited to severely depressed persons.

Coyne's (1976b) findings on induction of depressive mood have been replicated by several

other investigators employing variations on the original methodology (e.g. Boswell &

Murray, 1981; Hammen & Peters, 1978; Winer, Bonner, Blaney, & Murray, 1981). As with

Howes and Hokanson (1979), some of these studies have used confederates role-playing a

depressed person, or have asked participants to imagine interactions with depressed person,

raising concerns about ecological validity in these cases (Coyne, Burchill *et al.*, 1990). Not

all of the relevant research findings are consistent with Coyne's ideas about mood induction,

however. Howes and Hokanson (1979) did not find group differences in self-reported mood

after participants interacted with their 'depressive' actors; similarly Gotlib and Robinson

(1982) and King and Heller (1984) did not find evidence of mood induction following

encounters with depressed college students and depressed outpatients, respectively.

The finding that depressed people tend to be rejected by conversational partners has been

more extensively replicated (Amstutz & Kaplan, 1987; Boswell & Murray, 1981; Burchill &

Stiles, 1988; Frank, Elliot, Wonderlich, Corcoran, Umlauf, & Ashkanazi, 1987; Hammen &

Peters, 1977, 1978; Hokanson, Loewenstein, Hedeen, & Howes, 1986; Hokanson, Rubert,

Welker, Hollander, & Hedeen, 1989; Howes & Hokanson, 1979; Robbins, Strack, & Coyne,

1979; Winer *et al.*, 1981; Yarkin, Harvey, & Bloxom, 1981; Youngren & Lewinsohn, 1980).

It is worth noting, however, that a handful of studies have not found elevated rates of

rejection of depressed people relative to controls (Dobson, 1989; Gotlib & Melzer, 1987;

Gotlib & Robinson, 1982; King & Heller, 1984). Other investigators have found that

participants are less willing to give positive reactions to depressed people (Robbins *et al.*,

1979) and that depressed participants receive fewer positive responses from others

(Youngren & Lewinsohn, 1980). Further evidence of rejection of people with depression

comes from investigation of everyday situations, such as the study by Yarkin *et al.* (1981)

which found that simply informing people that someone was depressed resulted in their

avoiding the person in question. Weissman and Paykel (1974) found that depressed persons

had fewer social contacts and limited support networks; while other findings indicate that

they are looked down on and perceived as less well adjusted (Boswell & Murray, 1981; Burchill & Stiles, 1988).

Research investigating interactions between depressed persons and strangers has permitted study of the effects of depressive behaviour without the confounding effects of a past history of interactions (Coyne, Burchill *et al.*, 1990). Overall, the findings indicate that strangers interact differently with depressed people and are themselves affected by these encounters, which are generally rated as aversive and lead to reluctance to agree to further interactions (Coyne, Burchill *et al.*, 1990). Clearly, however, the interpersonal context of depression is not limited to brief contacts between strangers and there is a limit to how far findings on laboratory encounters can be generalised to social relationships in the outside world, where "events seldom occur only once, but persist, overlap, and recur with maddening complexity" (Coyne & Holroyd, 1982, p. 114).

Studies of depressed college students and their roommates have addressed this issue to some extent, widening the scope of interactional research to include people who are more closely involved with one another. These studies suggest that depressed students are rejected and disliked by their roommates to a greater extent than non-depressed students (Burchill & Stiles, 1988), while their roommates tend themselves to be more depressed than controls (Howes, Hokanson, & Lowenstein, 1985) and may become increasingly involved in a care-taking role (Hokanson *et al.*, 1986). Depressed students are more likely to regard their roommates as distrustful and competitive yet nevertheless seem to become increasingly dependent on them over time (Hokanson *et al.*, 1986). In a longitudinal study by Joiner, Alfano, and Metalsky (1992), it was the combination of depression, reassurance seeking, and low self-esteem that put target participants at most risk of being rejected.

These studies indicate elevated levels of antipathy and rejection in relationships between depressed students and their roommates. There is also support for the notion of mood induction in people living with a depressed person. Recently, however, Coyne (1999) has

raised serious doubts about the wider relevance of studies of self-reported distress (or "ersatz clinical depression") conducted with college students. He contends that current distress *per se* does not constitute a reliable indicator of depressive disorder (Fechner-Bates, Coyne, & Schwenk, 1994) and, moreover, questions "the assumption of a continuum from everyday distress to clinical disorder" (p. 372). These criticisms notwithstanding, one might anticipate important differences, as well as perhaps similarities, in the way that depression operates within more intimate relationships. The studies described in the following section extend interactional research on depression to the more complex area of relationships between partners.

Depression in couples

Over the past 30 years, empirical findings have accumulated on the relationships and interactions of depressed persons and their partners. An association between depression and relationship difficulties of various kinds has emerged from this work. McLean, Ogston, & Grauer (1973), for example, reported that all of a sample of 20 depressed patients hoped for assistance in ameliorating communication in their marriages; while Weissman and Paykel (1974) found that marital relationships in their sample of depressed women were marked by friction, poor communication, dependency, and reduced sexual satisfaction. Moreover, spouses corroborate their depressed partners' negative descriptions of their relationships (e.g. Coleman & Miller, 1975; Kahn, Coyne, & Margolin, 1985), which cannot therefore be dismissed as a reflection of the latter's negative outlook (Coyne, Burchill *et al.*, 1990). There is an abundance of evidence supporting the notion that marital interactions of couples with a depressed partner are globally more negative than those of non-depressed couples (McCabe & Gotlib, 1993). However, the nature of the relationship between depression and marital difficulties is difficult to specify. Thus, marital difficulties have been proposed as a vulnerability factor for depression, as well as its precipitant, concomitant, and consequence (Briscoe & Smith, 1973; Coyne, Burchill *et al.*, 1990; Coyne *et al.*, 1987).

Marital interactions of people with depression

A study by Hinchcliffe, Hopper, Roberts, and Vaughan (1975) found that, compared with non-depressed controls, interactions between depressed patients and their spouses were characterised by higher levels of tension, negativity, and more frequent emotional outbursts, as well as marked inconsistencies between spouses' verbal and non-verbal behaviour. Much less negativity was evident in interactions between the depressed spouses and strangers, however. These authors report that marital interactions improved over the course of recovery, though, to a lesser degree, negativity, unresponsiveness, and disruptive conversational exchanges continued to be discernible. Merikangas, Ranelli, and Kupfer (1979) found that depressed women tended to give in more in disagreements with their husbands; similarly, Hoover and Fitzgerald (1981) reported that depressed women were more likely to be dominated by their husbands. From Linden, Hautzinger, and Hoffman's (1983) investigation of interactions in maritally distressed couples with and without a depressed partner, it emerged that spouses in the depressed group responded more negatively, judged their relationships negatively, and rarely agreed with each other's statements; moreover, spouses' offers of support were characterised by ambivalence.

Studies conducted at the Oregon Research Institute (Biglan, Hops, Sherman, Friedman, Arthur, & Osteen, 1985; Hops, Biglan, Sherman, Arthur, Friedman, & Osteen, 1987) have used sequential analysis to explore the marital interactions of depressed people. When couples with a depressed female partner engaged in a problem-solving discussion, depressed women offered less self-disclosure (excluding comments about their well-being), while their husbands proposed more solutions. In these couples, husbands' facilitative behaviour reduced wives' depressive behaviour. In maritally distressed couples with a depressed female partner, women's depressive behaviour decreased husbands' aggression, as expressed through sarcasm and irritation, while husbands' aggression reduced wives' subsequent depressive behaviour. Each partner was therefore able to influence the other's behaviour to some extent and gain brief periods of respite (Coyne, Burchill *et al.*, 1990). When couples

were observed at home, it was apparent that depressed wives' depressive behaviour also suppressed husbands' outward hostility, though expressions of caring were similarly inhibited (Hops *et al.*, 1987; see also Nelson & Beach, 1990; Schmaling & Jacobson, 1990).

Kahn *et al.* (1985) investigated how couples with a depressed spouse sought to manage conflict during a brief discussion of a marital issue. Depressed persons and their spouses reported less constructive problem solving and more destructive behaviour than did partners in non-depressed couples, as well as greater dissatisfaction with their marital relationships. After the laboratory discussion, both spouses in depressed couples felt sad and angry and experienced the other as hostile, competitive, mistrusting, and detached, as well as less agreeable, nurturant, and affiliative than partners in control couples.

McCabe and Gotlib (1993) combined self-report and observational methods to investigate the behaviour of couples in which the wife was either clinically depressed or non-depressed as they engaged in a problem-solving interaction. Self-report data from this study indicated that depressed wives viewed their families in a more negative light than did their husbands, and more negatively than spouses in non-depressed couples. After participating in the problem-solving interaction, spouses in the depressed couples rated each other as more dominant, hostile, and less friendly than spouses in the non-depressed couples. Observational ratings indicated that both partners in the depressed couples became increasingly negative the longer they interacted with each other. Compared with the non-depressed couples, couples with a depressed wife showed increasingly negative verbal behaviour over the course of their problem-solving interactions.

These studies have shown that depressed persons and their spouses can be hostile and aggressive in their interactions yet also inhibited and withdrawn. Kahn *et al.* (1985) suggest that these almost paradoxical aspects of depressed relationships may be contributing to a vicious cycle in which ineffective attempts to resolve difficulties result in withdrawal and avoidance, negative affect, and mutual suspicion. Inevitably, problems will eventually be

encountered that cannot be avoided; in tackling them, however, there is then the additional

burden of unresolved issues and antipathy. The ensuing interactions are likely to be highly

emotional and not conducive to effective problem solving, reinforcing the view that

problems cannot be discussed and making it more likely that they will be allowed to

accumulate without resolution.

Gender differences

Most studies of interpersonal aspects of depression have involved depressed women as target

participants; consequently relatively little data are available on how gender might affect the

relationship between depression and marital interaction (Johnson & Jacob, 1997). Data from

the few studies to investigate this issue suggest that depressed wives tend to show more

negativity than depressed husbands (Gotlib & Whiffen, 1989, Hautzinger, Linden, &

Hoffman, 1982; Hinchcliffe *et al.*, 1975; Kahn *et al.*, 1985). In an attempt to replicate this

finding, Johnson and Jacob (1997) conducted a large-scale study exploring possible gender

influences on the problem-solving interactions of couples with or without a depressed

spouse. Analysis of observational codings revealed that interactions in couples with a

depressed member displayed less positivity and congeniality and a higher proportion of

negative communications. It also emerged that couples with a depressed wife showed lower

levels of positivity (and a trend towards higher levels of negativity) than couples with a

depressed husband; and that depression amongst wives was associated with more severe

marital disturbance than depression amongst husbands. Overall, wives in this study

expressed higher levels of congeniality and showed a trend towards higher levels of

negativity than husbands. Johnson and Jacob (1997) suggest that, if wives typically express

more emotion-based communication in their marriages (e.g. Margolin & Wampold, 1981),

depression in women may have a somewhat greater impact on the affective tenor of family

life than depression in men.

The partners of people with depression

A handful of studies have provided important data on the experiences, views and characteristics of the partners of people with depression. As suggested by the research reviewed above, reports of marital distress in couples with a depressed member should not be viewed purely as the consequence of the depressed partner's contribution (Kahn *et al.*, 1985). Indeed, Rush, Shaw, and Khatami (1980) opine that "the spouse of the depressed person cannot be considered neutral. He or she becomes frustrated, confused, overly solicitous or angry, or withdraws emotionally" (p. 105). In this light, the findings from a study by Leff and Vaughn (1985), indicating that the majority of partners of people with depression were critical of them, may seem unsurprising, although here the partners' criticism was not only focused on current behaviours but often also related to longstanding characteristics of the depressed person. It is also known that the partners of people with depression are themselves at risk of distress for various reasons. Their lives may be subject to disruption associated with their partner's depressive episodes, while providing support at these times is likely to demand much in the way of patience and understanding (Coyne, 1999). Moreover, for people who are not themselves vulnerable to depression, it may be hard to understand how such difficulties could persist in someone they are close to (Coyne, 1999).

Research indicates that the partners of people with depression are more likely to have histories of psychological disturbance, and that they experience increased rates of psychological and physical difficulties during the spouse's depressive episodes (Coyne *et al.*, 1990). Merikangas and Spiker (1982) found that over 50% of spouses of patients with affective disturbance met criteria for at least one lifetime psychiatric disorder and, for the most part, the onset of affective disturbance in both patients and spouses had occurred after marriage. Women seem to be more vulnerable to becoming depressed when living with a depressed partner than do men, though this may reflect their greater likelihood of having a past history of affective disturbance (Coyne *et al.*, 1990).

Fadden, Bebbington, and Kuipers (1987) interviewed the spouses of 24 patients who had been depressed for three years or longer, to explore the impact of their husband or wife's depression on their lives. Nearly half reported finding work a strain as a consequence of their added responsibilities and a similar number reported a decline in their financial situation. A common consequence of the latter was a reduction in family leisure activities. Most spouses reported at least some decline in their social activities. Several partners felt that they had no one to turn to for help or support, though feeling embarrassed or reluctant to talk to others about the spouse's difficulties was also a common experience. While spouses spent long periods in close contact with their depressed husband or wife – a mean of 65 hours per week – around half of those interviewed referred to difficulties in their marital relationships. Many of those interviewed said that they could no longer discuss their own difficulties with their depressed spouse, because they were reluctant to add to his or her distress, considered their own concerns trivial in comparison, or because they doubted the depressed person's ability to provide support. The symptoms that spouses found most difficult to cope with were worrying, irritability, and nagging. Many participants had no idea what they might do in practical terms as a way of managing their husband or wife's depression or the impact it was having on their lives.

From a study of a fairly heterogeneous sample of significant others (e.g. partners, siblings, friends, parents), Coyne *et al.* (1987) found that just over 40% of people living with a currently depressed person were themselves sufficiently distressed to warrant therapeutic intervention (compared with 17% of those living with someone who had been depressed in the past). People living with a depressed person felt burdened and upset by the latter's symptoms, particularly their loss of interest in socialising, their hopelessness and worrying. More recently, Benazon and Coyne (2000) investigated spousal burden in 49 couples with a depressed wife and 30 couples with a depressed husband. Spouses in this study reported elevated levels of depressed mood compared with population norms, and higher rates of

depression for both partners were associated with the depressed person being male. Amongst the most significant burdens for spouses were the depressed person's feeling of worthlessness, the possibility of the depression recurring, and the emotional strain that the spouse him/herself experienced.

Benefits and costs of depressed persons' close relationships

Numerous studies have linked life events, social support, and intimacy with depression (Coyne, Burchill *et al.*, 1990). These have usually been interpreted as showing that life events play a role in the onset of depression and that social support and intimacy can offer protection from depression – either directly or by providing buffers against stress (Coyne, Burchill *et al.*, 1990). Research findings have indicated an association between depression and having a smaller social network, fewer close relationships, and fewer supportive close relationships (Billings & Moos, 1984; Schaefer, Coyne, & Lazarus, 1981). It has, however, been proposed that it is the quality of one's closest relationships that is of greatest importance and that support available elsewhere does not compensate for an inadequate intimate relationship (Coyne & DeLongis, 1986).

From their well-known study of depression in women living in an inner city, Brown and Harris (1978) found that a confiding spousal relationship was a powerful mediator of the association between life events and depression. Women who did not have a close and confiding relationship had a three times greater risk of depression following a life event, while having such a relationship negated the effects of other risk factors (e.g. having three young children at home, being unemployed, loss of one's mother in childhood). From a later analysis of their data, Brown, Bifulco, Harris, and Bridge (1986) estimated that only a third of the marital difficulties previously reported were likely to be contingent on women's pre-existing low mood. Indeed, two thirds of the marital problems occurred in the context of a relationship with a spouse judged to be "grossly undependable." Brown, Andrews, Harris, Adler, and Bridge (1986) reported that women facing significant life stressors were at more

than three times greater risk of becoming depressed if their marital relationship was characterised by negative interactions (as assessed at an initial interview). Data from retrospective interviews suggested that this effect was largely the consequence of a lack of support from the partner during crisis periods, particularly for women who had expected it – i.e. those who felt "let down".

As discussed earlier, there has been increasing recognition in the social support literature that close relationships may generate stress, conflict, and disappointment as much as they provide support (Coyne & DeLongis, 1986). Survey data from the US are illustrative, indicating that the risk for depression increases about 25 times for both men and women in unhappy marriages (Weissman, 1987). Beach, Sandeen, and O'Leary's (1990) marital discord model of depression holds that the marital relationship plays an important role in the development of depressive symptoms for some groups of vulnerable people. Data are inconsistent on the impact of gender on the discord-depression relationship, however. Thus some authors have proposed that the marital relationship is of greater importance in predicting depressive symptoms in women than in men, because relationships have special significance for women (e.g. McGrath, Keita, Strickland, & Russo, 1990); however, certain data suggest that the marital discord-depression relationship is essentially similar for husbands and wives (e.g. Weissman, 1987).

Research findings support the notion of marital problems as a predictor of subsequent depression (reviewed in Beach, Whisman, & O'Leary, 1994). Thus, a longitudinal study of 577 women in full-time employment found that dissatisfaction with the marital relationship predicted depressive symptoms 12 months later, even after controlling for initial symptom levels (Beach, Harwood, Horan, Katz, Blum, Martina, & Roman, 1995, cited in Katz, Beach, & Joiner, 1998); while findings from a study by Fincham, Beach, Harold, and Osborne (1997), investigating how marital satisfaction related to depression in a sample of 150

newlywed couples, were consistent with the notion of a causal role for marital dissatisfaction in women's depression 18 months later.

Other investigators have presented findings consistent with a trend in the opposite direction – i.e. that depression may lead to a decline in the quality or amount of support received. Dew and Bromet (1991) used a longitudinal design to investigate the impact of major depression on perceptions of the nature and availability of social support in a large community sample of women. They found that, even after controlling for baseline levels of social support, experiencing an episode of depression was associated with a greatly increased risk of having no marital partner at follow-up. For women who remained married, depression was associated with an increased risk of a poorer marital relationship. These authors conclude: "Contrary to the view that much of the causal flow is from social supports to psychological distress ... our data indicate profound effects in the reverse direction as well" (Dew & Bromet, 1991, p. 209).

Data from a small number of studies suggest that the nature of a person's close relationships may influence his or her chances of suffering a relapse of depression within a given period. Thus, Vaughn and Leff (1976) found that depressed patients living with relatives who made two or more critical remarks about them during an interview were more likely to relapse during a nine-month follow-up period than those who received less criticism. Hooley, Orley, and Teasdale (1986) sought to replicate these findings in a study of the impact of spousal criticism (assessed on the basis of speech content and tone of voice) on the relapse rates of 39 depressed hospital inpatients. Using a cut-off point of two or more critical comments during the first hour of the interview, these authors found that 59% of patients with a critical spouse had relapsed over a nine-month follow-up period. However, a more recent longitudinal study failed to replicate these findings; instead it emerged that the level of criticism from spouses varied in relation to the course of the patients' depression – that is,

spouses became less critical as patients recovered (Hayhurst, Cooper, Paykel, Vearnals, & Ramana, 1997).

There are also some data indicating a relationship between whether or not a person is in a close relationship and the outcome of various forms of treatment. Married patients have been found to respond less well to antidepressant medication (Keller, Klerman, Lavori, Coryell, Endicott, & Taylor, 1984); while in studies of depressed persons receiving psychotherapy (Parker, Tennant, & Blignault, 1985), being seen in general practice (Parker, Holmes, & Manicavasagar, 1986) or identified in a community sample (Parker & Blignault, 1985), people who have recently ended a relationship tend to show greater improvement than those in ongoing relationships. These findings presumably reflect the fact that many people with depression are caught up in a depressogenic interpersonal cycle with their partners (Coyne, Burchill *et al*, 1990). Moreover, various reports in the literature suggest that marital problems experienced by people with depression may be a negative prognostic indicator for treatment with antidepressants (Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979), individual psychotherapy (Corney, 1984), and cognitive therapy (Jacobson, Schmelling, Salsalusky, Follette, & Dobson, 1987, cited in Coyne, Burchill *et al.*, 1990). While it is likely that more effective interventions would target the close relationships of the depressed person, it is also possible that the marital difficulties in question would actually serve as an obstacle to the couple seeking help or being able to benefit from conjoint therapy (Coyne, Burchill *et al.*, 1990).

Chapter summary and rationale for the current study

Psychological problems affect a substantial proportion of the general population and rates of depression are particularly high. However, the majority of people with psychological difficulties, including depression, do not receive professional treatment. Instead, it appears that people generally prefer to call upon informal helpers in their natural networks. Research suggests, on the one hand, that extensive training is not necessarily required in order to

provide effective psychological help, and, on the other, that everyday support attempts, while arguably beneficial to well-being, can also be experienced as unhelpful by those on the receiving end. People coping with a serious physical illness, for example, may find that others exaggerate or appear dismissive of their symptoms; while the bereaved may encounter forced cheerfulness from those around them, or receive unwanted advice, including exhortations to get over their loss. Moreover, there is some evidence to suggest that unhelpful social encounters may be detrimental to the well-being of both the person on the receiving end and the would-be helper.

Time and again, research findings have identified the spouse or partner as the most important informal helper for people facing stressful circumstances. However, there is also some evidence to suggest that people with depressive symptoms are less likely to look to their partners for support. The research reviewed above suggests there may be several reasons for this. Numerous studies have shown that people who interact with depressed persons, even briefly, are at risk of some level of psychological distress themselves. Moreover, people with depression are more likely to be rejected or criticised by those with whom they interact. Similar findings have emerged in respect of depressed persons' more intimate relationships. Thus it is known that the partners of people with depression have elevated levels of depressed mood compared with population norms, and also may be critical of their depressed spouse. Importantly, there is some empirical support for the notion that people experiencing low mood themselves are less likely to provide support.

Other research findings are also relevant to the issue of people with depression seeking or receiving support from their partners. There is evidence that depressed marriages are characterised by negativity and conflict, that depression may trigger marital problems and vice versa, and that spousal criticism may predict relapse rates. There is also evidence that partners of people with depression experience significant psychological burdens. They may find themselves limited in social and leisure activities, experience strained marital

relationships, and feel at a loss to know how to go about helping the person with depression or improve matters generally. Furthermore, it would not be surprising if partners of depressed persons became more intolerant of the disruption and burden experienced as their own moods deteriorated (Benazon & Coyne, 2000). Thus it would seem that depression can have a detrimental impact on both partners in a relationship.

However, while there is a growing literature on the helping process in couples facing various forms of physical illness, this has not so far extended to couples in which one partner is suffering from depression. Indeed, the support process in couples coping with a partner's psychological difficulties in general has received surprisingly little attention from researchers. Perhaps unsurprisingly, the focus has tended to be on the problematic and conflictual aspects of these relationships rather than how partners try to help each other. Thus considerable data has accumulated on the challenges and difficulties experienced by such couples but much less is known about how partners try to help and what the recipients of partner support find beneficial.

Given the prevalence of depression and its impact on family relationships, there would seem to be a good case for exploration of the support provided by partners to people with depression. That such informal helping relationships are perhaps even more likely than others to be problematic, or even break down entirely, further strengthens the case for their investigation. Research may suggest ways to improve the match between what depressed persons are offered by their partners and what they would actually find helpful. Moreover, improved helping is likely to lead to general improvements in the relationship, which may, in turn, have implications for recovery from depression and the likelihood of relapse.

The current paucity of data on the helping process in couples with a depressed member suggests the need, at this stage, for an exploratory study investigating the experience of giving and receiving support for depression in the context of an intimate relationship. A qualitative study, involving in-depth interviews with a limited number of couples with a

depressed member, would seem most appropriate for this purpose. The goal of the investigation would be to obtain a rich and detailed picture of the support process in a small sample of couples, from the perspective of both support provider and recipient, in a way that captures individual nuances and complexities yet, it is hoped, also speaks to the experience of giving and receiving support for depression at a more general level.

Specifically, this qualitative study addresses the following questions:

- What kinds of help and support are people with depression offered by their partners?

- What things that partners say or do are perceived as helpful or unhelpful?

- What sort of help do people with depression want from their partners?

- How do the partners of people with depression experience the process of providing support?

- How do people with depression experience the process of being helped by their partners?

Chapter 2: Method

In this descriptive, qualitative study, nine people with depression and their partners were interviewed about their experiences of giving and receiving support for depression in the context of a close relationship. After a first interview, couples were sent a tentative summary of the themes and issues they had raised and invited to participate in a briefer follow-up interview. This was an opportunity for couples to give their views on the investigator's summary and to explore some of the issues they had raised in more detail. Both interviews with each couple were tape recorded and transcribed; the interview data was analysed using Interpretative Phenomenological Analysis (IPA; Smith, 1996a). Participants also completed several questionnaire measures, to provide additional contextual information on their relationships, depressive symptoms, and attitudes towards expressing emotion.

Ethical approval

This study was reviewed and approved by three research ethics committees: The Joint UCL/UCLH Committees on the Ethics of Human Research; Camden and Islington Community Health Services NHS Trust Local Research Ethics Committee; and Riverside Research Ethics Committee. The letters of approval can be found in Appendix I.

Recruitment

The inclusion criteria for depressed participants were as follows: (a) the person was aged 18-64 years; (b) the person was, in his/her own opinion, experiencing, or had experienced within the past four years, an episode of depression (which was not substance induced nor due to a general medical condition); (c) in the judgement of the investigator or any clinician involved, the person was not currently so depressed that his/her participation in the study would have been inappropriate; (d) the person had been in a relationship with his/her current partner for at least 6 months; (e) the person's relationship with his/her partner had overlapped significantly with a period of depression; (f) the partner was also willing to

participate in the study; and (g) the couple lived within a two-hour drive of the investigator's base.

Several recruitment strategies, involving both voluntary organisations and NHS services, were employed over a 12-month period. In respect of the former approach, an advertisement for the study appealing for volunteers (see Appendix II) was placed in a magazine circulated to members of 'Depression Alliance', a national charity for people with depression which runs a network of self-help groups throughout the UK. The advertisement gave a brief outline of the study and its objectives and provided the investigator's contact details (telephone number and e-mail address), so that people who were interested in hearing more could get in touch directly. (Handouts displaying the same information were also circulated to Depression Alliance self-help groups in the London area.) People who were interested in taking part contacted the investigator by telephone and e-mail. The investigator explained the objectives of the study and what taking part would involve, and answered any questions that people had. Potential volunteers were then sent an information sheet (see Appendix III) and given at least one week to decide with their partners if they wished to participate. After a week, the investigator made contact again, to answer any further queries and arrange an appointment with couples who had decided to take part.

An attempt was also made to recruit people who were being treated for depression within the NHS. To this end, GPs at two inner London primary care practices and clinical psychologists working in two large outpatient psychology departments were enlisted to help with recruitment. Participating clinicians were asked to identify appropriate depressed persons from their caseload and briefly describe the study to them, emphasising that there was no obligation to take part. People who expressed an interest in participating were then asked if they objected to the investigator contacting them directly. With their permission, the contact details of potential volunteers were given to the investigator, who telephoned to explain the study in more detail and sent an information sheet to those still interested in

participating. The investigator re-established contact one week later, to answer any further queries and, if appropriate, arrange an appointment with the couple.

Participants

In total, 15 people with depression expressed an interest in taking part in the study. Nine of these 15 depressed persons, and their partners, were subsequently recruited. Of the remaining six people, three did not wish to involve their partner, two were no longer in a relationship, and one subsequently decided that she did not wish to take part.

Five people with depression and their partners were recruited through Depression Alliance. Of the remaining four couples, one was recruited from a GP surgery, one from an outpatient psychology department, one was told about the study by a colleague of the investigator's (following her participation in the colleague's study), and one was invited to participate by a friend who was taking part in the current study.

Thus, despite the efforts of colleagues working in two large psychology departments and two GP surgeries, only two people with depression were recruited through the NHS. Several clinicians who had offered to help with the recruitment later commented that, having reviewed their caseload, they had been able to identify few, if any, persons meeting the inclusion criteria.

People with depression

Of the nine people with depression who participated in the study, eight (89%) were female and one was male. The mean age of people with depression was 44 years (range: 28-53) and all were White British. The eight persons who were married or living with a partner had been together for 13 years on average (range: 1-30 years); one person was in an ongoing relationship (of 5 years) but not currently living with his partner. In terms of educational attainment, two (22%) people had left school at age 16, one (11%) person at age 18, two (22%) had intermediate vocational qualifications, and four (44%) had university degrees.

Five (56%) people worked in professional or semi-professional occupations, one (11%) in a skilled occupation, and three (33%) did not work outside the home (of these latter three, one person had taken early retirement from a semi-professional occupation on grounds of ill (physical) health). Eight (89%) people reported having experienced one or more episodes of unipolar depression; one (11%) person had a history of bipolar depression. Eight (89%) people had suffered more than one depressive episode (this includes one person who reported being depressed for the majority of his adult life); and one (11%) person was experiencing a first depressive episode (of three years' duration). All nine participants had received professional help for their difficulties and four (44%) had been hospitalised at some stage. It is important to emphasise that participants in this study were self-defined as suffering from depression and that no systematic diagnostic information was collected. Information on participants' current depressive symptoms is presented with other questionnaire data in Chapter 3.

It was originally hoped that it would be possible to recruit equal numbers of depressed women and men. As detailed above, however, only one depressed man was finally recruited. Analysis of the interview data suggested that the themes arising in this couple's account were consistent with those from couples with a depressed female member. It therefore seemed appropriate to retain data from this couple in the overall analysis.

Partners

The partners (eight male, one female) of depressed participants had a mean age of 46 years (range: 29-57). Eight (89%) were White British and one was Black Afro-Caribbean. Two (22%) partners had left school at 16 or earlier, two (22%) at 18, one (11%) had an intermediate vocational qualification, three (33%) had gained undergraduate degrees, and one (11%) had a doctorate. Six (67%) partners worked in professional or semi-professional occupations, one (11%) in a skilled occupation, one (11%) was a full-time student, and one (11%) did not work outside the home. Two (22%) partners reported having experienced past

episodes of depression (in both cases this was prior to beginning their relationship with the depressed person).

Investigator's perspective

Addressing the issue of good practice in qualitative research, several authors have recommended that the investigator explicitly acknowledge his or her own theoretical orientation and expectations as relevant to the area under study (e.g. Elliott, Fischer, & Rennie, 1999; Stiles, 1993). This issue is discussed in greater detail in Chapter 4.

As a trainee clinical psychologist, I have developed an interest in non-directive, exploratory approaches to psychological intervention, as reflected in my choice of an elective placement in adult psychoanalytic psychotherapy. I am also interested in systemic family therapy and group psychotherapy. My own therapeutic preferences aside, I am of the view that people understand their experiences in different ways and therefore also have differing needs in terms of the type of psychological help that they would find most beneficial and/or compatible with their beliefs. I would expect this also to be the case for the help people receive within their natural support networks. I was motivated to investigate the area of informal helping for depression by an interest in how ordinary people understand and try to ameliorate psychological problems and, in particular, by a personal connection with a couple in which one member had been depressed. I had anticipated that giving and receiving support for depression in the context of an intimate relationship was likely to be a form of informal helping that was especially fraught with difficulties for 'helper' and 'helpee'.

Procedure

All but one couple chose to be interviewed in their home; one preferred to be interviewed in the hospital psychology department where the person with depression was receiving treatment.

Prior to the interview, participants were asked to complete an informed consent form and provide some brief demographic details. Couples were reminded that the interview was to be tape-recorded and their assent to this was confirmed. Following a brief reminder of the objectives of the study and an opportunity to raise any queries, couples were interviewed jointly using a specially devised semi-structured interview schedule (described below). The interview lasted about 90 minutes. Following the interview, each member of the couple was asked to complete four questionnaires, in order to provide contextual information on participants' relationship satisfaction, perceived empathy, current depressive symptoms, and attitudes towards expressing emotion (details of the questionnaires are presented below). Three couples completed the questionnaires in the presence of the investigator (this took 10-15 minutes); the remaining six couples chose to complete and return the questionnaires in their own time (an SAE was supplied for this purpose). (One partner did not complete the questionnaires.) The whole session generally lasted a little over two hours.

Either at the end of the first session or during a telephone conversation a little while afterwards, couples were asked if they wished to receive a written summary of the themes and issues that the investigator had noted in their interview (see Appendix VII for an example summary). All nine couples said that they wanted to receive a copy of the summary (in cases where the investigator telephoned, it was the person with depression who made this decision on behalf of the couple). Couples were also invited to take part in a briefer follow-up interview, at which they could give their views on the accuracy of the investigator's summary and also explore some of the issues raised in more detail. Couples were given as much time as they needed to decide together whether or not they wished to participate in a second interview; all nine couples eventually chose to do so. The follow-up interview was generally somewhat briefer than the first interview, lasting 40-80 minutes. There was some variation in the elapsed time between first and second interview for each couple, reflecting the difficulty of co-ordinating with participants' busy lives. On average, follow-up interviews were conducted 15 weeks after the first interview (range: 8-25 weeks).

There were two minor exceptions to the procedure outlined above. In the case of one couple, the person with depression was initially interviewed alone, as his partner had not at the time been available to attend, and then jointly with his partner on a second occasion. There was also one instance of the opposite scenario, whereby the couple were interviewed together on the first occasion, while on the second, the person with depression was interviewed alone, because her partner was busy with work-related commitments.

Interviews were tape-recorded and transcribed. All names and other potentially identifying material were omitted from interview transcripts. (Samples of first and second interview transcripts are provided in Appendix VI and Appendix VIII, respectively.)

The interview schedules

The interview sought to focus in a non-judgemental and non-blaming way on the experience of giving and receiving support for depression in the context of an intimate relationship. The intention was to obtain a rich account of the support process from the perspective of both the person with depression and his or her partner. The decision to interview couples jointly was made on the basis that this was likely to result in a more balanced overall picture, which both members of the couple would have a role in shaping. It was hoped that the joint interview format would be less likely to engender suspicion or resentment than might conducting separate interviews with each member of the couple.

The first interview

A semi-structured interview schedule (see Appendix V) was designed for the purpose of investigating participants' experience of giving and receiving support for depression. The interview schedule was developed by the author in consultation with two other researchers with expertise in the use of qualitative research methods and the field of informal helping in couples. The schedule was intended to provide a flexible guide to the areas ideally to be covered in the first interview. The questions asked were predominantly open-ended, and

were intended to elicit a detailed account of participants' experiences. Aspects of couples'

accounts that were unclear were gently and respectfully followed-up and reflections were

used to demonstrate understanding and encourage further exploration of certain issues

(Barker, Pistrang, & Elliott, 1994). As recommended by Barker *et al.* (1994), the style of the

interview was "one of empathic and non-judgmental attention, giving the respondent plenty

of space to think and talk, and avoiding bias by not suggesting possible responses" (p. 96).

The format of the interviews was modified somewhat as the study progressed. Thus,

questions about a person's past history of depression were reduced to a minimum in later

interviews, to allow an earlier focus on the couple's helping relationship. In later interviews,

couples were additionally asked how the possibility of relapse had affected their

relationship.

Introduction. The interview began with a reminder of the study's general aims and a further

opportunity for participants to ask questions before getting underway. It was emphasised in

the preamble that, in all close relationships, attempts to be supportive do not always go to

plan and can sometimes feel quite unhelpful to the person on the receiving end. Couples

were encouraged to share both their positive and negative experiences of the support

process, without either party feeling criticised or blamed. It was also stressed that the

interview was intended to be a collaborative process and that the couple, as the experts on

their relationship, were welcome to direct the interviewer towards personally meaningful

aspects of their experience that might otherwise be missed. Participants were also

encouraged to let the interviewer know if the conversation had moved into areas that they

did not feel comfortable discussing.

Brief history of depressive episodes. The person with depression was first asked to provide a

brief history of his/her depression, including details of the nature, number and severity of

depressive episodes.

Most recent / current episode. The couple were then asked to focus on the most recent depressive episode that they had experienced together (or the current episode if applicable), and to describe their experiences during a particularly memorable period within it (e.g. when things were at their worst).

Partner support during most recent / current episode. Whilst still focusing on the most recent / current depressive episode, the couple were asked to describe the ways in which the partner had tried to be supportive and how each party had experienced these support attempts. The person with depression was asked what kinds of support from the partner had been experienced as particularly helpful or unhelpful, about the impact of these support attempts, and whether there were particular things that he or she wished that the partner had done, or had done more often. The partner was asked to describe his or her experiences of trying to help and about the things that had facilitated or hindered him/her in this. The couple were asked whether or not they considered that they had similar ideas about being supportive. Couples who were reflecting on past depressive episodes were asked whether anything different had been happening in the relationship when the person with depression started to feel better.

Support available to non-depressed partner. The partner was asked whether he or she received any support from anywhere in the course of trying to help the person with depression, and also what kind of support had been beneficial or would have been desired.

Explanatory models and general ideas about helping. The couple were asked for their ideas about why people become depressed in general, and also how they would go about trying to help a depressed friend.

Debriefing. The couple were thanked for sharing their experiences and given the opportunity to ask questions about the interview or the research in general and to address any feelings or issues that had been raised. Couples were reminded how the interview data

would be used, told when they might expect to receive a summary of the study's findings,

and reminded how to contact the investigator should they subsequently have any queries or

comments relating to any aspect of the support process.

The follow-up interview

The follow-up interview was generally structured around the summary of the couple's first

interview and thus was individually tailored in each case. Nevertheless, the following basic

format was used in most cases:

- Couple's feedback on summary:

Was it consistent with the couple's impression of the first interview?

Was it accurate in its presentation of detail?

Were any important details or issues omitted?

How did it strike each of them emotionally?

- Opportunity for couple to comment on the first interview and research process in general

- Further exploration of interesting issues raised in first interview

- Filling in of any gaps left over from first interview (e.g. questions that had been omitted

  as a consequence of running out time)

- Where appropriate, discussion of salient links with other couples' accounts

- Final debriefing / opportunity for couple to ask questions about the research process

Quantitative measures

The following quantitative self-report measures were used solely for the purpose of

describing the sample, in terms of participants' relationship satisfaction, perceived empathic

responding, current depressive symptoms, and attitudes towards expressing emotion.

Locke-Wallace Marital Adjustment Test (MAT: Locke & Wallace, 1959). This 15-item scale

was used to assess participants' relationship satisfaction. It was chosen in preference to the

more recent Dyadic Adjustment Scale (Spanier, 1976), which was considered too lengthy for

the purposes of this study. Although developed several decades ago, the MAT is a well-established measure with good reliability and validity, and continues to be used in relationship research. Possible scores on the MAT range from 2-158, with higher scores indicating greater relationship satisfaction. (See Appendix IV.)

Empathy Questionnaire. This is a 10-item modified version of the empathy sub-scale from the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1978), originally developed for psychotherapy research. This scale has been used in previous couple research to assess the degree to which people perceive that their partners understand them (Pistrang & Barker, 1995). Sample items include 'S/he nearly always knows exactly what I mean' and 'S/he may understand my words but s/he does not see the way I feel'. Respondents rate each item on a six-point scale ranging from 'strongly untrue for me' to 'strongly true for me'. The total sub-scale score is divided by 10 to yield a final score ranging from 1-6; higher scores indicate higher levels of perceived partner understanding. The scale has good internal consistency (coefficient alpha of 0.84; Pistrang & Barker, 1995). (See Appendix IV.)

Beck Depression Inventory (BDI-II: Beck, Steer, & Brown, 1996). The BDI-II is a well-validated self-report measure of depression. Possible scores on the BDI-II range from 0-63, with higher scores indicating more depressive symptoms. It was given to both members of each couple to assess the extent of any current depressive symptoms.

Attitudes towards Emotional Expression scale (AEE: Joseph, Williams, Irwing, & Cammock, 1994). The AEE is a 20-item self-report measure of negative attitudes towards emotional expression. Respondents are asked to rate 20 statements on a five-point scale ranging from 'strongly disagree' to 'strongly agree'. Possible total scores on the AEE range from 20-100, with higher scores reflecting more negative attitudes towards emotional expression. Sample items include 'I think getting emotional is a sign of weakness' and 'When I am upset I bottle up my feelings'. The scale has good internal consistency (coefficient alpha of 0.9; Joseph *et al.*, 1994). Convergent validity with the Ambivalence

over Emotional Expressiveness Questionnaire (AEQ) has been demonstrated (Laghai &

Joseph, 2000). (See Appendix IV.)

Qualitative analysis

The goal of the qualitative analysis was to identify themes that were common across couples

relating to the experience of giving and receiving support for depression. Interview data

were analysed using interpretative phenomenological analysis (IPA; Smith, Jarman, &

Osborn, 1999). IPA attempts to understand how participants themselves make sense of

particular experiences by enquiring about the special meanings of these experiences for

them. This contrasts with traditional approaches to scientific research in that the aim is not to

derive "an objective statement of the object or event itself" (Smith, 1996a). The term

'interpretative phenomenological analysis' captures the duality inherent in this approach:

while IPA strives to get as close as possible to the participant's perspective, there is also

recognition of the fact that research is a dynamic, interactive process. As Smith (1996a)

states: "Access [to the participant's world] is both dependant on, and complicated by, the

researcher's own conceptions which are required in order to make sense of that other

personal world through a process of interpretative activity" (p. 264).

Smith *et al.* (1999) offer a detailed account of how to analyse interview transcripts using IPA

but emphasise that "there is no single definitive way" to perform such an analysis: IPA is a

personal process and it is therefore appropriate that the investigator make whatever

adaptations seem appropriate to suit his or her way of working.

Of particular importance within the IPA approach is the investigator's intimate knowledge of

the data under investigation. In this study, the investigator's familiarity with the interview

data was ensured through a process that involved repeated exposure to the material. Thus,

subsequent to interviewing a couple, the investigator listened to a tape-recording of the

interview and made detailed notes on the issues arising. These notes were subsequently

organised into a summary of the main themes and issues raised by the couple, which could

itself be construed as a preliminary analysis. (As detailed above, the summary was then given to the couple, who were invited to comment on its validity and thus influence the direction of the analysis thereafter.) The next stage in the analysis involved a detailed reading and re-reading of the couple's transcribed interview. Here the process followed was much as described by Smith *et al.* (1999). This involved an iterative process whereby points of interest or apparent significance were noted with each reading of a transcript and eventually developed into tentative theme titles – i.e. key words which seemed to capture the essence of what was being described in the text. The next stage involved looking for connections between the emerging theme titles and beginning to organise them into clusters, potentially reflecting some form of hierarchical relationship between themes and sub-themes. It was important to check at this stage (and throughout the analytic process) that emerging theme clusters tallied with what participants had actually said in the interview. The derived themes and sub-themes were then organised into a coherent structure, excluding any that seemed inconsistent with the overall structure or which lacked evidence in the data.

This process was repeated with each of the nine first interviews, with earlier analyses guiding later ones. Thus, themes which emerged in the course of analysing subsequent transcripts were compared with those previously derived, to determine whether they were more appropriately conceptualised as new themes or as exemplars or modifiers of an existing class. Once this process was complete, a master list of the themes for all nine couples was constructed and organised into a coherent overall framework. To be included in this final framework, it was necessary that a theme be supported in the interview data at both an individual and group level. (While a given theme needed to connect the couples' accounts in a meaningful way, it was not necessary for the same theme to be evident in every couple's account). Transcripts of the follow-up interviews were analysed in a similar way, using the master list of themes for the whole sample as a guide; care was taken to be attentive to the emergence of new themes as well as further illustrations of existing ones.

Credibility checks

Credibility checks were implemented at several points in the analytic process. First, providing participants with a summary of the major themes and issues that the investigator had discerned in the first interview could be construed as a type of 'member validation' – i.e. an opportunity to check the investigator's interpretation of the data with participants (Smith, 1994). Several authors have proposed member validation as a potential criterion of validity in qualitative research (Elliott *et al.*, 1999; Smith, 1996b; Stiles, 1993). It should be emphasised, however, that the interview summaries stayed close to the spirit of participants' accounts and involved little interpretation. It is therefore perhaps not so surprising that, almost without exception, these were considered accurate in both detail and overall 'flavour' by participants. The summaries would inevitably have influenced the direction of the subsequent in-depth analysis of the interview data, so establishing their accuracy from participants' point of view was clearly an important and relevant aspect of the analytic process.

A second type of credibility check on the derived themes and the overall structure into which they were organised was performed by a second researcher with expertise both in qualitative research methods and informal helping in couples. The second researcher conducted independent analyses of three full interview transcripts and these were then compared with the investigator's analyses of the same three transcripts. There was considerable overlap in the themes identified by investigator and second researcher. Following the investigator's analysis of the remaining transcripts, the investigator presented his findings to the second researcher (who had also listened to a substantial proportion of the taped interviews), to check their consistency with her reading of the data. Investigator and second researcher discussed areas of disagreement and themes were modified or abandoned accordingly. Finally, a third researcher, also with experience of qualitative research methods, listened to a selection of taped interviews and audited the themes identified by the investigator and second researcher at several points in the analytic process.

Chapter 3: Results

The qualitative analysis of the interview data will form the main part of this chapter. In order to set a context for these findings, I first present the quantitative data on participants' relationship satisfaction, perceived empathy, current depressive symptoms, and attitudes towards emotional expression.

For clarity, the term 'partner' will refer to the member of the couple who is trying to help, unless the context is unambiguous; the term 'person with depression' (PWD) will refer to the member of the couple who was or had in the past been depressed.

Background information

Background data from the self-report measures are summarised in Table 1. A wide range of scores was obtained on these measures, particularly by people with depression, and therefore the overall means are potentially misleading (as suggested by the large standard deviations). Table 2 presents the data for each couple, in order to provide a picture of who the individual participants were.

Relationship satisfaction

Overall, most couples reported satisfaction with their relationships, as indicated by the mean score on the Locke-Wallace Marital Adjustment Test (MAT). As can be seen in Table 2, one couple obtained scores below 100, which is a commonly used cut-off to indicate marital distress. One other PWD also had a score in the distressed range (no data were available from her partner, who did not complete the questionnaires).

Empathy

Couples also reported moderate levels of empathy within their relationships. As can be seen in Table 2, in most couples the PWD and the partner reported feeling 'slightly' or

'moderately' understood (scores of 4 and 5, respectively) by one another. Only one PWD

reported feeling moderately misunderstood (score of 2) by her partner.

Depressive symptoms

Using the descriptive categories proposed in the Beck Depression Inventory manual (BDI-II;

Beck *et al.*, 1996), four people with depression scored within the 'severe' range for current

depressive symptoms, one person in the 'moderate' range, and four people within the

'minimal' range. Thus, five people with depression obtained a BDI-II score within the range

expected for a clinically depressed population. None of the partners scored within the

clinical range for current depressive symptoms.

Table 1. Summary of background data

Measure	People with depression			Partners		
	M	*SD*	range	*M*	*SD*	range
MAT [a]	112.78	24.71	68-141	115.13	16.87	82-137
Empathy [b]	3.97	0.91	2-5	4.29	0.45	4-5
BDI-II [c]	20.56	16.52	0-44	4.50	1.41	3-7
AEE [d]	59.22	24.32	33-99	37.25	8.10	28-54

[a] Locke-Wallace Marital Adjustment Test: possible scores range from 2-158, with higher scores indicating greater relationship satisfaction.

[b] Empathy questionnaire: possible scores range from 1-6, with higher scores indicating greater perceived partner understanding.

[c] Beck Depression Inventory II: possible scores range from 0-63, with higher scores indicating more depressive symptoms.

[d] Attitudes towards Emotional Expression scale: possible scores range from 20-100, with higher scores indicating more negative attitudes towards emotional expression.

Attitudes towards emotional expression

Norms are not available for the Attitudes towards Emotional Expression scale (AEE),

though Joseph *et al.* (1994) report a mean of 45.03 (SD = 12.75) following its administration

to a sample of 180 undergraduate students. Three people with depression obtained AEE scores more than two standard deviations (using Joseph *et al.*'s SD) above the mean for the student sample, suggesting that a third of the people with depression had unusually negative attitudes toward expressing their feelings. As detailed in Table 2, partners appeared to hold somewhat less negative attitudes towards emotional expression.

Table 2. Background data for people with depression and partners presented by couple

		Married / living together (years)	Age	MAT	Empathy	BDI-II	AEE
Couple 1:	1F [a] (PWD)	1	31	120	5	29	99
	1M [b] (partner)		37	122	4	3	42
Couple 2:	2F (PWD)	3	28	128	5	37	59
	2M (partner)		29	132	5	4	54
Couple 3:	3F (PWD)	16	39	139	4	2	35
	3M (partner)		40	110	4	3	39
Couple 4:	4F (PWD)	25	49	68	2	8	53
	4M (partner)		50	82	4	4	37
Couple 5:	5F (PWD)	12	43	116	5	8	48
	5M (partner)		42	108	5	4	33
Couple 6:	6F (PWD)	30	53	82	4	0	38
	6M (partner)		54	-	-	-	-
Couple 7:	7F (PWD)	3	49	119	4	22	33
	7M (partner)		55	117	4	7	34
Couple 8:	8M (PWD)	-	50	102	4	35	80
	8F (partner)		57	113	4	5	31
Couple 9:	9F (PWD)	11	51	141	5	44	88
	9M (partner)		50	137	4	6	28

[a] F = female participant

[b] M = male participant

Qualitative data

The findings of the qualitative analysis of the interview data are presented in two sections, the first entitled, 'Couples' experience of depression: A longitudinal perspective' and the second, 'The helping relationship'. The two sections can be considered higher order domains

of experience, which largely reflect the areas covered in the interview schedule. The first

domain offers a longitudinal account of the couples' experience of depression and thus

provides the contextual background to the second domain, which focuses specifically on

couples' experience of giving and receiving support. Each domain is comprised of five

themes, with each one reflecting a substantive aspect of the couples' experience. The

majority of themes are broken down into sub-themes, providing a further layer of detail in

each case. The themes and sub-themes emerged from the qualitative analysis of the

interview data. The overall framework into which the domains, themes and sub-themes have

been organised is shown in Table 3.

Excerpts from interview transcripts have been edited for brevity and to enhance readability.

Omissions are indicated as follows: '...' represents an omission from within an

uninterrupted conversational turn; '...//...' represents the omission of intervening comments

from other speakers. The provenance of each quotation is given in square brackets – e.g.

[1M] would indicate the male partner from Couple 1. Where dialogue is presented, 'I'

indicates the interviewer, 'PWD' indicates the person with depression, and 'P' indicates the

partner.

Couples' Experience of Depression: A Longitudinal Perspective

One of the most striking aspects of these couples' experiences of depression was the

changing context in which their helping and coping efforts went on. Thus people with

depression and their partners struggled to cope with a condition that presented a variety of

different challenges over the course of its developmental path from onset through to

recovery. For some, a more or less insidious onset phase led into a period of severe distress

and incapacitation followed by a protracted recovery phase. This process unfolded gradually

over the course of several months for some couples; for others, it occurred in miniature over

a few days or weeks. Whatever the time-scale, however, this overall trajectory imposed

complex and changing demands on couples' resources, as what was wanted or what seemed

helpful varied in most cases with the developmental phase of the depression. Moreover, the

nature of the relationship between the PWD and partner was also influenced by the

vicissitudes of this developmental journey. In this first section, I describe the couples'

experiences of the various phases in this process.

Table 3. Organising framework for domains, themes and sub-themes

Higher-order domains	Themes	Sub-themes
1. Couples' experience of depression: A longitudinal perspective	1. Becoming depressed	1. Recognising depression 2. Not being able to find the words to explain
	2. "Battling through" – coping with a family emergency	1. Withdrawal from family life 2. A 'parental' role for partners 3. "All hands to the pump" 4. Waiting for the medication to start working
	3. Coping with the "long, grey periods"	1. "Treading water" 2. Distance and disconnection – a relationship "on hold"
	4. Starting to "swim again" – the recovery phase	
	5. The possibility of relapse	
2. The helping process	1. "Stumbling along"	1. Finding out what works through trial and error 2. "What I want isn't necessarily what's good for me" 3. Aiming for a "moving target"
	2. "Walking on eggshells"	1. Fear of getting it wrong 2. Saying the wrong thing
	3. Communication in depression – a "Catch 22" ?	1. Talking and listening 2. Playing it by ear / Being receptive 3. Making time to talk 4. Goal setting – recovering "common ground"
	4. Working together	1. Depression disrupts established ways of relating 2. Providing encouragement 3. Offering practical solutions / advice 4. Qualities of helpful relationships 5. The importance of support from the partner
	5. Managing one's feelings as a helper	1. Frustration, impatience, and anger 2. The partner's support needs 3. The emotional rewards of helping

Becoming depressed

For some couples, the onset of depression was sudden and dramatic – a clear emergency entailing early involvement of medical personnel and activation of a support network comprising both formal and informal helpers. This was particularly the case for couples experiencing a recurrence of depression, who thus had some idea of what was going on, what to expect, and to whom they might turn for assistance. For others, however, depression was a more insidious experience, which might not be so easily recognised, or acknowledged, by the depressed person, or partner.

Recognising depression

Recognising depression was something that emerged as a source of difficulty and upset for couples. Particularly during the early stages of a relationship or during a first depressive episode, some partners felt baffled by the dramatic changes in the PWD's mood or behaviour. As one partner commented: "It used to drive me crazy … I thought, what the hell's the matter with the woman?" [7M]. Others interpreted the changes they observed as some kind of accusation, provoking defensiveness and hostility rather than sympathy: "I found it difficult to distinguish your behaviour as depression, as opposed to some other emotion, like anger or a desire to take me down a peg or two" [4M]. One partner considered that he had made little progress over the years in recognising depression in his spouse; thus she would generally have to tell when she felt depressed or "act the depression" for him in some highly visible way.

Moreover, some people with depression found it hard to talk about feeling low with their partners, because this was something they did not yet themselves fully acknowledge, or because they had become accustomed to keeping negative feelings to themselves – a habit that became difficult to break (even where partners strongly encouraged emotional expression) for fear of provoking some of kind of rejection or criticism. This could be a disconcerting experience for partners – particularly those who had not previously

encountered depression – who could see that something was wrong but did not know what it was, what they should do, or whether they were in some way to blame: "I didn't know what was going on ... and I didn't know why ... I just kind of thought, well, I've done something. I don't know what it is" [1M].

Some couples described a process of building trust, facilitated by the partner's evident desire to help and non-critical acceptance of their emotional experience, which in time made it easier for depressive feelings to be acknowledged and talked about. This was particularly the case for couples who had experienced an episode of depression in the context of forming a new relationship. Partners described how they had decisively opted in as active participants in the relationship and therefore also in the helping process:

> I didn't ... want to be excluded [from person's depression], and I didn't feel anymore
> that I wanted to be ... a passenger on this mad journey, bit like a roller-coaster, really,
> because you don't know ... the corner's coming; then you get to the corner and you're
> kind of flying off and you don't know why. [1M]

Where the PWD struggled to recognise or acknowledge depressive feelings, the partner potentially had a role in helping with this process. Thus in one couple, the partner's refusal to accept assurances that there was nothing wrong would sometimes culminate in his confronting the PWD with evidence to the contrary – e.g. the impact that her depressive behaviour appeared to be having on others. This partner's ability to intervene effectively in this way seemed to be based on an understanding of the pattern of the PWD's depressive cycle.

Recognition of a person's depression also provoked unsettling questions about its cause, however. This was particularly troubling where there had been no obvious trigger. For example, one couple described how they had agonised over whether there might be anything in their relationship that could have caused the person's depression:

... we were searching back into the history of our relationship... the odd episode where perhaps it hadn't been quite as close ... there were times then when ... I was convinced that we were reading too much into ... some events that had passed and we dealt with. [3M]

Not being able to find the words to explain

Almost without exception, people with depression felt that words were inadequate for conveying what being depressed actually felt like:

... I find it frustrating because I can't find the words to explain. All the words that I think of ... they only kind of explain the mild form ... If you could times a word by ten in its intensity, then that is how it feels ... [2F]

Wishing that the partner could have more of an understanding of what it was like to be depressed was also a common experience. One depressed person felt strongly that her partner had been unable to understand the extent of her incapacity, failing to recognise that even everyday tasks could seem like a terrifying and impossible ordeal: "[P] had no idea why making a stupid, simple phone call was so absolutely terrifying and impossible ... it's just like [your thoughts are] all furred up like the inside of a kettle" [6F]. Moreover, this person described how the cognitive difficulties that interfered with her ability to perform such tasks also prevented her from explaining clearly to her husband why these things were so difficult: "because you can't think properly, you can't explain it properly either ... even the inadequacy of you not being able to do that leads to distress" [6F].

For some partners, the fact that, physically, the PWD appeared the same was difficult to reconcile with the accommodations they were expected to make. People with depression could also be painfully aware of this:

> ... [being depressed is] sort of like climbing Everest with ... an amputated leg ... It's just so bloody difficult. And it's not obvious to people, you know, because it's just such a ... invisible sort of thing and ... undefined sort of condition. [6F]

For partners, the experience of seeing a loved one in distress could be very upsetting; however, many acknowledged that, as well as feeling sympathetic, they also felt baffled by the PWD's low mood. Several partners took the view that, as they had not themselves ever been depressed, they could not be expected to know what it felt like for someone else, and particularly not if the PWD did not feel able to explain. This lack of a shared understanding of the experience of depression emerged as a stumbling block for most of the couples at some time or other:

> ... the phrase that kept coming up ... was, "I wish you could know how I felt". And you sit there thinking, "Yeah, I wish I could, but I can't"... there's a part of you that actually also says "and I never will, because I'm not going to get this illness"... because there is a bit of you that's still looking to, well, why has this person got this illness? [3M]

"Battling through" – coping with a family emergency

For people who had experienced more severe depressive episodes, there was often a fairly rapid transition from realising that something was wrong to coping with a full-blown family crisis. During the most severe phases of depression, a common experience for couples was a desperate and seemingly fruitless search for something that might alleviate the PWD's distress. As this went on, people with depression withdrew from family life, relationship roles and responsibilities were redrawn, and partners sought to mobilise whatever other support might be available.

Withdrawal from family life

During the worst of their depression, several people had experienced a narrowing of their focus to the painful business of getting through each day. As one person commented: "I just didn't know how anything was going to turn out ... surviving each day was just as far as I could see at that time. It was survival" [6F]. For some people, being severely depressed was associated with almost complete withdrawal from family life and diminished awareness of what was going on around them. One person described how she could see family life continuing around her yet felt quite unable to participate: "I felt like I was in a glass bubble and I was inside knocking to try and get out of it ... I could see all my relatives and all my friends doing their daily things" [3F].

Often, however, the daily business of family life ceased to hold any interest for the PWD. Consequently, people were often grateful for their partners' efforts in taking over the responsibilities associated with running the household, particularly in relation to looking after children. One person described how, struggling to engage emotionally with her son whilst severely depressed, she had been very glad of her partner's availability to spend even more time than usual with him.

A 'parental' role for partners

During more severe phases, people with depression generally felt very dependent on their partners:

> ... you can't look after yourself at a time like that. You are just completely dependent ... I wasn't sure that [P] understood quite how dependent I was, and that made it difficult sometimes. [6F]

This was not only experienced in relation to the partner's role in keeping family life "ticking over" but, for some, was also reflected in the partner's increased involvement in the depressed person's daily routine – e.g. providing prompts to get up, washed and dressed, or

to eat regular meals. Thus some people were required to negotiate a role change from partner to something approaching parent. This was not the case for all couples, however, and partners varied in the extent to which they sought to prompt, persuade or cajole the PWD to persevere with activities of daily living, or, indeed, felt confident that this was the right thing to do. I discuss this issue in greater detail in the second section.

One PWD had looked to her partner to be "paternal" in a different way, asking him to reassure her that everything would be alright during a period of great distress. Her partner described how this would have involved a role change that was unacceptably at odds with the principle of equality that had they had both valued within their relationship:

> I was concerned about the confusion in the relationship, that we would move from a period of equality between us to a period where I was being asked to give the bear hug, to be the man, to be the father. [4M]

"All hands to the pump"

Two partners used this expression to describe the experience of coping with this phase; another spoke of planning a "military operation", conveying the complexity involved in deciding who would help with what and when. There was a sense of having to respond quickly and vigorously to an emergency – a response which entailed making a rapid assessment of both the depressed person's immediate support needs (e.g. for supervision, nourishment, *etc*) and what was needed to keep the family "afloat" (e.g. getting children to and from school, taking care of housework). Other network members (usually relatives and friends) might then be recruited into the support process, filling any gaps leftover by demands on the partner's time or particular profile of strengths as a helper:

> ... [PWD]'s mum found it easiest to go round hoovering and doing the washing ... I tried to provide the reassurance to the extent of my limited tolerance levels and there were people ... who would come in and sit with [PWD] for an hour or so, providing

that reassurance ... I think you need to ... have that wide circle ... and play to strengths almost in doing so. [3M]

Partners' emotional experience of the emergency phase varied. Some described struggling with ambivalent feelings. Thus sympathy for the PWD's plight might be intermingled with resentment and irritation at the disruption to family life and the additional burden of responsibility partners were consequently required to shoulder. As one partner commented: "it was a great strain on the whole family ... And I was ... very definitely getting extremely impatient with the whole damn thing ... It was just interfering with family life" [6M]. However, another partner described taking some comfort in at least having a clearer sense of his role during the emergency phase, when the depressed person's physical needs seemed to be paramount and there were well-defined practical problems for him to tackle:

It was as though normal rules don't apply ... this is an emergency and I have problems to solve. And ... that's something I'm comfortable with. So [PWD] wasn't eating ... I did look and imagine there were several contributory factors to the illness. Here was one I could do something about. [5M]

Waiting for the medication to start working

Several participants felt that, during the worst of the depression, nothing that anyone could do or say really seemed to help. Both the PWD and the partner often felt quite desperate and helpless as the situation seemed to get inexorably worse, leading some to the conclusion that finding an effective antidepressant was the only viable course of action. As Couple 3 put it:

I think there comes a point when ... you're really bad, only the medication really will help. [3F]

I reached the stage where I ... wasn't sure there was anything I could do to help the situation ... And therefore ... I started to think it was more about not doing anything to worsen the situation, so sort of wait for the medication to work. [3M]

Thus the psychiatrist or GP often became a prominent figure in the support network during this phase. Some partners involved themselves very actively in the depressed person's medical care, finding a role in providing feedback on the PWD's progress during consultations and keeping track of what the doctor advised. While partners generally found it beneficial to be included in this way, they could also feel rather adrift during the long periods between consultations. This seemed to be particularly so for couples who had been advised that there was nothing further they could or should do for themselves:

> ... you're battling through just thinking alright ... I know that there's no support really being provided by the medication for the next six weeks, but let's just keep our fingers crossed ... I mean, you're seeing the psychiatrist every month, but in between you feel really very much on your own. [3M]

Coping with the "long, grey periods"

For some couples, there was what one partner described as a "long, grey period" when the depression seemed to stabilise after the initial crisis of onset. The most salient aspects of this phase were the sense of little changing from one day to the next and the distance and disconnection experienced in the relationship between the PWD and partner.

"Treading water"

Some couples had experienced a long phase during which the depression did not seem to get worse but neither did it show any sign of getting better. As one partner put it: "we would go from one day to the next and nothing would change ... at best we were treading water... [Things] weren't getting worse; they weren't getting better" [2M]. This could be a lonely time for both members of the couple, and one experienced as particularly wearing and demoralising for the partner. The same partner described how it became difficult returning home to his wife each evening, knowing that she would have little to report from her day and

that the onus would be on him to find the energy to respond attentively and sensitively to her needs:

> ... sometimes I'd ... come home and I'd just think, "Oh, I don't need to be going through this tonight" ... that was the low point for me when I ... almost resented coming home to ... the situations or the atmosphere. [2M]

A further difficulty arising during this phase was the loss of "common ground" for sharing experiences; thus, the partner's busy working life might continue much as before, while the PWD engaged in a severely limited range of activities at home. Several partners described going to work as a very welcome respite from the situation at home. At times, however, it could also be hard for partners to find the energy to continue with their daily routine: "It really did require effort to get up and say, 'I've got to carry on. Because if I don't carry on I'm just going to disintegrate' " [4M].

Distance and disconnection – a relationship "on hold"

Even where the PWD had not felt incapacitated or dependent to the extent described above, depression was universally associated with distance and disconnection within these couples' relationships. Describing the PWD's disengagement from the usual conversations and plans associated with family life, one partner spoke of the relationship going "on hold" during this phase:

> It is not the relationship that existed prior to the illness ... So the things that you talk about in a relationship which are around plans for the future ... about the children and where you might go on holiday or ... what's happening in the world or what's happened today. You don't have any of those conversations, because the person with the depression has no interest in those conversations ... So actually it's a very lonely period. [3M]

Couples described how their established *modus operandi* was severely disrupted and this was felt particularly acutely in relation to communication between partners, which tended to be markedly impoverished during periods of depression. As already noted, people with depression generally felt very alone with painful feelings which they both doubted their ability to convey and doubted their partner's capacity to understand. Moreover, wary of doing anything to make the situation worse, partners also tended to be reluctant to discuss their feelings about what was happening. Thus there was a marked decline in the flow of emotion-related information within these couples, often with each partner feeling that the other could not or would not understand him or her in some important way. These couples' accounts conveyed a powerful sense of depression as a profoundly isolating and lonely experience for both members of the couple. As one PWD put it: "we were like two people living [under] the same roof, but completely separate" [2F].

Several people said that there were times during their depression when they had just wanted to be on their own. For some this was about being relieved of the pressure of hiding the full extent of their distress. One PWD commented: "when I'm on my own, I can be myself and I don't have to put on a face ... of normality, or a face of any kind ... because putting on a face ... is very tiring" [2F]. In general, however, partners were very aware of the PWD's distress, and, moreover, anxious to find some way of relieving it: "you don't like to see a loved one ... going through something ... as isolating as depression. And ... there's an eagerness for you on the outside to get in there and ... support" [2M]. However, feelings of frustration might arise where the PWD remained unresponsive to the partner's attempts to communicate; one partner commented that at times this had been "just like talking to a brick wall" [2M]. Moreover, the depressed person's unresponsiveness to the partner's overtures might be experienced by the latter as quite demoralising. One partner said of the PWD's perceived "indifference" to his support attempts: "[It] erodes your ... own self-esteem and ... your willingness to continue along ... the path that you're taking" [2M].

Starting to "swim again" – the recovery phase

Couples described the recovery phase as a subtle and protracted experience. For those who had been more severely depressed, there was a sense of a gradually increasing awareness of the world around them, while for people with depression generally there were signs of a greater willingness or desire to communicate and interact with their partners. However, while the overall trend was towards improvement, this phase brought its own particular stresses and strains for couples. Couple 6 conveyed the subtlety of the recovery phase as follows:

> And it was a very gradual improvement, wasn't it? I mean, there came to a point where suddenly it was gradually getting better ... [6M]

> You're drowning and then suddenly you can, sort of, swim again. [6F]

As they began to feel better, people with depression described becoming gradually more aware of the world around them, and of their partners in particular. As one PWD put it: "my awareness knob gets turned on a little bit more and I'm a bit more aware of other things. And of course the first thing I'm always aware of is ... [P] and how he is really" [2F]. Another person described how her growing awareness brought with it concern for what her partner might be feeling in relation to providing support: perceiving indications of his irritation and frustration, she had the sense that it was high time that she started to get better:

> ... so when [P] was starting to get cranky, I was kind of aware that this had gone on for quite some time, that it must be quite frustrating. And I do remember ... thinking I ought to be coming out of this now. I ought to be getting better. [5F]

Partners were also aware of changes in the depressed person's behaviour. One partner described how the PWD became increasingly likely to initiate conversations and ask questions: "You're more open when I come home ... You want to talk about things that have happened to you ... rather than me proactively seeking interaction with you" [2M].

The recovery process brought its own challenges, however. One partner found this "transitional period" on the way to recovery much more difficult than the preceding phases. He had felt a clearer sense of his role as support provider when the PWD had been more severely depressed and it had seemed appropriate to prioritise her needs and set aside his usual expectations for the relationship (e.g. equality, reciprocity). As his wife's depression appeared to lift, however, their roles as helper and helpee seemed much less clearly defined. This meant that the PWD's expressions of negativity were more likely to be interpreted by her partner as indications of a lack of consideration or respect for him, rather than the symptoms of her low mood:

> ... when you're very ill, then it's sort of all hands to the pump and ... you've just got to do the best you can. And when you're well, that's fine. It's in the transitions when you're a little bit ill and then you'll be reacting in unusual and unreasonable ways. And I can get really irritated then, and then I can catch myself and think, "Well, perhaps that wasn't you being cussed and unreasonable and unfair. That was you being ill". [5M]

Another partner described the opposite experience, explaining how he had developed a clearer sense of his role during this period, as well as more of a shared agenda, through supporting and reinforcing the strategies associated with his partner's cognitive behaviour therapy.

The recovery phase was by no means plain sailing for people with depression, however, some of whom described how they had wanted their partner's acknowledgement that they were making progress but not the expectation that normality would suddenly be restored:

> I think to acknowledge that I was getting better – I think that was quite important. But not to think I was completely better ... I did notice the irritation levels rising at that

stage ... he seemed to have lost a lot of patience with it and that wasn't particularly

helpful to me. [5F]

Thus there was considerable potential for misunderstandings and angry exchanges between

partners as the depressed person gradually resumed former activities, interests and

responsibilities. Moreover, even for people who were reflecting on past depressive episodes,

there was no sense of a sudden return to their old self. Most people felt they had changed as

a consequence of being depressed, and potentially in ways that were quite positive – e.g. by

developing greater self understanding.

The possibility of relapse

Most of the couples had experienced more than one depressive episode and were therefore

mindful of the possibility that the PWD might at some point suffer a relapse. Several people

with depression expressed the view that, however they were feeling currently, they could not

imagine a time when the threat of recurrence would not seem to be "hovering" somewhere in

the background:

> I live with my depression every day. It's not something that ever goes away for me ...
>
> even though I am perfectly fine, for me, I am always aware of it ... it's apparently
>
> most likely I'll be on the tablets for the rest of my life. [2F]

> I think we're both aware that it's happened and ... you know, it's a possibility of
>
> happening again. [5F]

This was clearly a highly anxiety-provoking prospect for both members of the couple and

not something that all felt able to discuss with each other. Nevertheless, some couples felt

that they would be better equipped to handle future episodes of depression, having

assembled their own "tool box" of helpful coping techniques:

It seems like both of us are investing ... both individually and as a couple, in the relationship. So we're almost like building some stuff in a tool box, creating mechanisms, so that when something does happen, we can be both there and we can cope with it. [1M]

Another partner was confident that even if the same support strategies seemed not to work so well in the future, he and his partner would still be able to find other ways of coping: "They're tools and they're familiar tools. And if they were blunt, we'd try something else" [2M]. Couples also felt better informed about the services they might call upon for additional support in the future and generally considered that they had established good working relationships with formal helpers of various kinds (e.g. GPs, psychiatrists, psychologists, psychotherapists) – though, with formal helpers as much as informal helpers, there had often been some not particularly helpful encounters in the process of establishing who was good for what. One PWD described working to build a "safety net" since she had been feeling better so that her support needs would be covered both at home and work should things take a turn for the worse:

> ... I have some kind of support from people that I know and trust ... wherever I go. You know, it's kind of creating, not just a safety net when I'm at home but at work, because when I was upset at work ... what did I do? [2F]

Thus for some couples, while relapse was, without question, viewed as a very unwelcome possibility, it was one that could now be thought about with a greater degree of confidence in their ability to cope both individually and as a couple. As one partner commented: "if it were to come along it would [have] ... less impact ... because ... we've kind of got ways of dealing with it ... and probably had the first and worst bite of it" [1M]. Not all participants felt quite so optimistic, however. One PWD was concerned that future episodes would be just as difficult for herself and her partner, as there was little indication that lessons had been learned from their past experiences of trying to cope together. Another person was worried

that being wise to her partner's support strategies might render them ineffective if used in the future; indeed, she considered that in a depressed frame of mind she might even feel inclined to scupper them on purpose.

Some people with depression expressed concern over the extent to which they felt dependent on their partners in being able to cope with depression. Thus while there might be a level of confidence in their ability to cope with future episodes as a couple, there was also some anxiety about the extent to which they were reliant on their partner in this way:

> I think that what we've been through and what I've learnt on a personal level in the past year and a half, and what we've learnt together, equip us much better to head it off ... or to cope with it. I mean my worry I suppose is partly ... we've learnt together how to deal with it together, but what if you weren't there? Would I be able to cope with it? [1F]

Couples varied in the extent to which the issue of relapse, or indeed the person's depression in general, was something that could be openly discussed; this was the case even where reminders of one sort or another were frequently encountered within the household environment (e.g. the PWD's medication). Sometimes the PWD found it difficult to raise the issue with the partner for fear of provoking anxiety or otherwise rocking the boat now that something like normality had been restored; this seemed to be particularly the case where partners conveyed a wish to put the whole episode firmly behind them:

> I think I don't talk about it because I think you get anxious about it and worry about it if I do. And then ... it sort of stops there, it doesn't go on from there ... And when I have ... talked about it, I do get this feeling that you'd just rather not think about it. [4F]

Some people considered they had developed a better understanding of themselves and the causes of their depression. Thus several people described becoming more mindful of the

need to avoid stressful situations or not to push themselves to the extent they might once have done. Partners often had similar considerations in mind and might be more careful not to behave in ways that might upset the PWD:

> ... I can remember in the past us having disagreements and ... me really getting sort of rather self-indulgently angry and sort of ... just emotionally ... letting rip ... I think I'd be very, very cautious about ... doing that again ... [5M]

The Helping Process

In this section, I focus specifically on couples' experiences of giving and receiving support for depression. As I try to convey through the themes below, there were several factors complicating the partner's role as support provider, and often these were in some way connected with disrupted communication within the couples. Thus, even where there was a shared acknowledgement that something was wrong and the partner's help was required, it was much less clear what being helpful would actually entail. While desperately hoping for something that might ameliorate their distress, people with depression often had no idea what exactly they wanted from their partners, or else felt unable to say what was needed. This posed challenges for partners who were required to find their way through trial and error based mainly on intuitive notions of what might be helpful – having in most cases found that professionals had disconcertingly little to say on the issue. Partners approached this task in a highly resourceful manner yet most were also subject to troubling doubts about the appropriateness of the support they provided – their uncertainty compounded by a general lack of feedback, or of feedback perceived to be reliable, from the PWD. Moreover, partners were generally very concerned not to do anything that might exacerbate the PWD's distress, which in itself led to troubling dilemmas about the best way to intervene and meant also that partners tended to become quite guarded about their own feelings. The situation was complicated further by participants' differing personalities and coping styles, and the extent to which established, complementary ways of working together were disrupted.

"Stumbling along"

Providing support for depression was described as a challenging and often confusing experience, fraught with uncertainties, ambiguities and misunderstandings. Partners often had little idea in the first instance how to go about helping and, with little to guide them, later found it hard to feel confident in their "home-grown" support strategies (as one partner described his ideas). Moreover, partners' lack of confidence was compounded by the PWD's changing and variable needs and, at times, a mismatch between what was wanted and what seemed most beneficial. "Stumbling along" was how one partner described the experience of trying to build an effective helping relationship with the depressed person.

Finding out what works through "trial and error"

Partners were strongly motivated to find some way of alleviating the PWD's distress yet found themselves in what was potentially a bewildering situation in which something seemed to be required of them but no one, including often the PWD, could say what it was. Partners who had not previously encountered depression in someone they were close to, or who had not themselves been depressed, could feel particularly at a loss to know what to do. One partner described this situation as follows:

> ... I'm a simple kind of guy. These problems ... [were] ... big problems for me. I didn't know which way to approach them ... and I thought, well, I've got to look through this, I've got to sort this out. [7M]

Partners often consulted the psychiatrist or GP for guidance on how they should help; however, the advice provided generally seemed to have been of little practical assistance in meeting the day-to-day needs of the PWD. One partner commented: "you're constantly thinking ... what is the right thing to do. And no one can tell you ..." [3M]. Either because useful guidance was not forthcoming from other sources or because they wished to arm themselves with as much information as possible, some partners set about educating

themselves on depression, reading whatever books or information leaflets were available. In most cases, however, support strategies that seemed too obviously imported from elsewhere (e.g. suggestions from self-help books) were not experienced as helpful by the PWD and could be vigorously rejected. Partners therefore found they had little choice but to work out for themselves what was beneficial in the context of their particular relationship, trying out their own ideas and whatever other suggestions came their way in a lengthy and at times uncomfortable process of trial and error:

> ... it was a sort of trial and error, that's the way it felt to me ... So ... I don't know whether it's the right thing or not, well let's try it. Oh, it doesn't seem to work, well let's try something else ... [3M]

"What I want isn't necessarily what's good for me"

What was wanted by the PWD and what seemed to help were not necessarily one and the same thing. Consequently, some partners found themselves in an uncomfortable position in which doing what they believed ultimately would be most beneficial entailed disregarding the PWD's wishes and, in some cases, getting into a battle of wills that, at least initially, might provoke further distress or antipathy.

Several partners experienced a troubling dilemma over how they should respond to the PWD's desire to opt out of the daily routine. As one partner put it: "you don't know whether to allow the person to disengage from the life around them" [3M]. In particular, partners were unsure whether, or in what way, they should encourage the PWD to get out of bed each morning, as opposed to validating the desire to rest or withdraw. As one commented: "we ... didn't really know ... to what extent we should try and cajole and encourage, bully even, [PWD] to be involved in things – or should we just let her go to bed all day" [5M]. Moreover, this partner perceived a marked discrepancy between the expressed wishes of the PWD and what had actually seemed beneficial:

Do I say, "Right, that's what she wants – she should listen to her own body"? That ... seemed not to be right in the sense that on those days when for some reason [PWD] had to get up, then by the end of the day she would be much more lively, reactive. [5M]

On the issue of overriding the PWD's wish to remain in bed, this partner added: "I had a fair ... suspicion that I ought to be ignoring that and ... that's not something I'm used to doing ..." [5M].

Reflecting on what had been helpful to them, some people with depression confirmed that certain things that they had experienced at the time as aversive had subsequently turned out to be beneficial. One person had found it uncomfortable when his partner, perceiving that he was through the worst of his depression, had insisted that he start to take more responsibility for managing his own affairs – e.g. making sure he opened his mail each morning. With hindsight, however, he considered that her vigorous "encouragement" had probably been what he needed at the time. Similarly, another person confirmed that she ultimately found it helpful to be confronted by her partner when he perceived that she was becoming depressed:

> ... what I want is sort of within my comfort zone ... people just ignoring me or waiting for me to come out of it ...//... What I want isn't necessarily what's good for me at that time ... over the past 30 years, that's just perpetuated things – it hasn't helped. [1F]

Aiming for a "moving target"

While partners' confidence in the support they provided might be influenced by the extent to which it seemed to improve matters, the situation was complicated by the depressed person's changing needs over time. Thus what seemed beneficial one day might be much less welcome the next, or could even appear to have the opposite to the desired effect. As one partner commented: "I could use the same techniques to try and deal with the situation that

had … worked perfectly the night before … and get a completely different response" [2M].
In the same couple, the PWD described herself as a "moving target" in relation to her
partner's support attempts, conveying the difficulty of predicting what she would find
helpful on any given occasion.

The depressed person's need for different things at different times was exemplified by the
issue of whether or not the partner's close attention was wanted. Several people with
depression said that there were times when they found it helpful to have their partner's
undivided attention and other times when they just wanted to be alone (though usually with
the partner's unobtrusive presence in the background somewhere). Moreover, the partner's
ability to anticipate what was needed without having to be told constituted an important
aspect of the support process for some people with depression. As one person commented: "I
wanted [P] to … almost read my mind, so he would know when I wanted him to be with me
and then he would suddenly know when I wanted a bit of space" [2F].

Some partners became quite adept at sensing what the PWD needed from them at a given
time. However, it could also be very difficult for partners to anticipate want kind of response
was required and, inevitably, even those who were skilled at "mind-reading" got it wrong
from time to time. This could be an upsetting and frustrating experience for both the PWD
and partner:

> I think for the 80 percent of the time when I feel like I am mind-reading, then our
> perspective is the same. And then for that 20 percent when things can go terribly
> wrong … I would say we couldn't be further apart … And the obvious frustration in
> the support being wrong is … amplified by [PWD]'s reaction. [2M]

One partner, whose skill in anticipating what was needed was much valued by the PWD,
commented that he "put [his] foot in it" when she conveyed a misleading impression of how
she was feeling or else changed her mind about something that they had decided on together.

Another partner felt that one of the key aspects of providing effective support was his capacity to "think on [his] feet", and thus respond flexibly to the PWD's changing and, at times, unpredictable needs.

"Walking on eggshells"

At some point, most partners worried about causing the PWD to feel worse through something that they did or said. There was a general belief amongst partners that the PWD might be adversely affected by their getting it wrong in some way, making it necessary for them to proceed very carefully:

> As [PWD] said, "walking on eggshells" ... I didn't know what to say to him, to make him feel better. But I was also afraid of saying anything at all because any little thing could have made him feel worse. [8F]

Fear of getting it wrong

Partners were understandably anxious not to do anything that might make things worse rather than better. However, a lack of feedback to this effect from the PWD did not always help them to feel confident that they were not in some way harming rather than helping. Partners described how, from their point of view, it was hard to know how the PWD was feeling, or how the support they provided was being received:

> ... being on the other side ... it's hard for me to really appreciate what's really happening or how she feels ... I don't know what it's like ... [1M]

> ... at no stage do you actually know what they can cope with, until you've done something wrong ... and even then you only know if you get a reaction. [8F]

Sometimes there were clear indications as to whether or not a particularly support strategy had been beneficial – e.g. the partner might hear directly from the PWD on this issue. More often than not, however, the situation was much less clear-cut – either because feedback

from the depressed person was not forthcoming at all, or because the feedback was too ambiguous for the partner to feel confident that he or she was doing the right thing. Suspecting that the PWD did not always welcome his prompts and reminders, one partner commented that even an angry response would be preferable to her silence and withdrawal:

> ... if I come and remind her about something, she never bites my head off about it.
> And sometimes I wish she would ...//... she goes quiet for about two or three hours
> ... But sometimes I just wish she'd go, "Bugger off!" [9M]

Saying the wrong thing

Several partners considered that, in the course of providing support to the PWD, it was crucial to choose their words extremely carefully. As one put it: "every word you use to somebody who is depressed is vitally important. That's why when he was very bad, I hardly spoke, because I was so afraid that one word might upset him" [8F].

Some partners felt instinctively that the PWD must be acutely sensitive to each and every word they uttered. For others, a concern to avoid saying the wrong thing had developed from experience of provoking the depressed person's distress, anger or withdrawal through comments that, with hindsight, they considered were ill-judged:

> ... the majority of the damage I do is in flippant remarks ... I think we're on the same
> wavelength and I'll say something that [PWD] would laugh at one day and the next
> day ... it can be a big issue. [2M]

Feeling tired after a long day at work could also make it harder for partners to respond as sensitively as they might otherwise wish. As one commented: "You're tired, you've had a long day, you're hungry ... You can't always think, that split second you've opened your mouth before you put your brain in gear" [7M]. Another partner described how, at times, he needed to be able to provide rapid clarification of his meaning, in order to prevent a misunderstanding that might result in the PWD becoming upset:

... you have to be ... prepared to ... back it up with a sort of quick succession of

bullet points, so she knows exactly what ... angle you're coming from when you say

something, in order not to have it misinterpreted. [2M]

Some people with depression confirmed that they had been very sensitive to their partner's

words whilst depressed; as one commented: "one word can just push me back, straight back

again" [2F]. Others were less certain about the impact of their partner's words, however.

Thus, one person was unsure whether he had been "sensitive or totally desensitised" whilst

severely depressed [8M]; whilst another participant considered that, during the worst of her

depression, her partner's comments "wouldn't have registered" at all [3F].

Whether or not saying the wrong thing would have had the negative consequences feared,

the experience of trying to support someone perceived to be so highly sensitive was

generally anxiety-provoking and emotionally-wearing for partners. One partner, who

described herself as forthright and vigorous by nature, had found this experience of "walking

on eggshells" particularly uncomfortable; she commented: "it was very, very emotional and

very upsetting for me to see him and to be trying to use the right words and ... do the right

things. It was very hard indeed" [8F].

Communication in depression – a "Catch 22"?

Issues around communication emerged as a highly salient theme for these couples. As noted

in the first section, communication between the PWD and the partner could be severely

disrupted at times. Often this was because people with depression found it too difficult or

painful to try and express what they were experiencing, or else because they simply desired

to be left alone. Moreover, partners were wary of doing anything that might exacerbate the

PWD's distress and this meant that they too became less inclined to discuss their experience.

Thus the flow of emotional information, at least via verbal channels, could be drastically

reduced. Other types of communication were also affected, however. In some cases, the

depressed person's reduced awareness of, or loss of interest in the outside world meant that

conversations about family life became strained or stopped altogether. There was often also

a loss of common ground as the day-to-day experience of the PWD and partner diverged.

Moreover, talking to someone suffering from depression could in itself be a disconcerting or

distressing experience for partners. One partner described the experience as follows:

> ... it's as though when you are communicating with [PWD] ... you were doing it
>
> through a translator ... and ... the translator was faulty and was interpreting
>
> everything in a particular ... downbeat sort of way ... [5M]

What also emerged, however, was the extent to which, while potentially a source of great

difficulty, distress and frustration, communication was also considered a crucial component

of the support process by these couples. The notion that open and honest communication

was a fundamental aspect of effective helping and coping was expressed explicitly by

several people with depression:

> ... the key to us dealing with my depression, for me ... it's being able to communicate
>
> about it and being accepted for ... whatever it is you expose ... [1F]

> I mean, communication ... if you haven't got that, how can you sort things out? [7F]

Partners generally seemed to be thinking along similar lines:

> ... I think it's so, so, so important to speak the truth, to say what you mean and to
>
> communicate properly and not ... assume that that person knows what you're thinking
>
> and feeling. [8F]

Paradoxically, however, while facilitating communication seemed to be about the most

important way in which partners might help the PWD to feel better, there were times when

people with depression found it next to impossible to talk. One person summed up the

predicament of talking to her partner whilst depressed as follows: "it's sort of 'Catch 22' that the hardest thing to do is the thing that would ... pretty much take the problem away" [1F].

Talking and listening

Almost without exception, being able to talk things over with someone was regarded as an essential component of the support process by people with depression. In most cases, the PWD looked to the partner for this kind of support:

I: What would you say was the most important way that [P] is supportive? What would you put at the top of the list?

PWD: Talking. He lets me talk. Because when I do need to, I do need to ... probably a load of rubbish comes out, but at least I get it out. [7F]

Opportunities to talk freely, without fear of being judged or criticised, were something that most people with depression felt strongly that they needed from their partners (though, as I discuss under the next theme, this was not something that all partners were able to provide). Some partners were very aware of and responsive to this need in the PWD and conveyed a strong message of acceptance. As one partner commented: "I ... try and allow her to just say whatever it is, and I don't really mind what she says, because ... it's not going to make me feel any different" [1M].

For people with depression, talking to the partner seemed to help them to feel less burdened by negative feelings; as one person put it: "Talking gets my frustrations and anger out". [7F] Some people emphasised the importance of being listened to very attentively by their partners. One partner described what was required of him at such times as follows: "She wants me to sit down, she wants me to look into her eyes, and then really listen" [7M]. His wife described the emotional benefits of being listened to in this way: "It takes a load off ... it calms me down ... You're not quite so on your own. You don't feel quite so isolated. I think you just come out of your hole a bit" [7F]. It could be difficult at times, however, for

partners to listen with the required intensity. In the couple just quoted, the partner acknowledged that this was particularly hard to do when he came home feeling tired after a long day at work. Consequently, there were times when he had not in fact listened as carefully as it had appeared to the PWD – something which could prove a source of considerable frustration and upset when it subsequently became apparent to the PWD, who described how this realisation left her feeling "very empty, and very lonely" [7F].

Talking was also a way in which the PWD and partner tried to sort out difficulties in their relationship and understand each other better. Often this process of working things out together occurred through conversations lasting for several hours, as this comment from a partner suggests: "some days we sat down here till three, four o'clock in the morning ... trying to hammer things out, and get it out in the open" [7M].

Playing it by ear / Being receptive

Some partners emphasised the importance of taking the lead from the PWD in relation to what was talked about and when, and whether their role was principally to listen or to offer their view: "I ... just let her bring it up in her own time. You know, don't push the subject .../ /... if [PWD] wants to talk, I listen. If she wants feedback, we discuss it" [9M]. Other partners expressed similar ideas about being receptive and flexible in responding to the depressed person's need to communicate:

> ... it's kind of my job to ... open as many communication channels as possible, so that whichever you decide is comfortable for you, then you can take it. [1M]

> I try to be open and receptive. And when [PWD] wants to talk, I try to be receptive to talk. [2M]

This approach took account of the fact that people with depression did not always feel able or willing to talk. One depressed person confirmed the importance of being allowed to talk

to her partner in her own time: "It's definitely ... when I'm ready. I mean, you have tried

before, you know, "Talk to me. Talk to me" and that's been a bit disastrous, hasn't it?" [2F].

Making time to talk

There was also a clear sense from these couples' accounts that effective communication was

not predicated solely on one person's need or desire to talk, however. It seemed that the

feelings of both the PWD and the partner (expressed or otherwise) had an important

influence on how constructive or supportive a particular conversation seemed to be. One

partner commented on the issue of negotiating talking time as follows:

> ... there are inappropriate times for both of us ... We both have different thresholds at
>
> different times ... Sometimes [PWD] is up for a talk late at night, and I just want to go
>
> and ... sleep. And then it switches round ... [4M]

He went on to say that the two of them had come to manage this problem by establishing

times during the week when they both expected to be able to talk things over. Another

couple, who had been finding it hard to make time for emotionally supportive conversations,

despite working together, described how they had tried booking in an hour's support time –

something they both experienced as very helpful. The partner described some of the

advantages of planning time to talk in this way:

> It's booked, we know it's coming in advance, it's not going to be as a result of a row,
>
> which sometimes maybe it's more difficult to then manage ... and if it happened
>
> spontaneously then maybe one of us isn't up for it ... [1M]

Goal setting – recovering "common ground"

As noted in the first section, depression could be an isolating and alienating experience for

both the PWD and partner. One aspect of this was a loss of common ground as many of the

previously shared experiences dwindled or disappeared from the daily routine. This could

make it hard to find things to talk about, even when both members of the couple desired to

communicate. One partner considered that most of his support strategies, and certainly the more successful ones, were attempts to recover some of the common ground between himself and the PWD. An example of this was setting the depressed person daily goals of gradually increasing difficulty. These were well received by the PWD who found it helpful to have this external focus and experienced a sense of achievement at what she had accomplished at the end of the day. She commented: "I'd just focus on the goals and not think about anything else. I've got to do this today. And ... be really pleased when I'd done it ... ended up doing some DIY!" [2F]. This person also started to look forward with a degree of excitement to her partner's return from work and the opportunity to show him what she had achieved, while her partner found it easier to respond positively when he knew that she had been involved in some constructive activity during the day:

> ... just something ... so it's not a "How was your day?" "Oh, I sat on the couch, and then I got dressed" or "I didn't get dressed" ... because I fail to return with a positive answer from that ... I find it difficult to ... keep reaffirming that it's OK. [2M]

In turn, the PWD found her partner's praise helpful in recovering a more general sense of purpose: "[P] saying, "Oh, that's a really good job. Well done!" ... It ... almost gives you ... a bit of purpose back and a ... reason to live almost" [2F]. Importantly, working on the goals had a very positive knock-on effect, with particularly beneficial consequences for the couple's communication:

> ... it meant that our conversations were less automated ... and then [PWD] would interject with something else that had happened, because in the scheme of doing ... something that I'd suggested ... something else had happened, then ... she started opening up. [2M]

Thus, for this couple, goal setting was a way of breaking the monotony of the daily routine, provided something to talk about, and importantly, was a source of pleasure and motivation

for both partners. They both agreed, however, that it was important that the goals were meaningful and not too obviously contrived. As the PWD commented: "It's got to feel natural … the goals, for me, have to be something that is beneficial, that we need doing anyway … there's got to be a point to it" [2F].

This person also considered that being set goals was not something she would have welcomed whilst more severely depressed. This view was consistent with the experience of another couple in which the partner's attempts to set small goals for the PWD during a phase of quite severe depression had been completely unsuccessful:

> "Well at least get up and wash your hair – you'll feel better" … reflecting back, I don't think any of that helps, because I don't think the person with the illness sees the distinction between whether they've got clean hair or not … the feeling of desperation is so overpowering that physical things and environment aren't really that important. [3M]

> I mean, all these well meaning people … they're all telling you to do different things … And it just doesn't mean a thing. It doesn't mean anything. You're just in another … world. [3F]

Working together

In several couples' accounts there was a strong sense of partner and depressed person 'working together' in responding to the challenges they faced in the course of giving and receiving support for depression. As one partner put it: "we work together …//… it takes a team effort to help anybody" [9M]. In some cases, the PWD and partner shared similar ideas about what was needed in terms of support; in other couples, a compromise was achieved between two quite different helping styles. Ultimately different couples found that different types of support were helpful in the context of their relationship. Nevertheless, there also

appeared to be some important overarching qualities – e.g. trust, acceptance, understanding, mutual support – that were common to couples' accounts of working together successfully.

In some couples, both partners had very similar ideas about what factors might cause a person to become depressed. Most participants emphasised the importance of adverse psychosocial factors, both during childhood and later in life; several also mentioned biological factors, though only one partner considered the depressed person's difficulties were purely biological in origin. Different models of depression were associated with different ideas about what was needed. Thus, a partner who believed that depression was the result of bottling up one's feelings about difficult past experiences encouraged the PWD to express her emotions more freely. At the opposite extreme, the partner who favoured a purely biological explanation, felt that, beyond the practical aspects of support, there was little more that could be done other than wait for the medication to take effect.

Needless to say, it was not always easy for couples to work together. Indeed, most couples found there were times when depression could have quite the opposite effect on their relationship.

Depression disrupts established ways of relating

During the normal course of things, most couples had established a way of relating that took account of differences in personality, skills, or coping style, or indeed turned these differences to their advantage:

> [P] is generally a happy person. I would say I'm more … serious. We're opposites, but we do meet in the middle somewhere, obviously. [7F]

> … we have rather stereotypic … sexual division of skills. So, whereas I tend to be good at the sort of practical, physical things, [PWD] is much more aware of the emotional things and needs of people. [5M]

These differences tended to be seen as mutually complementary under normal circumstances, allowing couples to draw on each other's strengths in functioning as an effective team. As one partner commented: "we prop each other up and we steady each other out" [7M]. However, in most couples, depression seemed seriously to disrupt established ways of relating. One PWD commented on this issue as follows: "we have a very different way of going about things ... mostly it's reasonably complementary but depression distorts a lot of things in the way you operate" [6F]. Thus, particular attributes in the partner that may previously have been viewed favourably, in the sense of complementing those of the PWD, could come to be experienced as quite unhelpful:

> ... sometimes when you're depressed you don't want somebody happy around you. [7F]

> I think [P]'s nature was to leave me alone, which suits me extremely well a lot of the time. It doesn't suit me when I'm feeling depressed. [4F]

Something different could thus be required of partners during periods of depression, and in some cases this was a difficult adjustment to make. As the person just quoted went on to say: "he doesn't know ... at that point how to step forward, which is what I want but I don't get it" [4F].

In most couples, the PWD and partner had different ways of coping with or tackling problems. Again, these differences could be complementary in the normal course of things yet pose problems when the partner tried to apply his or her style to the PWD's difficulties:

> [P]'s an extremely practical sort of guy. He's a solution bloke, who actually likes to see a problem and see a solution to it. And depression is not ... quite like that ... there's no ... sort of clear parameters to it. [6F]

Such differences between the PWD and partner meant that, in some cases, ideas diverged widely over what was needed. For example, there were marked differences of opinion over how far the PWD should be allowed to take things at his or her own pace. One partner described his thinking on this issue as follows: "[if] she'd had a very clear structure to her day and she had to do X, Y and Z, then perhaps she'd have had less time to brood, think and be miserable" [6M]. The PWD considered that her partner's attitude had been a factor in her twice returning to work before she was ready.

In some cases, certain differences between the PWD and partner came to be seen as more, rather than less, beneficial during episodes of depression. Thus, two people mentioned that they had found their partner's consistency and stability reassuring whilst depressed:

> [P] is very consistent in how he is. What you see is what you get. There's nothing hidden. And if he wasn't such a stable person ... it wouldn't work with us. [7F]

> ... the way in which I think [P] has been very good for me ... is his levelness ... the stability, and that I wasn't actually destroying him as well ...//... he would get up and go to work. I wasn't able to get him down ... it was very good that he was going through the motions of the day in ... a normal way. [4F]

For one of these people, however, the partner's ability to carry on going about his usual daily activities, even during the worst of her depression, represented both a source of security and a mark of his insensitivity to her needs.

Providing encouragement

As noted earlier, several partners had felt concerned about how or whether to try and encourage the depressed person to be more active. Some forms of encouragement seemed to work better than others, moreover. In some cases, there was a good fit between the partner's instinctive ideas about what was needed in this respect and what the PWD found beneficial. Thus two partners felt strongly that the depressed person should be allowed to take things at

her own pace without their putting any pressure on. One of them summarised his attitude as follows: "You just let them take it at their own pace. You don't push them, but you're there for them" [9M]. This kind of gentle encouragement was appreciated by the PWD in both cases:

> ... when I couldn't get dressed for two or three days at a time, then the next day you'd say, "Come on, let's just go for a little walk" ... But ... not [in] a bossy way, just a nice way really. [9F]

> ... I'm lucky [in] the fact that [P] doesn't put pressure on me, although some people would put pressure on and say, "Oh, you don't have a ... regular job to go to" ... And that makes me feel guilty ... [7F]

One PWD who had felt uncomfortable with the pressure his partner had put on him at times was unsure whether there were better and worse ways of encouraging activity. He commented that there was "a terribly fine dividing line between saying, 'Pull yourself together!' ... and ... encouraging people to progress" [8M]. There was a general sense that highly coercive efforts to encourage greater activity had been neither successful nor experienced as helpful by people with depression. As one partner reflected:

> ... looking back, any attempt to push the person, shock the person, shame the person, any of those sort of blunt motivational techniques were pointless. All they did was probably worsen the situation in the context of the person's self-confidence. [3M]

Offering practical solutions / advice

Several partners considered that their natural inclination was to take a problem-focused approach to the difficulties they encountered. This sometimes extended to proposing solutions to something that was troubling the PWD. The extent to which the PWD welcomed these solutions varied between couples and could also vary from one time to the next within the same couple. Advice from a partner could also be a powerful motivator – an opportunity

to do something that would please a loved one: "So if I think ... it's a good idea, it might just work and [P] would be pleased with me, then ... those three combined are actually really motivating" [1F]. The credibility of the partner's advice emerged as an important determinant of how it was received, however. As this person went on to explain:

> ... some people you might take advice from and you think, well ... what problems have they ever faced? What do they know? ... But I know that you've actually made a really big effort to make yourself who you are today and to deal with all the crap that you've had to deal with ... I've got a lot of respect for the suggestions that you come up with. [1F]

Credibility of advice seemed to be a particular stumbling block when it came to suggestions in self-help books. This applied both to an author's perceived credibility as an authority on depression and to partners' suggestions based on their reading of these books. One partner commented: "if you've read the same book as we had, quite often what you get thrown back at you is 'All you're doing is giving me the claptrap out of the book'" [3M]. But even in couples where the partner's solutions or advice were often welcomed by the PWD, this was generally not the kind of support that was looked for during phases of more severe depression, and, even at other times, such a response could be experienced as unempathic or rejecting. One partner considered that it had been necessary to moderate his own highly methodical, problem-focused approach in providing support to the PWD, to take account of her somewhat different style: "how I would cope with depression isn't the way that everyone would cope with it ... our ways of working are kind of ... a softening of how I would cope with it myself" [1M]. This willingness to be flexible in coming to terms with differences appeared to be an important aspect of providing effective support.

Qualities of helpful relationships

There seemed to be a number of factors contributing to these couples' capacity to work together during an episode of depression. In some cases, the PWD and partner apparently

had quite similar ideas about the overarching qualities of effective support – for some

participants these were considered an integral part of what was needed to make their

relationship work in the normal course of things. As already discussed, the importance of

good communication was frequently emphasised, as were trust, acceptance, understanding,

and several other qualities described below.

Trust and acceptance. Several participants emphasised the importance of trust as an

essential ingredient of effective helping. As one PWD commented: "If you trust someone …

you're halfway there" [7F]. A close connection between trust and communication was also

noted. Couples' accounts suggested that trust was considered both a necessary precursor of

open communication and, where there was also acceptance, the product of it. The partner's

acceptance of the depressed person's feelings was seen as particularly helpful. Moreover,

feeling accepted by the partner could have wider implications for how people thought about

themselves. As one PWD remarked: "Just having somebody accept me in this way is really

good. That makes me think, well, maybe … the whole world isn't going to reject me if they

know" [1F]. One PWD described what she wanted whilst depressed (but did not get from

her partner) as "uncritical being there" [6F]. The kind of patient acceptance she and other

people with depression had found helpful seemed to be captured quite well in one partner's

description of his attitude towards providing support:

> The way I look at it, if you care for a person, you've got to let them be who they want
>
> to be at that time. If they want to talk, they talk. If they don't want to talk, they don't
>
> talk. If they just want to sit there and stare into space, but as long as you are there for
>
> them. [9M]

Understanding. The issue of whether or not people with depression felt understood by their

partners, or vice versa, was frequently raised. People with depression often complained that

their partner did not understand what it was like to be depressed, while for partners it could

seem as if the PWD had very little insight into or interest in their experience, at least during

more severe phases of depression. This state of affairs seemed to arise out of and be perpetuated by the kinds of communication problems described earlier. However, one of the most striking features of accounts of helping relationships that seemed to work well was the extent to which partners strongly desired to understand more about the PWD's experience and thus be better equipped to know how they might try to help. One partner considered that such understanding could only develop through time and patience:

> I think you have to build a relationship with somebody in that position. And you need to ... understand what makes them tick ... I think supporting or offering support to ... people with depression is something that you only build over time. [2M]

Responding sensitively and flexibly. The idea of partners sensitively feeling their way in trying to be helpful to the depressed person was also a common feature of accounts in which there was a sense of people working together. A corollary of this seemed to be the partner's capacity to be flexible and 'go with the flow' according to what the PWD seemed to need at a particular time. One partner described this as follows: "I kind of just feel ... it out, I suppose, and ... pick up on what's going on and make a couple of suggestions and eventually ... you'll respond to one and then we'll just do whatever that one is" [1M].

Not letting problems store up. Some couples emphasised the importance of acknowledging the problems they were facing rather than allowing them to store up, as these comments from partners illustrate:

> ... even if we can't solve it now ... part of the healing or solving process is acknowledging it and accepting it and then however that gets looked at later on is fine, but to just ignore it ... it just stores it up. [1M]

> Keep milling it over, talking it over ... I think we've both found if we bottle it up and hold it back, it does no good, it just festers. [7M]

Related to this idea was the notion of being able to put aside grievances following conflictual or hurtful exchanges. One couple commented on this as follows:

> We don't bear malice ... if we upset each other ... [7F]

> We have got the ability to talk to each other and apologise ... [7M]

Being physically affectionate. Several people emphasised the importance of their partner's physically affectionate behaviour while they were depressed. Thus one PWD said of her partner: "when we're out and I've just got no confidence ... he'll ... just put an arm round me or hold my hand" [9F]. As with other supportive acts, however, this was something that partners had to approach with a degree of sensitivity, as clearly there were times when the PWD wanted to be left alone rather than be embraced. In some couples, displays of physical affection became exclusively platonic in nature, on account of the depressed person's loss of interest in sex. One person had been glad of her partner's physical affection yet had found his affectionate comments quite disconcerting:

> I needed to be shown, I think, the physical affection. That was important. But if he used to say he loved me, I found that quite difficult because I couldn't really understand how anyone could love me the way that I was feeling ... I felt I couldn't respond really appropriately. [5F]

Helping each other. In most cases, support did not flow exclusively from partner to PWD and several couples emphasised occasions when the situation was reversed. Indeed, opportunities to reciprocate the support received from a partner seemed to be welcomed by people with depression. One partner described the intended effect of disclosing some of his own difficult experiences:

... it levels us out an awful lot ... And if [PWD] ... sees maybe he's just the same, she'll feel less bad about herself and be less isolated ... "He understands me because maybe he's felt something like that a bit before" ... [1M]

The PWD described her feelings about this opportunity to offer her partner some support: "I felt this is really good because you're talking to me and I want to be supportive to you as well, and I want to know what's going on in your life" [1F]. She explained that there were also implications for how she would feel about seeking support from her partner in the future: "I'm more likely to ask for your support if you've asked for mine".

The importance of support from the partner

With few exceptions, people tended to assign greatest importance to the support received from their partner during depressive episodes. As one person put it: "[P]'s support is ... *the most, the* most important ... followed closely by my parents" [2F]. Thus, while other family members or friends may also have been helpful, the relationship with the partner generally constituted the depressed person's emotional mainstay. As another person explained: "I couldn't be in a relationship and still have to rely on my mates for that kind of support. It has to come from within the relationship" [1F]. Also emphasised was the partner's greater dependability or commitment in times of need:

> If anything when I'm poorly, as far as my friends are concerned, I disappear ... I'm sure they would have probably given me some support, but I suppose it's just the ... overall trust thing ... friends can easily just walk away and I need a bit more that feeling of a permanency thing. [2F]

However, while the partner's support was generally viewed as most important, some people nevertheless had reservations about being so reliant on one person in coping with their depression. As this person commented: "I need to learn to talk to other people as well

because ... it might not work out, we might not be together forever ... I don't want to be totally reliant on you" [1F].

For the two people who felt that their partners were not able to provide what they needed in terms of emotional support, there was an awareness of having to look elsewhere for this. For one, it had been hard finally to accept that her marital relationship would not thus be able to meet all of her emotional needs:

> You learn who's good for what ... but you have to open your eyes and see ... it's like when you're little ... your best friend's going to be everything ... But they're not, and you know that you can go to the cinema with one person, play football with another person and go drinking with the third one. It's the same sort of thing. [4F]

This acknowledgement and acceptance of the partner's "limitations" seemed to have eased some of the tension in the relationship, as suggested by the following comment from her partner:

> I think you've come more and more to accept me for what I am, with limitations, but with some strengths. You're not trying to obtain from me that which you've come to believe I can't give. [4M]

Managing one's feelings as a 'helper'

Partners emphasised that they too experienced strong emotions about the situations in which they found themselves. Moreover, two partners insisted that they did not wish to be portrayed as "saints" – they were ordinary people doing their best under difficult circumstances and therefore liable to all the feelings of frustration, impatience and anger that that would naturally entail. As another partner commented: "you're only human and ... you carry around baggage from your day to day life"[2M]. This theme is concerned with the feelings evoked in partners in the helping process and also the ways in which such feelings were managed.

Frustration, impatience, and anger

What several partners had found particularly hard was the sense of not being able to do anything to help the PWD to feel better – something which could evoke strong feelings of frustration. As one partner put it: "you have like a big sort of seething mass of emotions ... so even in the support role you're ... not completely yourself all the time" [2M]. Moreover, it could be very hard for partners when their attempts to help failed or were greeted with indifference or antipathy. The PWD's unresponsiveness could be particularly distressing for partners. As another commented: "There was absolutely nothing coming back from him to make me think that I was getting anywhere at all" [8F]. Partners also experienced a dilemma over whether they wanted the PWD to be aware of their feelings about the situation:

> ... on the one hand you ... want the person to know how difficult it is for you. On the other hand, that is of no purpose whatsoever, because ... one of the things that goes with this illness is this lack of confidence and this feeling of guilt. [3M]

Most came to the conclusion that it was better keep their feelings to themselves (at least during more severe phases of depression) and thus avoid doing anything that might exacerbate the PWD's distress. As one partner commented: "[PWD] doesn't need to know that I'm not fine. [She] doesn't need to know that I'm having difficulties" [2M]. Most partners felt strongly that, in particular, becoming angry with the PWD was an obstacle to effective helping and therefore something that they needed to be careful to avoid:

> I've got to be quite careful that I don't ... allow my temper to get in the way of what I'm trying to say to her ... I'm trying to be as objective about it as possible ... And I bite my tongue quite a lot because I know it's just me being angry. [1M]

This kind of restraint itself came at an emotional cost, however. Thus one partner remarked: "I'm very outspoken. I'm very practical ... I just want things done ... So it was very, very hard for me ... because I just got out of patience, and I couldn't show it" [8F]. And there

were of course times when partners found that strain or fatigue temporarily overwhelmed their emotional self-control. As one partner put it: "there comes a time when your mind is just so overloaded with it, you just let it come out" [3M]. However, most had found that venting their frustration on the PWD was highly counterproductive: "I see the harm and I see the damage that it does. And I think, God ... got to curb that ... And I don't feel any better for it ... it's just that ... sometimes it gets the better of you" [2M].

It was not just the sense that their efforts to help were not having the desired effect that evoked strong emotions in partners, however. There were also particular aspects of the depressed person's mood or behaviour that could prove upsetting at times. As well as sadness and despair, people with depression also commonly experienced feelings of anger and frustration, which sometimes were directed at their partners. One partner described his response to the depressed person's anger on occasions when he returned home a few minutes later than expected: "You wanted to say something, but you couldn't, because if you say the slightest thing at that time, [she'd] break down in tears ... And then ... she seemed to go back into herself" [9M]. Some partners managed the PWD's anger by not taking it as personally directed. One commented: "I don't take it as a criticism that she's either upset or had a go at me, personally, not now. I've learned to back off and be quiet" [7M]. This was not something that all partners found easy, however:

> I have an immense desire to defend myself against all charges at all times ... Well, nowadays I have the sense that this is not going to get me anywhere and that your need to be comforted is greater than my need to create lame excuses. [4M]

Partners indicated that they had found the ambiguities and lack of certainty associated with depression particularly disconcerting. One partner commented: "that's one of the things that I found quite difficult about this illness. There's nothing black and white about it. There was no right or wrong" [3M]. For another partner, it had been what he perceived as the PWD's 'irrational' behaviour that had been particularly troubling:

It's not like you'd broken a leg and I would just go upstairs and make you a cup of tea
and help you ... You'd go up there and there's somebody in tears and ... behaving
nonsensically ... I'm treating it in a rational basis ... and I'm not getting that back.
[6M]

The partner's support needs

Partners sought support for themselves from family members (their own and also those of
the PWD), friends, and colleagues. Most partners emphasised the emotional importance of
this support, which represented an opportunity to talk about the difficulties they faced and to
express feelings that they wished to conceal from the PWD:

You need to be able to talk [about] what's going on with other people ... you need
that respite in order to provide the right sort of support. Because I think every time
you do that, you come back with a refreshed ... energy level and tolerance level ...
[3M]

While most partners sought some level of informal support, there was some variation in
terms of what and how much was wanted. Thus, for some, feeling supported involved briefly
unburdening themselves to friends or work colleagues from time to time; while others spoke
to friends about their experiences at much greater length or more regularly. Partners
described feeling revitalised following these opportunities to speak freely about their
experiences and thus able to continue being attentive to the PWD's needs:

I can talk to one or two people at work. And just by me talking to them, if I'm worried
about her ... I'm fine then ...//... I got that back up which means I'm clear then when
I come down to [PWD] ... [9M]

Partners experienced going to work as beneficial in other ways, too, several commenting that
they had been glad of this space away from the difficulties at home. As one put it: "I can go

to work and I can switch off. I don't take the problems with me, although if I sit waiting somewhere I'll try and think about it ...//... That's my space away from the problem" [7M].

None of the partners had used formal helpers specifically for their own support needs, or said that this was something they had felt a need for. As noted earlier, however, some found it helpful to be included in the PWD's medical consultations and thus be party to specialist formulations of his or her difficulties. One partner commented that he would have liked to have made contact with other couples in a similar situation, seeing this as an opportunity to compare notes on providing support: "if I can learn from other people how they're coping or what they're doing then that will make ... what we're doing stronger and better ... I don't think we should do it in isolation" [1M]. Another partner, who had found it helpful to be able vent her anger and frustration in vigorous workouts at the gym, alluded to the wider importance of support providers taking care of themselves: "I felt that I had to keep myself OK ... if I am not in good nick I can't ... help [PWD]" [8F].

People with depression encouraged their partners to find additional support for themselves and several expressed concern at the level of burden the partner was otherwise shouldering alone. As one person commented: "I would hate the thought of [P] just kind of struggling on, on his own ... because I rely so heavily on [him]. I see me leaning on him ... and yet who does [he] lean on?" [2F].

Nevertheless, there was also a sense that partners could at times resent the expectation that they would be able to look after themselves – as illustrated by the following comment:

> ... I think that when you're very, very depressed, you're very, very selfish, and you
> don't give a damn about the people around you. Because you know that it's you
> who's ill, not them. So you expect them to kind of look after themselves. [8F]

The emotional rewards of helping

Several partners referred to aspects of the support process that were emotionally rewarding.

Thus positive feelings were evoked by signs that the support provided was having a

beneficial impact on the PWD:

> ... when you have wins as a helper ... when you can see that your support is working
>
> ... when you see the person that you love open up slightly ... when you feel like
>
> you've made a difference ...//... It reaffirms what it's like in the better times. [2M]

One partner emphasised the importance of being thanked by the PWD:

> ... she's not one to come and put her arms round me and to say, "Oh thanks" but the
>
> odd time she does, that makes all that effort worthwhile ... that makes the world of
>
> difference ... And going off to work, knowing that I have helped ... is helpful to me
>
> to go on to the next time. [7M]

Partners were also encouraged to find that the PWD was actively taking steps to help him- or

herself. For one partner this was about the PWD taking greater responsibility for how she

was feeling. For several couples, the experience of finding their way together through an

episode of depression seemed to have strengthened the relationship. Indeed, one partner

commented that it was this sense of developing a closer and stronger relationship with the

PWD, through both their efforts, that made his hard work as support provider seem

worthwhile:

> Things that make it easier are just like the little things that she's doing [to help
>
> herself]. That makes me kind of think, well, it's all worthwhile ...//... Because she's
>
> changing and her behaviour's changing and the environment therefore in our
>
> relationship is changing. And we're just getting stronger and closer together ... [1M]

Chapter 4: Discussion

This descriptive, qualitative study explored couples' experiences of giving and receiving support for depression. Nine people who were or had been depressed were interviewed jointly with their partners on two separate occasions. Partners were asked what their attempts to be supportive had entailed, what had helped or hindered them in providing support, and how they had experienced the support process. People with depression were asked how they had experienced their partner's support attempts and, in particular, what they had found helpful or unhelpful. The interview data were analysed using interpretative phenomenological analysis, the aim being to identify themes that were common across couples relating to the experience of giving and receiving support for depression in the context of an intimate relationship. Several themes emerged, which were organised within two higher-order domains. The first domain, 'Couples' experience of depression: A longitudinal perspective', was concerned with the changing context of the couples' experience and thus provided a dynamic backdrop to the second domain, 'The helping process', which focused specifically on participants' experiences of giving and receiving support for depression. Couples' accounts suggested that the challenges they faced over the course of an episode of depression were many and could vary substantially from one phase in this developmental journey to the next. This added a further layer of complexity to the already difficult circumstances in which the couples' coping and helping efforts took place.

In this chapter, I review the main findings of the study and relate these to the existing literature. I then consider methodological issues which may have influenced the quality of data obtained, the interpretation of these data, and the extent to which the study's findings may be applicable to a wider population. Issues of good practice in relation to qualitative research are also discussed. Finally, I offer some suggestions for further research and consider the clinical implications of the current study.

The helping process

Five themes relating to the helping process emerged from the qualitative analysis of the interview data. In this section, I briefly discuss each of these themes, within the context of the longitudinal perspective on couples' experience of depression, and consider the study's principle findings in the light of previous empirical and theoretical work on informal helping and depression.

"Stumbling along"

This theme was concerned with partners' uncertainty about how they might best try to help the depressed person, the factors underlying this uncertainty, and the lengthy process of trial and error couples worked through on the way to discovering what worked best for them. There are parallels here with some of the findings from the Fadden *et al.* (1987) study of 24 spouses of people with depression. Nearly half of the spouses in Fadden *et al.*'s sample considered that they had no idea what they might do in practical terms as a way of managing their husband or wife's depression; moreover none could recall being given any advice on how to respond to aspects of the depressed person's behaviour that they found difficult to cope with. Similarly, several partners in the current study cited a lack of guidance from professionals as one of the factors in their uncertainty about how to help. Indeed, in one of the more extreme examples of this, one couple said that they had been told by their psychiatrist that there was nothing that the partner could or should do whilst waiting for the medication to take effect.

The current study suggested some additional factors in partners' uncertainty about how to help, however. Most strikingly, people with depression themselves often had no idea what they wanted, particularly during periods of severe depression, or else felt unable to communicate what they needed from their partner. In other instances, partners perceived a discrepancy between what the depressed person said that he or she wanted (e.g. to be left alone) and what actually seemed beneficial (e.g. encouraging some level of activity).

Moreover, some people with depression confirmed that what they wanted and what ultimately seemed 'good for them' were not necessarily the same thing. The situation was complicated further by the fact that the same kind of support could elicit a very different response from the depressed person from one day to the next, reflecting fluctuations in his or her mood and a need for different things at different times.

"Walking on eggshells"

This theme related to partners' concern not to do or say anything that might exacerbate the depressed person's distress, or otherwise make the situation worse. Partners were anxious that their support attempts should help rather than harm and their unease was often compounded by a lack of feedback to this effect from the depressed person. In their paper on the support provided to people who had been bereaved, Lehman *et al.* (1986) suggest that potential helpers may be particularly likely to feel anxious when faced with someone in distress, or when feedback on their support attempts is not forthcoming. These authors propose that helper anxiety may be one of the reasons that well-intentioned support attempts sometimes go awry. In the Lehman *et al.* study, participants frequently attributed examples of miscarried helping to close friends and family.

While there was plenty of support for the notion that partners in the current study felt anxious in their helping role, their response to the depressed person's distress generally was not, as might have been anticipated from Lehman *et al.*'s findings, vigorously to involve themselves in efforts to distract or cheer him or her up. Instead, partners tended to become extremely careful about how they behaved in the depressed person's presence, particularly in relation to what they said and how they said it. As discussed in more detail below, most partners also tried hard to conceal the impatience, frustration and anger that they sometimes experienced in the course of trying to help. Spouses in the Fadden *et al.* (1987) study reported some similar changes in how they responded to the depressed person, including thinking more carefully before speaking, arguing less, and more often acceding to his or her

wishes. Thus there are indications that the experience of walking on eggshells was not limited to partners in the current study.

Communication in depression – a "Catch 22"?

This theme reflected the paradoxical nature of couples' experience of communication during episodes of depression. Thus, trying to communicate with one another represented a source of great frustration and upset for people with depression and their partners yet, simultaneously, couples considered communication to be a fundamental aspect of the support process. People with depression generally considered it most helpful simply to be able to talk to their partners and, perhaps most importantly, to feel that what they communicated had been accepted without judgement or criticism.

Where the current study differs most significantly from the majority of previous work on the intimate relationships and interactions of people with depression is in its focus on the supportive rather than conflictual aspects of these relationships. This difference in emphasis seemed particularly apparent in relation to the issue of communication. Communication problems in depressed relationships have been frequently reported in the research literature (e.g. McLean *et al.*, 1973; Weissman & Paykel, 1974), and previous studies have suggested that the marital interactions of people with depression can be hostile and conflictual yet also marked by inhibited communication and withdrawal (e.g. Hinchcliffe *et al.*, 1975; Kahn *et al.*, 1985). However, by contrast with the hostile, mistrustful and unproductive encounters described, for example, by Kahn *et al.* (1985), depressed participants in the current study considered that talking to their partner helped them to feel less isolated or burdened by negative emotion. Communication also provided a means by which couples could try to sort out difficulties in their relationship or other problems that they faced. This latter role for communication resonates with the well-known conclusion from marital interaction studies that better functioning couples depend on good communication skills to resolve conflicts (e.g. Jacobson & Margolin, 1979, cited in Cutrona, 1996).

At times, however, people with depression nevertheless found it extremely hard to talk to their partners. Some found it too frustrating or too painful trying to convey their experience of depression in words; others wanted to conceal the full extent of their distress from their partner and therefore wished to be left alone. Thus people with depression found themselves in what one person described as a "Catch 22" whereby the thing that was perhaps most likely to help them to feel better was also the thing that seemed hardest to do. Partners were generally very aware of the importance of talking and listening to the depressed person and some understood their role as support provider largely in terms of facilitating communication, creating multiple opportunities for communication to take place and being flexible and responsive in following the depressed person's lead. The kind of uncritical listening ear that people with depression generally needed was not something that all partners were able to provide, however.

The importance of being able to talk about one's feelings has been emphasised by support recipients in previous studies of informal helping (e.g. Lehman *et al.*, 1986). Other research points to quantifiable benefits of emotional disclosure in relation to physical well-being. For example, studies by Pennebaker and his colleagues suggest that being able to confide in someone about stressful experiences (or even just writing about them) may be a moderating variable in the relationship between stress and disease (e.g. Pennebaker 1995; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). The interactions described in the current study as most supportive, and beneficial to both members of the couple, were intimate in the sense described by Fruzzetti and Jacobson (1990). These authors describe intimate interactions as those that "increase the understanding and vulnerability between partners and are accompanied by positive emotional arousal" (p. 127). Such interactions would include ones in which feelings about the relationship or the other person were expressed, or in which feelings were expressed by one partner and understood and accepted by the other (Cutrona, 1996). Intimacy and empathy would thus seem to be closely entwined.

Empathy

In the current study, in addition to providing a channel for emotional disclosure, talking things over was also viewed by couples as a means of improving mutual understanding. However, communication seemed to be hampered at times by the depressed person's lack of confidence in his or her ability to convey the experience of depression or likelihood of being understood by the partner. Previous studies of informal helping in couples have shown that misunderstandings or failures of empathy are common in conversations between women with a serious physical illness and their partners (e.g. Pistrang & Barker, 1992; Pistrang *et al.*, 1997). While the current study found that misunderstandings between people with depression and their partners were also fairly common, what was perhaps more striking was the extent to which partners actively involved themselves in trying to understand the depressed person's experience. Thus partners invested considerable effort in trying to get the depressed person to talk openly, so that they might better understand what he or she was going through and thus be better placed to respond appropriately. While some partners emphasised that, as they had not themselves been depressed, they could not know what the experience felt like, this did not seem to indicate a lack of empathy in most cases so much as a realistic acknowledgement that their subjective experience differed from that of the depressed person. Indeed, several partners had become adept at anticipating the depressed person's needs without needing to be told what he or she wanted – something which was greatly valued by the depressed person in these couples. (Somewhat similarly, a study by Cutrona, Cohen, and Igram (1990) found that support proffered spontaneously was valued more highly that that which was forthcoming only after a direct request.)

Where upsetting misunderstandings did arise, these often seemed to reflect an absence of communication or communication that was misleading (e.g. the depressed person saying he or she was 'fine' when this was not in fact the case) rather than the partner's difficulty in putting him- or herself in the depressed person's place. People with depression generally

valued their partner's efforts to understand, even if they did not always feel particularly well understood. Pistrang *et al.* (2001) report a similar finding in their study of couples expecting a first baby. Women in this study found certain responses from their partners empathic even when they misrepresented their experience: thus in some cases, the sense that the helper was trying to understand was of greater significance to the helpee than the fact of his getting it wrong.

In an earlier study of the helping process in couples, Pistrang and Barker (1992) found that the partners of women with breast cancer sometimes employed misguided helping strategies, such as trying to cheer them up or distract them when they actually wanted to discuss their worries. It is perhaps one of the more surprising findings of the current study that misguided attempts to cheer up the depressed person were mentioned hardly at all. Only one depressed participant said that she sometimes resented her partner's attempts to lift her mood with jokes or good-natured teasing. Interestingly, another person commented that there were times during her depression when she would actually have welcomed a humorous response from her partner.

Activating partner support

Barbee *et al.* (1993, cited in Cutrona, 1996) suggest that indirect support activation strategies, such as crying or other signs of distress, run the risk of misinterpretation in that they are dependent on the partner's attributions for the behaviour he or she observes. In the current study, being able to put the right label on the depressed person's distress was emphasised by one partner as important in determining how he responded. For this partner and one other, there was a sense of uncertainty about the extent to which the depressed person's symptoms were under her control, and this had implications for whether they responded with sympathetic concern or antipathy. These partners' ambivalence can be understood in the context of previous research indicating that when people believe that the cause of another person's difficulties is out of his or her control, they are likely to be

sympathetic and offer assistance, but when the cause of the misfortune is perceived to be within the person's control they are more likely to be antipathetic and disinclined to help (Weiner, 1980, cited in Cutrona, 1996). It was evident that sending and receiving signals indicating the need for support remained a problematic area for a minority of couples.

Working together

The couples who seemed to have fared best in this study seemed similar in the extent to which partner and person with depression were able to 'work together', or find new ways of working together, in responding to the challenges they faced during an episode of depression. In some couples the person with depression and partner shared similar ideas about what was needed in terms of support; in other couples, the partner was able to moderate his or her own characteristic style in recognition of the fact that the depressed person needed something slightly different. In couples who worked together there seemed to be a shared acknowledgement that the partner's help was required, an acceptance that things might take time to improve, and a willingness to persevere with the support process despite the frustration and upset that could be encountered along the way. In the course of working together, partners tried out different forms of support, some beneficial and others less so, and ultimately different couples found that different types of support were helpful in the context of their particular relationship. However, while there clearly were individual differences in the detail of what each couple had found helpful, there were also some overarching qualities that seemed to link couples' accounts of working together successfully. For some couples, moreover, the qualities underpinning effective support were considered integral to making the relationship work in the normal course of things. These qualities included trust, acceptance, open communication, understanding (or, perhaps more accurately, a desire to understand), sensitive and flexible responding, acknowledgement of problems, being physically affectionate, and being mutually supportive.

The list of qualities associated with working together is strikingly similar to the key characteristics of supportive relationships emphasised by users of mental health services in *Strategies for Living*, a report produced by the Mental Health Foundation (2000). Asked about their ways of coping with mental distress, participants in the Mental Health Foundation study similarly emphasised the importance of acceptance, understanding, having someone to talk to or confide in, the reciprocal aspects of supportive relationships, and the sense of security from someone "being there" (this is rather similar to how some people in the current study described their partner as a trusted presence during times of severe distress). The *Strategies for Living* study addressed the issue of informal helping in relation to psychological problems in general; moreover, it was not specifically concerned with the support people received within their intimate relationships. Nevertheless, the points of similarity with the current findings suggest that some of these may be characteristics of supportive relationships in general.

For some couples in the current study, being mutually supportive was seen as an integral part of the relationship, such that both members had an expectation of support from the other in times of need. This notion seems similar to how authors such as Holmes and Rempel (1989) and Cutrona (1996) conceptualise the foundation of trust in couples. Alternatively, the kind of mutual responsiveness some couples emphasised could be described in terms of the operation of 'communal' norms in these relationships. According to Clark and Mills' (1979) model, people in communal relationships experience a sense of mutual obligation and a desire to be responsive to each other's needs. From the point of view of people with depression in the current study, the expectation of mutual support meant that the partner would naturally be turned to first in times of distress and, moreover, was seen as the most important, though not necessarily the only, source of informal support. Some people with depression contrasted support from their partner with that received from friends, referring to the partner's greater accessibility and reliability. One person emphasised the importance of receiving support from her partner (and vice versa) in the context of an ongoing relationship.

Thus, for people with depression in this study, support from their partner did seem to have a special status (as Brown and Harris (1978) and Coyne and DeLongis (1986) have suggested). Moreover, for couples who described working together, helping and being helped seemed to define their relationship in a particularly important way. This has parallels with how Coyne, Ellard *et al.* (1990) conceptualise 'dispositional interdependence'. Coyne, Ellard *et al.* (1990) argue that "the payoffs of [supportive] transactions are not just the concrete costs and gains but also what they establish about the persons involved and the kind of relationship that they have" (p. 144). According to Coyne, Ellard *et al.*, it is the support that would seem most burdensome to someone outside the relationship that constitutes the best opportunity for developing dispositional interdependence. Other authors have similarly proposed that the exchange of supportive behaviour constitutes a fundamental aspect of close relationships (e.g. Stafford & Canary, 1991).

Managing one's feelings as a 'helper'

This theme was concerned with the idea that partners often had strong feelings of their own to contend with in the course of trying to provide support. As noted earlier, partners were generally careful to avoid expressing their feelings of frustration, anger and impatience for fear of the impact this would have on the depressed person. Indeed, some had found that venting their anger in the presence of the depressed person, while not necessarily disastrous, was counterproductive and not conducive to providing effective support. Consequently, partners generally tried to conceal their negative feelings from the depressed person. This in itself could be a strain at times – particularly for those who were typically more forthright about their emotional experience – and meant that partners were often grateful for the opportunity of unburdening to friends or work colleagues. Thus, in several couples, there was an interesting paradox whereby the partner went to considerable lengths to encourage the depressed person to express his or her feelings whilst becoming increasingly reticent about his or her own. Coyne, Ellard *et al.*'s (1990) concept of "dilemmas of helping" seems to provide a fitting description of what was occurring in these couples.

Dilemmas of helping

Coyne, Ellard *et al.* (1990) proposed this term to describe situations involving a conflict of interests between the needs of helper and helpee – originally in relation to couples in which the husband was recovering from a heart attack. These authors found that spouses' efforts to conceal or deny their own worries and to avoid conflict had a beneficial impact on their husband's well-being but a detrimental effect on their own. The findings of the current study reveal a somewhat similar picture: people with depression generally had found it helpful to have been spared their partner's negative feelings; however, partners could at times feel heavily burdened by this load of unexpressed emotion. Indeed one partner explicitly referred to a dilemma between, on the one hand, wanting the depressed person to know how difficult things were for him and, on the other, wanting to spare her any further distress. Similarly, more than half the spouses in the Fadden *et al.* (1987) study reported that they no longer discussed their own difficulties with the depressed person. The reasons spouses gave for their reticence included being reluctant to add to the depressed person's distress, viewing their own concerns as trivial in comparison, and – something not mentioned by participants in the current study – doubting the depressed person's ability to provide support.

An interactional perspective on the current findings

Until relatively recently, theoretical models of depression generally had rather little to say about the interpersonal environment of the depressed person and his or her significant others. One influential exception to this rule was Coyne's (1976a) interactional account of depression. Coyne (1976a) suggested that the behaviour of the depressed person and those around him or her could give rise to "an emergent interpersonal system" in which all unwittingly became involved in perpetuating an unhappy situation. In this light, the obvious distress of the depressed person has the effect of engaging significant others, making them feel responsible, yet it is also aversive to them and potentially depressing. Other people try to control their discomfort by providing non-genuine support to the depressed person,

simultaneously communicating impatience, hostility and rejection. This antipathy – both subtle and explicit – reaffirms the depressed person's feelings of insecurity and provokes further expressions of distress. In this way, other people interact with depressed persons in ways that maintain or exacerbate their difficulties, leading to what Coyne has described as "an interactional stalemate" (Coyne, Burchill *et al.*, 1990).

An appealing feature of Coyne's model is its treatment of the development of depression as an unfolding process that occurs in an interpersonal context. It is therefore worth considering the extent to which the current study's findings on the contextual aspects of the couples' experience of depression seem to fit with this interactional account. A key feature of Coyne's model is the notion that other people seek to manage their own discomfort by responding to the depressed person with non-genuine concern and support. However, while several partners said that they had found the depressed person's distress upsetting at times and had felt strongly motivated to find some way of alleviating it, there was little sense that the support they provided was in any way non-genuine. While trying to alleviate the depressed person's distress could be construed as a means by which partners sought to manage their own discomfort, in most cases the desire to relieve a loved one's suffering seemed to represent an end in itself for partners.

Another finding of the current study potentially pertinent to Coyne's model concerned the extent to which partners actively tried to conceal their own feelings in the course of trying to help, in the belief that showing frustration, anger or other forms of distress would make the depressed person feel worse. Thus, with the possible exception of two partners who had at times been more openly antipathetic, partners encouraged emotional expression in the depressed person whilst suppressing their own feelings for much of the time. Coyne's model implies that the partner's 'true' feelings would nevertheless have been discerned by the depressed person, further compounding his or her insecurity. This was not quite the situation described by couples in this study, however. Instead, there inevitably were times when

partners vented their feelings of anger and frustration in the presence of the depressed person and while participants generally agreed that such outbursts were ultimately counterproductive and to be avoided, they did not seem to confirm the depressed person's worst fears in quite the way Coyne's model seems to suggest. Instead, most couples were able to weather occasional angry exchanges in ways that did not see the situation escalate to their detriment nor lead to an accumulation of resentment and hurt feelings. Moreover, during more severe phases of depression, people generally had little awareness of their partner's feelings, suggesting that hostile feedback was rather unlikely to have had a central role in maintaining their depressed mood. In fact, for some participants, becoming more aware of the partner's irritation and impatience was taken as an indication that they were starting to recover.

Reassurance seeking

Joiner and his colleagues (e.g. Joiner, 1994; Joiner *et al.*, 1992) have attached particular significance to depressed persons' reassurance seeking in trying to account for the rejecting behaviour they encounter from other people. Several participants in this study mentioned reassurance as something they sought or had sought from their partner and, for one couple, this had been a particularly prominent aspect of an episode of severe depression. In general, however, the impact of the partner's (verbal) reassurance was variable. Thus one depressed person acknowledged that her partner's reassurance was one of the few aspects of his supportive behaviour that made little impact on her, while another considered that she did find her partner's reassurance reassuring. In most cases, partners seemed to take a fairly ambivalent view of providing reassurance: on the one hand, it seemed an appropriate response to the depressed person's distress, while on the other, it rarely seemed to make any difference. One partner commented that it could be difficult to find the motivation to go on providing reassurance; another considered it an unreasonable thing for the depressed person to ask of him in the first place. Otherwise, however, there was little indication that reassurance seeking was experienced as highly aversive by partners in this study.

Partners' perception of their influence on the depressed person

Fadden *et al.*'s (1987) study of the spouses of chronically depressed persons found that almost the entire sample believed they had little or no influence on their partner's depression. The findings of the current study show both similarities and differences in relation to this picture. It was certainly true that when confronted with depression in a loved one for the first time most partners initially felt at a loss to know how they might help. However, in time, most partners did manage to assemble a repertoire of supportive behaviours that both they and the depressed person considered beneficial. Thus, while there was a sense that very severe phases of depression just had to be got through, taking care to avoid making the depressed person feel worse, at other times partners generally did feel that they were able to make a difference. Being supportive evidently required much in the way of patience, sensitivity and perseverance in partners and, at times, could seem like a tall order. Nevertheless, partners did not seem to view themselves as the helpless victims of the depressed person's low mood.

Methodological issues

In the sections that follow I consider the methodological strengths and limitations of the study. First, I discuss the characteristics of the sample and consider the extent to which the people who took part were representative of the wider population of couples with a depressed member. I then consider some of the issues that may have influenced the quality of interview data obtained. Finally, I describe how this study has addressed some widely accepted principles of good practice in qualitative research.

The sample

In this section I consider the extent to which participants were typical or atypical of the wider population of couples with a depressed member. I discuss the implications of including data from only one depressed man, the difficulty of recruiting people of either

gender for the study, and issues of the sample's homogeneity and heterogeneity on certain variables.

Participant gender

In all but one of the nine couples, the depressed person was female. While the original intention had been to recruit an equal number of male and female depressed persons, it proved to be very difficult to find volunteers of either sex for this study. The decision to include the data from this couple was made on the basis that the themes emerging from their interview were consistent with those of the other couples; however it is quite possible that different themes would have emerged from interviews with a larger number of depressed men and their partners. As the study stands, there is a need for considerable caution in generalising its findings to depressed men and their intimate others.

There is some evidence that men may be less skilled in the provision of social support (Sarason, Sarason, Hacker, & Basham, 1985) and less empathic (Bohart & Greenberg, 1997) than women. Thus it may have been the case that the male partners who took part in this study were, for the most part, unrepresentative of their sex in that they were unusually skilful informal helpers.

Recruitment difficulties

As detailed in Chapter 2, several different recruitment strategies were employed over a 12-month period, by the end of which only 15 depressed persons had either contacted or (with their permission) been contacted by the investigator. Feedback from NHS colleagues who were helping with the recruitment indicated that they had been able to identify very few people meeting the inclusion criteria on their caseloads. It seemed that the majority of people seeking help for depression from these services did not have partners and/or had such complex and longstanding difficulties that their participation in this study would have been inappropriate. This provides some anecdotal support for the notion that people turn to

professional helpers when their informal networks fail to meet their needs (Barker & Pistrang, 2002).

It is unclear why so few people responded to advertisements for the study circulated by Depression Alliance and other voluntary organisations. It may have been the case that people who were currently depressed lacked the motivation or inclination to respond, or else had partners who were unwilling to participate. Despite assurances to the contrary in the study's literature, people with depression and partners may have feared that, by volunteering to talk about their difficult experiences, they would have been likely to encounter blame or criticism.

Given that so few people volunteered for the study, it could be argued that those that did were, by definition, unusual. This is a potential hazard for any study relying on the self-selection of participants. It is only possible to speculate on the ways in which participants may have differed from the wider population of couples with a depressed member but, potentially, volunteers may have been unusually articulate, more interested in or willing to reflect on their psychological experience and relationships, and (for the most part) more secure in their relationships.

Homogeneity and heterogeneity in the sample

Only one participant in this study had bipolar depression. For the sake of consistency with the other interviews, the interview with this woman and her partner focused on times when she had felt depressed rather than high. Assessing the consistency of the themes in this couple's account with those of the other (unipolar) couples was complicated by the fact that they also reported a significant degree of marital distress. Thus it is hard to know whether differences (e.g. reports of conflict, misunderstanding, unproductive or unsupportive exchanges) were better considered reflections of relationship distress, bipolar depression, or the combination of these factors.

Eight of the nine depressed participants had experienced more than one depressive episode and one person was in a chronic first episode. In this respect participants' histories were consistent with the way that that depression is generally now conceptualised as a chronic, recurring condition (Coyne & Benazon, 2001). For example, a recent study of depressed primary care patients and psychiatric outpatients found that 85% and 78%, respectively, were experiencing a recurrence (Coyne, Pepper, & Flynn, 1999). What is perhaps less clear, given that empirical data on recurrence have been derived from people seeking professional help for depression, is the extent to which this picture is also representative of the silent majority of depressed persons who do not present to services (e.g. Weissman, 1987). To some extent, this problem can be resolved if the depressed participants in this study are viewed as a sample from the population of depressed persons who have sought professional help for their difficulties (as they all had).

Researchers face a trade-off in deciding between greater homogeneity or heterogeneity in sampling a given population (Barker *et al.*, 1994). Thus, in a conventional quantitative study of depression, greater homogeneity would reduce the noise associated with extraneous variables, making it easier to detect and specify a given effect, though at the cost of reducing the study's generalisability to a wider population (Barker *et al.*, 1994). A somewhat similar situation applies to the current study, though clearly the intention in qualitative research is not quite as just described. Sources of heterogeneity in the sample (e.g. in relation to participants' age, sex, and type of depression) increase the potential generalisability of the study's findings to the wider population of couples with a depressed member. However, as noted earlier in relation to bipolar depression and marital distress, with greater heterogeneity it becomes difficult to decide what certain differences observed amongst participants actually reflect.

The small size of the sample, its highly self-selected nature, and the fact that participants were predominantly White and well educated are, however, factors which limit the extent to

which the findings can be generalised more widely, particularly to people of other demographic and ethnic backgrounds. Moreover, although it appeared to be the case that the issues raised in later interviews seemed to overlap to a significant extent with those arising in earlier ones, it is quite possible that interviews with a larger number of couples would have generated further themes. It is not therefore possible to conclude that "saturation" (Yardley, 2000) was achieved: this must remain a question for further research.

The quality of the interview data

Participants in this study were highly articulate and able to convey their experiences of depression and the helping process in impressively rich detail. I now consider some of the other factors that may have influenced the quality of the interview data.

On the basis of self-report measures, around half of the depressed persons considered themselves currently depressed and reported current depressive symptoms at levels expected for a clinical population. There are likely to be advantages and disadvantages associated with interviewing people who are currently depressed versus asking people to reflect on past episodes. On the one hand, people who are currently depressed may be more likely to take a globally negative view of their situation and show a bias towards the recall of negative events; on the other, people who are reflecting on past episodes, while arguably in a better position to take a more objective overview of what ultimately proved helpful or unhelpful, may have forgotten important details or may reconstruct their experience in ways that do not reflect what it was like for them at the time. The pros and cons of reflecting on a current situation versus thinking about past experiences clearly also apply to partners (none of whom seemed to be depressed in this study, however). Given that there are likely hazards associated with either approach, perhaps it is reasonable to assume that a well-rounded picture would have emerged from interviewing both people who were currently depressed and those who were out of episode.

One potentially controversial aspect of the study's procedure was the fact that people with depression and their partners were interviewed jointly. It could be argued that depressed participants would have felt inhibited by the presence of their partner and vice versa. Thus people with depression may have found it harder to talk about unhelpful aspects of the support process, for fear of sounding ungrateful or critical, while partners may have been reticent about the stresses and strains they were under in case this upset the depressed person. However, one striking aspect of the interviews was that participants actually were quite forthcoming about both the positive and negative aspects of the support process. Talking about aspects of each other's behaviour that had been distressing, annoying or simply unhelpful was by no means always easy for couples, but in most cases this seemed possible without evoking a strong sense of criticism, resentment or blame. In some cases, the presence of the other person may have enhanced the validity of the data, by enabling participants to query or disagree with each other. Moreover, it could be argued that interviewing people with depression and their partners separately would have been more likely to evoke suspicion and resentment with potentially adverse implications for how they related to one another subsequently. The ethicality of such an approach would surely be questionable. As it was, couples seemed to find a mutually acceptable way of talking about their experiences and, moreover, a way that several considered had enhanced mutual understanding.

The interview protocol worked well in that it provided a flexible guide to the areas to be covered in the conversation whilst offering sufficient structure for the process to feel manageable to interviewees and interviewer. People with depression generally found it quite easy to begin by providing details of their past histories and there was subsequently a logical progression to talking about more recent or current experiences for both the depressed person and partner. The shift of focus from the couple's relationship to their more general ideas about depression and the helping process seemed to bring the interview towards a natural conclusion. Indeed, one partner spontaneously commended the structure of the

interview, saying that he had found the latter questions helpful in organising his own
thoughts and ideas about helping his wife. In later interviews, less detail was sought about
the person's past history of depression, as in some cases participants had provided so much
information on this that the interview was in danger of becoming unmanageably long. The
more immediate focus on the couple's experience of the helping process did not seem
problematic for participants, however, and in other respects later interviews strongly
resembled earlier ones.

The follow-up interview with each couple was another important feature of this study.
Because participants generally had few, if any, queries about the summary, the focus of the
second interview tended to be on further exploration of particular aspects of the support
process. It was also possible in some cases to ask participants about themes raised by other
couples, where these seemed particularly relevant to what they were describing. This process
served to enrich and expand the data that had already been obtained and enhance
understanding of certain important issues; in most cases, the follow-up interview also saw
the emergence of interesting new information about the couple's experience. Moreover,
several participants commented that they had found the process helpful or enjoyable and/or
were pleased to have received a summary of the views and experiences they had discussed. I
return to this issue below.

Good practice in qualitative research

There has been considerable diversity of method within the field of qualitative research and
in many cases the conventional standards for assessing quantitative studies are not
straightforwardly applicable to qualitative studies (Yardley, 2000). Consequently, a growing
number of authors have now proposed good practice guidelines for qualitative research
(Elliott *et al.*, 1999; Smith, 1996b; Stiles, 1993; Yardley, 2000). These principles were used
to guide the current study. Frequently emphasised issues of good practice relating to
sampling and principles of good interviewing have already been addressed. In the following

section I consider two further key areas relating to the analysis of interview data and the influence of the investigator's perspective.

Analysis

Credibility checks. Several authors have proposed methods by which researchers can check the credibility of themes derived from their data (e.g. Elliott *et al.*, 1999; Smith, 1994, 1996b; Stiles, 1993). The current study employed two such strategies. The first type of credibility check involved inviting couples to comment on a summary of their first interview, thus providing a form of 'member validation' – i.e. an opportunity for the investigator to check the results of a preliminary analysis with the participants themselves. It was emphasised to couples that inviting their comments on the summary was an attempt to make the study more collaborative, in the sense that they would thus have a hand in shaping the direction of the data analysis. This approach could also be construed as an attempt to involve participants as co-researchers (e.g. Smith, 1994).

All nine couples agreed to be interviewed a second time and several greeted this opportunity very enthusiastically. Perhaps because the summaries did not depart substantially from the detail of what had been said, all nine couples agreed that their summary provided an accurate account of the first interview. It is of course possible that participants disagreed with aspects of the summary but were not prepared to challenge the investigator's version of events. Smith (1996b), for example, suggests that participants may perceive the researcher as the more powerful person and therefore find it difficult to disagree with his or her interpretation. While this possibility cannot be discounted, it seems less likely to have been the case given that participants were generally willing to correct other misapprehensions that became apparent to them during the interviews. One of a very small number of queries about the summary was raised by a partner who was uncomfortable with the notion that he had been portrayed as "a saint" and was uncertain whether this reflected how he had described his experiences or the investigator's interpretation of what he had said.

The second type of credibility check involved the participation of two further researchers who, as detailed in Chapter 2, reviewed samples of the interview data and checked the investigator's interpretations of these against their own at various points in the analytic process. Moreover, one of the researchers conducted independent analyses of three full transcripts which were compared in detail with the investigator's findings in each case.

Grounding in examples. Qualitative researchers are encouraged to provide examples of the data so that the reader can assess the extent to which the data support the investigator's interpretation of them and thus be in a position to consider possible alternative readings (e.g. Elliott *et al.*, 1999; Smith, 1996b). With this aim in mind, the themes and sub-themes presented in Chapter 3 are extensively supported by extracts from the interview transcripts.

Coherence. Several authors have discussed issues of coherence in qualitative research (e.g. Elliott *et al.*, 1999; Smith, 1996b; Stiles, 1993; Yardley, 2000). As conceptualised by Elliott *et al.* (1999), achieving coherence requires that the findings from analyses are organised into a coherent overall structure. Smith (1996b) suggests that internal coherence in qualitative research relates to the extent a study presents a coherent argument that deals with "loose ends and possible contradictions in the data" (p. 192). In the current study, the organisation of the data into two higher-order domains, each comprising several themes, was an attempt to provide an integrated and coherent structure; the sub-themes provided a further layer of detail, which preserved nuances in the data. The involvement of two other researchers was relevant to the issue of judging the study's coherence, though clearly the views of readers who have not been connected with the research process will also be important in this respect.

Influence of the investigator's perspective

Issues of reflexivity in the research process have been frequently emphasised by authors discussing qualitative methods (Elliott *et al.*, 1999; Smith, 1994, 1996b; Stiles, 1993; Yardley, 2000). As suggested earlier, it is likely that my own interests, attitudes and beliefs

as investigator would have had an influence both on the data obtained in this study and on the interpretation subsequently put on the data. My therapeutic interests are likely to have been of particular relevance, given that this was a study of psychological helping. My personal preferences are for non-directive, exploratory styles of therapy and it is therefore possible that I would have been more receptive to aspects of the informal helping process described by participants that had qualities in common with those to which I subscribe most strongly. Thus it could be argued that in conducting the interviews I would have been especially likely to attend to issues of the support process connected with talking and listening, emotional disclosure, acceptance of others' feelings and so on; moreover, these may have been the themes I was most likely to emphasise in analysing and organising the interview data.

While it is obviously not possible to make a definitive statement on the extent to which this did or did not happen, there were a number of factors mitigating against the study's findings simply reflecting my own preferences. First, as investigator, I tried to remain mindful of attitudes and beliefs of mine that were particularly relevant to and therefore likely to influence the area under investigation. Second, the active collaboration of participants was sought throughout the research process and, in particular, couples were encouraged to take the interviews in directions that were most meaningful to them. Third, the interviews were conducted in a tentative and non-judgemental manner, with care taken not to suggest particular responses. Fourth, other researchers reviewed the taped interviews and performed credibility checks on the themes derived by the investigator – thus providing safeguards against the investigator's perspective unduly influencing the manner in which the data was obtained or how it was interpreted. Finally, participants had opportunity to comment on and potentially reject the investigator's summary of themes arising in their first interview.

Despite the measures described above, my own perspective as investigator would undoubtedly have influenced the study at every stage of the research process. Thus, while I

sought to avoid influencing participants' responses during the interviews, for example, semi-structured interviews can nevertheless be conceptualised as a form of conversation (e.g. Pidgeon & Henwood, 1997), which both interviewer and interviewee play a role in shaping. Therefore aspects of my behaviour, reflecting my own attitudes and beliefs, would have influenced the direction of the interviews in ways that were more or less explicit to participants (e.g. King, 1996), and vice versa. Moreover, in relation to the analysis, it is widely acknowledged amongst qualitative researchers, or indeed considered fundamental to the approach, that there is no one 'true' reading of the data. This is why it is important to provide the reader with information about the investigator's perspective; the reader is thus better equipped to make sense of the investigator's interpretation and decide whether or not he or she agrees.

Suggestions for further research

Further research could explore the informal helping process in a larger sample of couples with a depressed member and also with couples from other social and demographic backgrounds. It would be important to establish, in particular, whether depressed men want or need different things from their partners. For example, in the current study, the sole depressed male participant was one of the few people not to emphasise the importance of being able to talk to his partner about how he was feeling (though as already noted, other aspects of this couple's account shared common themes with the rest of the sample). It would therefore be important to determine whether this simply reflects one individual's preference, or whether it hints at gender differences in the kinds of informal support most valued for depression. Such research would also provide clues as to whether the experiences of female partners are generally similar to those described by the (predominantly male) partners in this study.

A potentially informative extension of the procedure described here would be the inclusion of purpose-built quantitative measures in further studies of partner support in depression.

Using the current study's findings as a guide, questionnaires could be designed to measure couples' use of particular support strategies, the extent to which these had been helpful, how the couple coped with particular challenges associated with depression (e.g. communication difficulties), and how far the depressed individual and partner were able to work together effectively. Given that the majority of previous observational studies of depressed persons have been concerned with conflict, it would also be relevant to explore how couples with a depressed member perform on support-related tasks, such as the Couples' Helping Exercise (Barker & Lemle, 1984).

Studies of the informal helping process in couples facing psychological problems in general are conspicuous by their absence in the research literature. The current study suggests that while recruitment of willing couples may be difficult, with some perseverance such research is nevertheless practicable and illuminating.

Clinical implications

Several couples commented that they had found their participation in this study helpful or therapeutic. In particular, the joint interview format was popular with most depressed persons and partners, who were glad of the opportunity to share their respective experiences in the presence of a sympathetic third party. In most cases, people felt that they had developed greater mutual understanding following their participation in this study and considered that it had been beneficial to reflect on both the trials and tribulations of the support process. Indeed, several couples commented that they had not previously shared their experiences or thought about the helping process in quite this kind of way. Participants also found it helpful to receive a written summary of the views and experiences they had described in the first interview. The possibility that research may be experienced as therapeutic by participants has been commented on by authors writing from a community psychology perspective (e.g. Kelly, 1986). It may therefore be worth considering how the procedure followed in this study could be developed into an intervention for couples in

which one member suffers from depression. Given that depression is, for most people, a chronic, relapsing condition, it could be that an intervention along similar lines to the procedure described for this study would be most appropriate for persons who are currently out of episode or experiencing relatively mild depressive symptoms. The exchange of information involved could help couples to identify the support strategies that had been most helpful in the context of their relationship, be aware of less helpful approaches, and thus be better equipped to work together in managing future or more severe episodes.

Intervening in this way with couples who are not currently in crisis may help to reduce the sense of struggling alone that was conveyed by several participants. It could also provide an opportunity to ensure that couples receive basic information about depression and details of local services: it was striking how often participants commented that such information had not been forthcoming without considerable effort on their part.

The focus of this study has been on how ordinary people try to help one another in times of psychological distress. To end, however, I would like briefly to consider how the study's findings might be relevant to formal interventions for depression. The National Institute of Mental Health Collaborative Depression Study reported recovery rates of 57% for antidepressant medication plus clinical management, 55% for interpersonal psychotherapy, and 51% for cognitive-behaviour therapy (Elkin, Shea, Watkins, Imber, Sotsky *et al.*, 1989). It has been suggested that the sizeable proportion of persons who do not appear to benefit in each case might reflect the fact that such treatments for depression generally focus on working with the individual and do not seek the involvement of persons from his or her ongoing interpersonal environment (Cordova & Gee, 2001). Moreover, most standardised couples therapies for depression treat depression by targeting marital distress (e.g. behavioural marital therapy, cognitive marital therapy, conjoint marital interpersonal therapy). Research into the effectiveness of marital therapy for depression (e.g. Beach & O'Leary, 1992; Foley, Rounsaville, Weissman, Sholomaskas, & Chevron, 1989; Teichman,

Bar-El, Shor, Sirota, & Elizur, 1995) has consistently shown that, while as good as or better than cognitive therapy when the depressed person is also maritally distressed, such interventions are much less effective in the absence of marital distress. Addressing this issue, Cordova and Gee (2001) describe a form of couples therapy for depression (CTD) which can be used to increase support and cohesion in both distressed and non-distressed couples. The principles of this approach, as described for treating non-distressed couples, bear striking similarities with the current study's findings on how couples worked together. Thus, fundamental to the CTD approach is encouraging the couple to adopt a common perspective towards the depression, which is seen as a shared problem rather than the sole responsibility or fault of either party. To this end, Cordova and Gee refer to fostering:

> a sense of 'we-ness' … in which the couple feels united in the struggle with depression rather than divided by it … We-ness provides a sense of being able to work together effectively and facilitates both partners taking an active role in addressing their common enemy (Cordova & Gee, 2001, p. 193).

Certain other components of CTD also resonate with the findings of the current study; for example, acceptance of aspects of the relationship that may not be amenable to change (e.g. the depressed person's ongoing vulnerability to further depressive episodes), increasing behavioural flexibility (e.g. by encouraging mutually empathic and supportive responding), and increasing the effective handling of aversive situations (e.g. through collaborative problem solving). CTD also emphasises the importance, for both members of the couple, of being able to tolerate depressive symptoms at some level. Preparation for relapse is a further component of CTD, enabling couples to prepare emotionally for the possibility of future depressive episodes, develop awareness of potential triggers, recognise warning signs, and prepare effective coping responses. Based on behavioural theories of depression and relationship distress, Cordova and Gee's CTD has not yet been empirically tested. Similarities between certain key elements of this approach and the current study's findings

in respect of how better functioning couples coped with depression seem promising, however.

Previous research suggests that most people with psychological problems prefer to seek the support of helpers in their natural networks. Moreover, there is no reason to suppose that informal helping stops when people take their difficulties to mental health professionals; indeed, it has been argued that seeing a therapist may increase a person's propensity to discuss aspects of his or her internal world with others (Barker & Pistrang, 2002). Surprisingly, however, informal helping for psychological problems has been neglected in the research literature. The current study has started to explore this area, focusing specifically on the experience of giving and receiving support for depression in the context of an intimate relationship. This study has suggested a number of ways in which partners can be helpful to people with depression and has also called attention to the difficult circumstances in which support for depression is provided. Taken with the findings of previous research indicating that satisfaction with the help received from a partner is an important determinant of overall relationship satisfaction (e.g. Barker & Lemle, 1984) and relationship maintenance (e.g. Pasch & Bradbury, 1998), the picture revealed here suggests that professional helpers should be mindful of the fact that their interventions occur in a wider helping context which often includes the efforts of intimate others. Moreover, couples and family therapists should perhaps be encouraged to show as great a willingness to intervene in cases of miscarried informal helping as shown in relation to interpersonal conflict. Finally, it should not be forgotten that many people facing psychological difficulties are not in intimate relationships. It is therefore important also to consider the nature and impact of informal support in other kinds of relationships in thinking about the needs of people seeking help.

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Appendix I:

Ethical approval for study

UCL
HOSPITALS

The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee Alpha Chairman: Professor André McLean

Please address all correspondence to:
Iwona Nowicka
Research & Development Directorate
UCLH NHS Trust
1st Floor, Vezey Strong Wing
112 Hampstead Road, London NW1 2LT
Tel. 020 7-380 9579   Fax 020 7-380 9937
e-mail: iwona.nowicka@uclh.org

Dr N Pistrang
Senior Lecturer in Psychology
Sub-Department of Clinical Health Psychology
UCL
Gower Street

April 6, 2001

Dear Dr Pistrang

Study No: 01/0059 *(Please quote in all correspondence)*
Title: **Partner support in depression**

Thank you for sending us your interesting project on partner support in depression.   The Ethics Committee agreed with this proposal, but asked me to put forward one suggestion (not requirement).   Would it help to interview two people separately before the joint interview?

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

Professor André McLean, BM BCh PhD FRC Path
Chairman

Pistrang6apr/aml/iin/April 6. 2001

Camden and Islington Community Health Service
LOCAL RESEARCH ETHICS COMMITTEE

Research & Development Unit, 3rd Floor, West Wing, St. Pancras Conference Centre
St Pancras Hospital, London NW1 OPE
tel: 020 7530 3376   fax: 020 7530 3235
e-mail: ayse.ali@cichs-tr.nthames.nhs.uk

Chair: *Stephanie Ellis*   Administrator: *Ayse Ali*

24 July 2001

Mr Thomas Harris
Sub Department of Clinical Psychology
University College London
Gower Street
London
WC1E 6BT

Dear Mr Harris

<u>LREC Ref</u>: 01/51 (please quote in all further correspondence)
<u>Title</u>: **Partner Support in Depression**

Thank you for you letter dated 4 July 2001 addressing the concerns raised by the Committee. I am pleased to inform you that after careful consideration the Local Research Ethics Committee has no ethical objections to your project proceeding. This opinion has also been communicated to the Research and Development Unit of Camden & Islington Mental Health NHS Trust.

PLEASE NOTE THAT THIS OPINION ALONE DOES NOT ENTITLE YOU TO BEGIN RESEARCH.

Camden and Islington Community LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility to decide whether or not the project should go ahead, taking into account the ethical advice of the LREC[1]. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management, who will need to be assured that the researcher holds an appropriate NHS contract, and that indemnity issues have been adequately addressed.

N.B. Camden and Islington Community Health Service LREC is an independent body providing advice to the North Central London Community Research Consortium. A favourable opinion from the LREC and approval from the Trust to commence research on Trust premises or patients are **NOT** one and the same. Trust approval is notified through the Research & Development Unit.

The following conditions apply to this project:

* You must write and inform the Committee of the start date of your project. The Committee (via the Local Research Ethics Committee Administrator or the Chair at the above address) <u>must</u> also receive notification:

     a) when the study commences;
     b) when the study is complete;
     c) if it fails to start or is abandoned;
     d) if the investigator/s change and
     e) if any amendments to the study are made.

* The Committee <u>must</u> receive immediate notification of any adverse or unforeseen circumstances arising out of the project.

---

[1] Local Research Ethics Committees Heath Service Guidelines (91)5, NHS Management Executive, 19 August 1991 *(commonly known as The Red Book).*

- It is the responsibility of the investigators to ensure that all associated staff, including nursing staff, are informed of research projects and are told that they have the approval of the Ethics Committee and management approval from the body hosting the research.

- The Committee will require a copy of the report on completion of the project and may request details of the progress of the research project periodically (i.e. annually for longer projects).

- If data is? to be stored on a computer in such a way as to make it possible to identify individuals, then the project must be registered under the Data Protection Act 1998. Please consult your department data protection officer for advice.

- Failure to adhere to these conditions set out above will result in the invalidation of this Letter of no objection.

Please forward any additional information/amendments regarding your study to the Local Research Ethics Committee Administrator or the Chair at the above address.

Yours sincerely

Stephanie Ellis
Chair, LREC

RIVERSIDE RESEARCH ETHICS COMMITTEE

20 December 2001

Mr Tom Harris

Trainee Clinical Psychologist
Sub-Department of Clinical Health Psychology
University College London
Gower Street
London
WC1E 6BT

Dear Mr Harris,

RREC 2924 - Partner Support in Depression

- -

Thank you for your application. The Chairman of the Riverside Research Ethics Committee, Dr Charles Mackworth-Young, has asked me to write to inform you that the above study has now been approved.
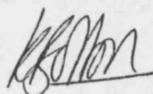
Please note the following conditions which form part of this approval:

[1]   Your study has been assigned a unique reference number. This number must be quoted in any correspondence with the Committee concerning this study.

[2]   This approval is for a limited period only. A letter from the principal investigator will be required in order to extend this period of approval.

[3]   Any changes to the protocol or investigator team must be notified to the Committee. Such changes may not be implemented without the Committee's approval.

[4]   Any revised study documents submitted must be given a new version number/date.

[5]   For projects with an expected duration of more than one year, an annual report from the principal investigator will be required. This will enable the Committee to maintain a full record of research.

[6]   The Committee must be advised when a project is concluded and should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

[7]   The Committee should be notified immediately of any serious adverse events that are believed to be study drug related or if the entire study is terminated prematurely.

[8]   Please note that research conducted on NHS Trust premises must receive the approval of the relevant Research and Development department. Approval by the Committee for your project does not remove your responsibility to obtain this approval.

[9]   You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, e.g., extra work for laboratories. Approval by the Committee for your project does not remove your responsibility to negotiate such factors with your colleagues.

[10] You must ensure that nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

[11] Pharmacy must be told about any drugs and all drug trials, and must be given the responsibility of receiving and dispensing any trial drug.

[12] All documents relating to the study, including Consent Forms for each patient (if applicable), must be stored securely and in such a way that they are readily identifiable and accessible. The Committee will be conducting random checks on the conduct of studies, and these will include inspection of documents.

May I take this opportunity to wish you well in your research. If any doubts or problems of an unexpected nature arise, please feel free to contact me at any time.

Yours sincerely

Miss Katherine Bolton
Administrator
Riverside Research Ethics Committee
(On behalf of the Chairman, Dr C G Mackworth-Young MA MD FRCP)

The Riverside Research Ethics Committee has approved the following:

RREC 2924 - Partner Support in Depression
- -

Mr Tom Harris

This study was considered by Chairman's action.

This study was first approved on the: 20/12/2001.

Approval for this study expires on the: 20/12/2002.

Study History:

~	Comments
Chairman's Action Application Form	Approved 20/12/01
Protocol (Revised Version December 2001)	
Interview Questions	
Draft Interview Schedule	
Participant Information Sheet & Covering Letter	
Participant Consent Form	
Psychologists Information Sheet	
Poster	
Camden & Islington LREC Application Form (06/06/01)	
Camden & Islington LREC Approval Letter (24/07/01)	
Camden & Islington R&D Approval Letter (24/07/01)	

Appendix II:

Advertisement for the study

(Appearing in 'A Single Step' – the magazine for members of Depression Alliance)

Giving and getting support for depression: Couples' experiences

If you get depressed, what sort of support do you need from your spouse or partner? If you are the partner of someone who's depressed, what sort of support do you try to give?

A research project at University College London is looking at how partners try to help when one member of the couple is depressed. We know from previous research that people tend to talk first of all to those they are closest to. But, despite the best of intentions, it can be hard for partners to know what to say or do that is helpful. This project aims to find out, from couples themselves, what seems to work and what doesn't.

We would like to interview people who have been depressed, and their partners, to find out about their experiences of giving and getting support. If you have experienced an episode of (unipolar) depression within the past two years, live in or near London, and think that you and your partner might be interested in taking part, please contact Tom Harris on 07977 099 036 (e-mail: tjrharris@freeuk.com) who will be happy to answer questions.

Appendix III:

Participant information sheet

Sub-Department of Clinical Health Psychology

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Dr Nancy Pistrang, Senior Lecturer in Clinical Psychology
Tom Harris, Trainee Clinical Psychologist

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PARTNER SUPPORT IN DEPRESSION

Information for volunteers

We are inviting you to take part in a study investigating the kinds of help and support offered to people with depression by their partners. We know from previous research that people who experience psychological problems tend to look first to those they are close to for support, particularly partners and spouses. But while it has been shown that depression can lead to difficulties for both partners in a relationship, little is known about how partners try to help.

In this study we are interviewing people who have been depressed and their partners, to find out about their respective experiences of receiving and providing support. We hope this study will suggest ways to improve the match between the help offered by partners and the support which people with depression find most beneficial.

What does taking part involve?

Should you decide to take part, you and your partner can choose to be interviewed in your home or at University College London, whichever you prefer. You would first each be asked to complete some short questionnaires and then interviewed jointly about your experiences of giving and receiving support during a recent episode of depression. With your permission, we would tape record the interview, so as to have a complete record of what was said. The whole session would last about 1½ hours.

Confidentiality

At all stages of the study we will take care to respect the privacy and right to confidentiality of participants. In writing articles for publication based on this research, we will not reveal the identity of anyone who took part.

Ethical approval

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

Taking part in the study

You do not have to take part in this study if you do no want to. If you decide to take part you may withdraw at any time without having to give a reason.

Further information

Please do not hesitate to contact Tom Harris (phone number and address above) if you have any questions about the study.

Appendix IV:

Self-report questionnaires

1. Locke-Wallace Marital Adjustment Test
2. Empathy Questionnaire
3. Attitudes towards Emotional Expression scale

COUPLES HAPPINESS AND AGREEMENT

Check the box on the scale below which best describes the degree of happiness, everything considered, of your present relationship. The middle point, "happy," represents the degree of happiness which most people get from their relationship, and the scale gradually ranges on one side to those few who are very unhappy in their relationship, and on the other side to those few who experience extreme joy in their relationship.

Very   Happy   Perfectly
Unhappy   Happy

State the approximate extent of agreement or disagreement between you and your partner on the following items:

ITEM	Always Agree	Almost Always Agree	Occasion- ally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
Handling finances						
Matters of recreation						
Demonstrations of affection						
Friends						
Sex relations						
Conventionality (right, good or proper conduct)						
Philosophy of life						
Ways of dealing with partner's family						

When disagreements arise, they usually result in: male partner giving in _____ Female partner giving in _____ Agreement by mutual give and take _____

Do you and your mate engage in outside interests together: All of them _____ Some of them _____ Very few of them _____ None of them _____

In leisure time do you generally prefer: To be "on the go" _____ stay at home _____ Does your partner generally prefer: To be "on the go" _____ to stay at home _____

Do you ever wish you had not gotten into this relationship: Frequently _____ Occasionally _____ Rarely _____ Never _____

If you had your life to live over, do you think you would: Choose the same person _____ Choose a different person _____ Not get involved with anyone _____

Do you confide in your partner: Almost never _____ Rarely _____ in most things In everything _____

How your partner responds to you

We are interested in how much you think your partner understands your feelings, concerns and experiences. The statements below describe a variety of ways in which your partner might respond to you. Please decide how much each one is true or untrue for you, by choosing one of the following answers:

1. Strongly <u>untrue</u> for me
2. Moderately <u>untrue</u> for me
3. Slightly <u>untrue</u> for me

4. Slightly <u>true</u> for me
5. Moderately <u>true</u> for me
6. Strongly <u>true</u> for me

Please put one number to the right of each statement:

Answer

1. S/he nearly always knows exactly what I mean. _____

2. S/he may understand my words but s/he does not see the way I feel. _____

3. S/he usually senses or realises what I am feeling. _____

4. His/her own attitudes toward some of the things I do or say prevent him/her from understanding me. _____

5. His/her response to me is usually so fixed and automatic that I don't really get through to him/her. _____

6. S/he appreciates exactly how the things I experience feel to me. _____

7. S/he just takes no notice of some things that I think or feel. _____

8. S/he does not realise how sensitive I am about some of the things we discuss.

_____

9. S/he understands me. _____

10. S/he realises what I mean even when I have difficulty in saying it. _____

Attitudes towards emotional expression

Please read the following statements describing attitudes to showing and sharing feelings. For each one, please circle a number from 1 to 5, according to how much you agree or disagree.

1. I think getting emotional is a sign of weakness.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

2. Turning to someone else for advice or help is an admission of weakness.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

3. It is shameful for a person to display his or her weaknesses.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

4. People will reject you if they know your weaknesses.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

5. If a person asks for help it is a sign of weakness.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

6. When I am upset I bottle up my feelings.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

7. When I am upset I usually try to hide how I feel.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

8. I seldom show how I feel about things.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

9. When I get upset I usually show how I feel.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

10. I do not feel comfortable showing my emotions.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

11. I think you should always keep your feelings under control.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

12. I think you ought not to burden other people with your problems.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

13. You should always keep your feelings to yourself.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

14. You should always hide your feelings.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

15. I should always have complete control over my feelings.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

16. I think other people do not understand your feelings.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

17. Other people will reject you if you upset them.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

18. My bad feelings will harm other people if I express them.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

19. If I express my feelings I am vulnerable to attack.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

20. If other people know what you are really like, they will think less of you.

1.	**2.**	**3.**	**4.**	**5.**
Strongly disagree		Neither agree nor disagree		Strongly agree

Appendix V:

Interview schedule

Semi-structured interview schedule

Introduction:

"We're interested in how people try to be supportive of their spouses and partners when they become depressed. In particular, we're interested to know what things are said or done that feel particularly helpful or supportive. Of course, in relationships attempts to do or say the right thing, however well intended, don't always feel helpful to the person on the receiving end; sometimes they can feel rather unhelpful. This is common in all relationships, whether or not someone is feeling depressed. Nevertheless, we are also interested to learn about those times when attempts to be supportive haven't worked so well.

"Some questions will be about what it is like to feel depressed and have a partner try to help, while others will be about what it's like trying to provide support. It's important to emphasise that there are no right or wrong answers to these questions. I hope you'll both feel able to talk about times that things haven't gone so well, as well as your positive experiences, without either of you feeling blamed in any way. If I ask about anything that you don't feel comfortable discussing, please let me know.

"Do you have any questions or comments before we get underway?"

[Comments normalising relationship difficulties and reinforcing a non-judgmental perspective should be made wherever appropriate throughout the interview.]

Brief history of depressive episodes:

"It would be helpful first of all if you told me briefly about the times you've been depressed as an adult; that is, times when you've felt low and not your usual self for two weeks or longer, with difficulties such as... [examples of symptoms].*"*

- Age at first episode
- Number of episodes
- Duration of episodes
- Most severe episode
- Number experienced with partner

Most recent episode:

"Can you tell me in a little more detail about your most recent experience of depression?"

- Date of onset
- Duration
- Sources of formal and informal help [provide list]

"When were things at their worst for you?"

Partner support during most recent episode:

"How were things between the two of you then? In what ways does [partner] try to be supportive or helpful when you feel low?"

- How does partner try to help? [both perspectives]
- What things are helpful? Why?
- What things are unhelpful? Why?
- What would person with depression like partner to do?
- What is it like for partner trying to help?
- What makes helping easier or more difficult at times?
- Do they have different ideas about helping or being supportive?

[If there have been previous episodes:]
"And what about when you begin to feel better? Is anything different happening then?"

Support available to non-depressed partner

"Do you receive any support from anywhere when you're trying to help your partner?"
"What kind of support do / would you find helpful at these times?"

Explanatory models and ideas about helping:

"I'd like to ask you both for your ideas about why people become depressed generally."

- Depressed person's ideas
- Partner's ideas

"Do you have any ideas about what would be helpful to someone else who was depressed – a friend, for example. How would you try to help?"

- Depressed person's perspective
- Partner's perspective

Debriefing:

"Thank you both very much for answering those questions so thoughtfully..."

- Opportunity for questions or comments
- Further normalising of responses
- Address any strong feelings or distress evoked
- Offer suggestions for additional support if necessary
- Reminder of how interview data to be used
- How to contact researcher
- Thank couple

Appendix VI:

Extract from transcript of a first interview

First interview with Couple 1

Bold – Interviewer (I)

Italic – Female partner (F)

Plain – Male partner (M)

Great. Um. So you'll know from the conversations that we've had and the information that you've had a chance to look at that we're interested in how partners, um, try and be supportive when a partner becomes depressed, um, and we're particularly interested in what, what particular things people do or say that, that feel supportive and helpful, um, and that's really what this what this interview is going to be about. Um. The other thing that we're very interested to, to hear about is that we, we know that in, in a close relationship, um, however well intended, that sometimes attempts to, to be supportive don't always feel terribly helpful, um, so we're quite interested to hear about times when, when helping doesn't, doesn't work so well, um, and I hope that you'll, um, feel comfortable to, to talk about things when, times when things haven't worked so well, um, as well. Um. And I very much hope that, you know, that you won't feel that there are sort of right or wrong answers to these questions and that, that you won't feel, um, sort of judged or, or criticised in, in any way. Um. Um. So some of the questions will be what it's, what it's, about what it's like to, to be depressed and have a have a partner try and help. Um. And other questions will be, you know, what it's, what it's like being a partner trying to provide support.

(laugh) Right.

Be nice.

Yeah. No. I'll just…

Be honest.

Yeah. So, you know, as I've said there, there are absolutely no, no right or wrong answers to these questions and, you know, and we know that things aren't always easy in any, in any close relationship but, um, I hope that you'll feel comfortable, um, talking about things that, um, you know, haven't gone so well, as well as more sort of successful support attempts. But, um, at, at the same time if I do ask you about things that you don't want to talk about, um, you know, do, do let me know and, as I say, um, do feel free to sort of direct me as, as well, you know, if, if you don't feel I'm asking about the, the really important, um, useful things, then, um, let me know. OK. So, first of all, it would, it would just be quite helpful to, um, hear, F, about, um, have a sort of overview of the, of your experience of depression, um, sort of the first time that you were depressed and, and so on, um.

OK. Um. I don't really know the answer to that question because I don't know how, quite how far back it goes **[Right]***. Um. What's happened recently is that I was in an accident, er, getting on for a couple of years' ago, which is what has sparked off this most recent depressed phase. But I know that I have been depressed in the past because I've been on antidepressants before* **[Right]** *and I'm now seeing a therapist who, together we're kind of exploring whether or not the signs of depression were there at* **[Right]** *a much earlier time which I hadn't really recognised* **[Right]***, which I think they probably were.*

Right. And, and, you, you became depressed in recovering from, from the accident is that, is that…?

Well, yeah, quite a while afterwards, really. I was in, um, the [train crash] **[Right]** *So I had post-traumatic stress disorder for a while* **[Yeah]** *but just sort of got on with things and*

1

actually went travelling a few months afterwards and at that time I didn't know M **[Right].**
*Um, and when I came back from travelling last summer we met. And at that point I felt that I
was on a pretty even keel* **[Mm-hm]** *and I hadn't even thought that I might become
depressed. I hadn't related it to my previous depression* **[Sure].** *Um, and then it was around
the time of the anniversary of the crash* **[Mm]** *when things started to get really difficult*
[Yeah], *um, and I started to see a therapist – things became difficult for us* **[Yeah],**
obviously, um, partly because I wasn't very aware of what was happening **[Mm-hm]** *to
myself. Um. Yeah, so I started seeing a therapist last October* **[Mm-hm]** *and then went on
antidepressants in February of this year* **[Right, right].** *And I'm still on both, so I'm seeing
a therapist and on antidepressants. But it, I mean, it's not... when I first started seeing my
therapist it was very much about the crash* **[Mm-hm],** *um, which I, I guess after sort of two
or three months it, it wasn't. It was about sort of deeper issues* **[Sure, sure].** *He realised the
crash was just a trigger* **[Yeah].** *So that barely comes up now. That's not really an issue. So
we're looking at all the kind of causes and* **[Sure]** *the bigger picture.*

**Sure. And you have a sense that there may have been times in the past when you've
been quite low but perhaps not** *[Yeah, but didn't understand what it was. Yeah]* **really
registered it as being depressed as such. Right. Have they been sort of long periods of
time, or, or how...?**

*Um, well, it depends how you define long I suppose. I mean, not years, but, um (5 secs
silence). I mean it comes and goes, really. There are phases that are, you know, looking
back, I think, you know, I clearly wasn't really happy at that time* **[Right].** *Although, you
know, I was going out with my friends and doing* **[Mm, mm]** *things that I enjoyed and all
the rest of it, but, you know, there would be evenings or days or, you know, spells of days
when* **[Yeah]** *I wasn't feeling good.*

Right, so it would be a sort of a run of, of *[A few days]* **a few a few days.**

Which is kind of how it goes now as well **[Mm]** *It goes in waves* **[Sure]** *like there'll be... I
don't know, well, how many days, anything between one and 10, I guess, of days when it's,
it's kind of bad and then I then I tend to come out of it again.*

**Sure. And, and you feel that sort of pattern has, has continued but perhaps become
somewhat worse since your experiences...**

The pattern's continued, yeah, but the, um, just the depth of it **[Yeah]** has got worse.

**Right, right. And, you did say but just let me check that I, that I understand. The two
of you met just before you started to become depressed** *[Yeah]* **after the accident, so,
and, and how, how long had you been sort of together as, as a couple prior to you
starting to feel quite, quite low?**

Well, we got together in July.

And the anniversary's October.

Yeah, but I think I'd started to... go [(laughs)] *before October. I actually think, um, having
the, being in a situation, being in a relationship and having, if you like, permission to, to feel
things and to acknowledge those feelings was probably, probably sparked it off, partly.*

Sorry about that!

Yeah.

(laughter)

You know what I mean **[Yeah].** *I think it's a positive thing that I didn't, I didn't have to keep
hiding it keep it in* **[Sure]** *and keep pretending to people. I was actually able to feel things.*

**Sure, sure. OK. So... if you think, think back to, to how things have, have been for you,
um, during this, this most recent time that you, that you've been low, um, when would**

you say things were, were at their worst for you? When were you sort of at your, at your lowest?

Um. Well there was a big spell before Christmas, really, from October through to (4 secs silence) *after Christmas probably. I mean, it wasn't every day was crappy but* [**Sure but at a sort of**] *was fairly consistently bad.*

For, say, a few months?

Yeah.

And how were things between, between the two of you during, during that time?

Well, rocky at times. I mean, considering we'd only been going out with each other for a few months and we didn't really know each other very well [**Right**] *I think M did quite well to survive it* (laughter). *Um, and I don't find it very easy to, well I don't find it easy at all, to express my emotions or communicate what I'm feeling and why. So, that's obviously really difficult for M to cope with because he can see me kind of disappearing somewhere* [**Mm-hm**] *and blocking him out but he can't, he doesn't know why, doesn't know if he's done something wrong* [**Right**]. *I mean, you don't know someone all that well* [**Sure**] *and I guess I didn't, I needed to build up trust* [Mm] *in M to be able to talk to him about it* [**Yeah**]. *So that process was quite hard and it was, um* (3 secs silence). *That's been our, the only time that we've really had big arguments and stuff.*

Mm. And how, how was that for you M? What was your experience of that time?

Um. It just like, a bit like F said. I didn't know what was going on [**Mm-hm**] and I didn't know why. And I, and I just kind of thought, well, I've done something – I don't know what it is. And I'm just like, well, I'm off (laughs) see you!

Right.

Um. You know, if you can't tell me what the matter is or whether I've done anything, then, you know, what can you expect me to do about it, if anything. And I just felt, oh, I can't cope with this.

So you, you attempted to [Well I did] **or talked about** [I kind of, I kind of] **taking yourself away from the relationship.**

Well, one night I came in from going out and then, you know, we had a...

Big row.

Well there was, there was just some communication that wasn't going between us properly. So I didn't understand what F really wanted [**Mm-hm**] or I thought I did but then me saying it maybe wasn't right or the way I said it wasn't right [**Right**]. So I just, "Well, look, if you can't tell me, I'm off". So I just got in my car, even though I'd had a few beers, I know I shouldn't have done it, and then I just went home.

Yeah.

And then we spent the next like three hours on the phone. She kept ringing me and I kept putting the phone down (laugh) and then we were [**Right, right**] having this really like stupid adolescent thing. And then it kind of, I mean, it was good for me to actually go home, I think, and just kind of sleep on it and just relax, because I was getting really annoyed [**Yeah**] Um, and of what I can recollect kind of the next day, we kind of, "OK, well let's talk". Um. "And even if we can't solve it, let's just see how far we get by talking". And I don't, we didn't solve anything (inaudible) up till then, really. But that, that was a real starting point of us actually... me having to realise that I've got a choice whether I'm in this or out of this [**Yeah**], um, and if I'm in this then F has got to realise that, you know, I want to be part of, of whatever's happening, so either I can, you know, give someone, give her someone she can just talk to, which is here all the time, or I can maybe let her know what is

happening or, or whatever [**Mm-hm**]. Um, but I didn't feel anymore want to be excluded, and I didn't feel anymore that I wanted to be, um, kind of just like a passenger on this mad journey *[(laughs)]*[**Right, right**], bit like a roller-coaster, really, because you don't know the corner, you don't know the corner's coming, then you get to the corner and you're kind of flying off and you don't know why. And, you know, so I didn't really want to be there any more and I felt that I had enough, kind of, sight of F that she was like nice enough and she was, she was cool and there wasn't a problem with her, so [**Yeah**] it wasn't like I was going to run off at the first sight of, you know [**Sure**], anything (inaudible).

So you sort of shared some of your ideas about how you wanted the relationship to, to be and what, what//

Well, I think, yeah. Um, well, I mean, the words I kind of were using was like, you know, "If I was going to run off and not, you know, not, not support you or not be around, then I would have just done that". It's like, you know, "I'm here, um, and I'm here for you, you know, and I'm here with this relationship, we're committed to this relationship therefore I'm committed to you. So, whatever that is that we have to deal with let's just kind of help each other and deal with it" [**Mm-hm**]. And part of the thing that helped me realise that F was, the one thing, the other thing I didn't want to happen was for F to say "Yeah, yeah, yeah – that'll all happen", and then, kind of, for just like nothing to happen. Because I've been in relationships before where, my previous kind of, you know, partner from a while ago, said she'd been to counselling and said she'd been, kind of, dealing with things or whatever. Wouldn't include me in the process so I didn't know. And then obviously nothing was, was happening, she was, you know, lying about it or whatever. Um, so it was good that F was going to see a counsellor. So as far as I was concerned that was positive [**Mm-hm**], um, you know, F supporting herself and looking after herself, which was the fir..., where it, kind of, for me where it has to start. So F was doing some, some good stuff and she was working through it, um, which meant that, you know, even through F's kind of counsellor our relationship was being supported in some way. Because it kind of feels, felt a bit isolated [**Mm, mm**]. I felt a bit isolated from what was going on//

Have, have [So it was quite, it was good], **have you been part of the counselling as such, or, or...?**

Um. I've not... I, kind of, at the beginning, kind of, felt maybe I should and I shouldn't, but then I thought no. Um, and F as and when she comes back and feels, in her own time, that she wants to say something about what was said or what happened then that's fine [**Mm-hm**] I don't, I try not to, hopefully this is OK, I try not to kind of ask her when she gets back like, "What did you say?" and [**Mm-hm**] you know, "Did you talk about me?" or "Did you talk about this?" [**Sure, sure**] or whatever. So I don't, I don't, I don't do that *[Mm]* [**Sure**]. So I kind of let F just, kind of, go with it as she goes with it [**Mm**]. Um, and for me that's, that's kind of, that's kind of cool enough [**Mm-hm**] Um...

Yeah. What//

So I don't really, you know, I just kind of get on with it, really.

Sure.

But the outcome of that now is I've got used to F's patterns [**Right**]. So, at, at the beginning I just didn't know what was going on *[(laughs)]* and it felt a bit, oh my god, just what is going on? [**Yeah, yeah, yeah**] I'm off! (laughs) And then I kind of kind of realised that, you know, if you're going to be here, get used to it, um, but then try and do something positive about it. So that's when I just kind of sat and watched and listened and kind of, you know, been able to kind of note the [**Mm**], the cycle or whatever it's called that F kind of goes through [**Mm**]. And then my intention from doing that was to try and say to F, well, you're getting to a point where you're, you're kind of going somewhere [**Right**]. Um. So the first point was just kind of saying, "Well, you're getting there". And the second point was, kind

of just well, trying to help her, kind of, figure out what it is that starts her going there, if anything [Mm]. Whether it, you know, whether it is something I've done or whether it's something that's happened in our relationship or whether it's just something else externally. Um. And just try to, um, just kind of try, trying to help, really, as best I can.

Mm, yeah. Well, er, er, er [(inaudible)] and let's, let's talk a little bit more about sort of helping and, and support and so on. So, perhaps if, if, if we if we concentrate on that difficult few months, um, over, over Christmas, um, um, as a kind of, a kind of focus for, um, thinking about how, how things have been for you and, and thinking about helping and supporting and so on. What, um, if I ask you first of all, F, can, can you say a little bit about how, how you felt, um, M tried to help during, during that time?

Yeah, it's actually easier for me to talk about more recent **[Right]***, um, episodes, just because they're more recent – I remember them better* **[But that's]***, and also because I think we've worked out how... we're better at dealing with it now than, than we used to be.*

Right, right.

Um...

Does, does that mean that perhaps helping works a bit better now than it, than it used to?

Yeah, definitely, yeah.

Is that...?

Well, I mean, only F can say.

Mm.

I mean I can, I can (4 secs silence), I can say how I feel as a result of trying to help and F's response and whether that **[Yeah, yeah]** feels better. But only F can really say **[Sure]** if what I'm doing is more or less helpful than it was **[Sure, sure]** (inaudible).

You might feel you're doing the same as what you were doing, but for me it feels different now.

Well, why don't why don't you say a little bit then about, about recent experiences of *[Yeah]*, of helping? Yeah.

Mm, well, in a nutshell, M has a go at me!

Right.

(laughter)

Would that be fair? (laugh)

That would be your interpretation.

That's how I take it anyway.

Yeah, that's your interpretation.

Because, um, I still find it very difficult to recognise the signs of when I'm going into a, a bit of a low.

Uh-huh.

Um, and I get very, kind of, stuck there (4 secs silence). And it's very isolating and, and, you know, and I know I'm behaving differently and I know I'm feeling differently but it's almost as if my brain, kind of, refuses to acknowledge that that's going on, or why it's going on **[Mm-hm]** *or whatever. And I often can't think, well, that was that trigger or... So when I'm feeling like that I tend to feel pretty negative about most things* **[Mm-hm]** *including*

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sometimes our relationship. So I'll find reasons to be pissed off with M but I'll, I'll kind of... they're fairly internal **[Mm-hm]** *but they'll probably affect my behaviour towards you. But they're not things that bother me when I'm not feeling low, so I know it's only, you know in retrospect, I know it's only because I'm feeling pretty low. And then it, I think usually it gets to a point where you get pissed off with me, and frustrated, and you'll be saying, you know, what's wrong are you alright. And I'll be going, "Yeah, I'm fine. Fine!" Until it reaches a point where...*

I say you're not fine (laughs).

Yeah, basically **[Mm-hm]***, you just have a bit of a go.*

Yeah.

And that's, that usually, although I hate it at the time.

Yeah.

Um.

Can, can, can you describe a little bit what, what, what having a go is, is like, sort of?

I feel like I'm being told off.

Right.

And I'm, I always react in a very defensive way, so I manage to tell you off for something. Because I don't want to admit that, you know, there's anything wrong or...

Mm, mm. So, so what sorts of things would, would M say to... *[Um]* **at that sort of stage?**

(7 secs silence) *Well last time he told me that, what impact my behaviour had had on other people. And he said, you know, "You don't realise what, what impact you're having and..." And that makes me think, oh god, I'm, you know, he thinks I'm really selfish and... And I'm not really aware of my impact, so... I mean, that always, it makes me get really annoyed* **[Mm-hm]** *because I feel like I'm just being criticised and told off.*

Right.

But that, I don't know how it works, but for some reason that tends to be enough to, to sort of give me the... almost like waking me up.

Right.

And something just (clicks fingers) kind of snaps and I think, you know, yeah, I'm there again. I've been, I've been depressed again.

(Interview continues)

(Transcript extract covers first 20 minutes of 95 minute interview)

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Appendix VII:

Example interview summary

Summary of first interview with Couple 1

1. Recognising the experience of depression

- In the past, F tended to keep her depressed moods to herself. She did not talk to others about feeling low and mostly did not herself recognise this experience as being depressed.

- During the early months of their relationship, F found it difficult to share her experience of depression with M, who was often left wondering if he was in some way to blame for her low mood.

- Following a particularly big argument and period of reconciliation, M let F know that he did not want to be excluded from what she was experiencing and was not prepared merely to be a "passenger" in the twists and turns of their relationship.

- As F and M got to know each other better, M came to recognise the pattern of F's depression. He was then able to help F by drawing her attention to the start of her depressive cycles and trying to identify possible precipitants.

2. Confronting

- M may confront F when, for example, he thinks that the behaviour associated with her depression is having a detrimental impact on how she is perceived by others.

- M considers that his awareness of how others may be viewing F's depressive behaviour is facilitated by his being able to draw on a viewpoint which is simultaneously "inside and outside the relationship".

- F describes being confronted in this way as M "having a go" at her. She tends to feel criticised, told off and annoyed afterwards, and arguments often follow.

- Subsequently, however, F realises, "I'm there again – I've been depressed" and her mood usually improves quite quickly.

3. Acknowledging, naming, regaining control

- F finds her and M's shared acknowledgement of her low mood helpful in regaining control of how she is feeling.

- Because F sometimes experiences her depression as "like an outside force", she feels that, by naming it, M enables her to regain a sense of control over the experience.

- M would like F to be able to acknowledge more easily how she is feeling – e.g. to be able to tell him, "I'm feeling really shit today".

4. Accepting

- M prefers to acknowledge and accept difficulties rather than ignore them – even if they can't be solved immediately.

- M has encouraged F to express whatever is on her mind without fear that he will be rejecting of her.

- F has come to trust that M is not going to be driven away by her depression. She is therefore able to feel confident in M as a source of emotional support.

5. Intervening in the right way

- M tries to avoid becoming angry and "personal" when confronting F, as he thinks that his anger gets in the way of effective helping.

- M sometimes worries after a heated confrontation that he has not intervened in the most helpful way.

- F does not experience these support attempts as unhelpful in any way. Unlike M, she does not tend to analyse his interventions afterwards.

- M has sometimes wondered if he waits too long before confronting F about the onset of a depressive cycle. He wonders if he could intervene sooner, or in ways that feel less invasive and are less likely to result in an "explosion".

- F makes the distinction between what she wants at the time (i.e. something "within [her] comfort zone") and what is ultimately helpful (i.e. being "mentally slapped around the face").

- F finds it helpful if M behaves as normally as possible towards her when she is feeling low.

- However, in F's view, there are no clearly right or wrong ways for M to behave in trying to help: she believes that being supportive comes from mutual understanding and insight into the past experiences that they both bring to their relationship.

6. What makes helping easier?

- For M, becoming closer and stronger with F as a couple makes his helping feel worthwhile, as do the things that F does to help herself in relation to her depression.

7. What makes helping more difficult?

- M finds F's "diversionary" comments unhelpful when he is trying to address difficulties in their relationship – e.g. when F says, "It's not you, it's me *etc*".

8. Sharing difficult experiences and feeling understood

- M has shared some of his own difficult experiences with F, in the hope that, through recognising similar emotional experiences, she may come to feel less isolated in her depression.

9. Being mutually supportive

- As working together doesn't necessarily present opportunities for discussing relationship issues, F and M found it helpful to book an hour's support time with each other while F's therapist was away.

- Through hearing about some of his difficult experiences, F has been pleased to have the opportunity of being supportive of M and to feel that the focus in the relationship is not solely on her needs.

10. Support in converting ideas into action

- M encourages F to pursue plans she has spoken of or to tackle difficulties she has avoided (e.g. taking trapeze classes, meeting with her mother). His attitude towards such things is "There's nothing actually stopping you".

- F finds it helpful that M doesn't allow her to "get away" with putting things off as she has sometimes done in the past. Knowing that M would very much like her to pursue some goal serves as a powerful motivating influence for F.

11. Support for M

- M does not always feel strong and has sometimes felt "left behind in the helping and healing process".

- At such times, M has found it very helpful to be able to talk to his sister about how he and F are doing.

- M's sister is able to understand F's depressive difficulties from a professional perspective, though also important for M is the feeling that she is concerned about his welfare.

- M's conversations with his sister are opportunities for obtaining emotional support rather than finding solutions, though M does also check out his ideas about helping with her.

- F is pleased that M can turn to his sister for support, as she feels this "takes the pressure off [herself] slightly". She thinks that the pressure on M might also be reduced if she were similarly able to find additional sources of informal support.

- M would like the opportunity of sharing experiences and gaining support from people in a similar situation to himself and F. He would therefore like to go with F to a Depression Alliance support group.

12. Helpful and unhelpful experiences of professional support

- M found sessions with a Relate counsellor very helpful and shared this good experience with F.

- This encouraged F to give professional therapy another go after an earlier bad experience with a clinical psychologist, whom she had found too "solutions-based". The

clinical psychologist had suggested F try breathing exercises when she actually wanted someone to acknowledge her emotional experience.

- F finds her current (non-directive) therapist far more helpful, as she is able to use these sessions to discuss whatever is on her mind (or to sit in silence if she chooses).

13. Partner support and individual therapy

- M was supportive of F's decision to seek support from a professional therapist, whom F now sees for weekly individual sessions.

- M is happy for F to share as much or as little as she wishes from these sessions.

- M does not view his role as competing with that of F's therapist but rather as providing a different and more continuous form of support.

14. Celebrating positive events

- F records positive events and achievements on a calendar. She is not sure how she came upon this idea but finds that it lifts her self confidence to have this reminder of the good things in her life.

- M is pleased that, through her use of this strategy and in other ways, F is taking responsibility for how she feels.

- F encourages M's niece to make more of her achievements (e.g. during climbing sessions). F considers that, as someone who would like to experience positive emotions with greater intensity, encouraging M's niece also serves as a reminder to herself to follow this advice.

15. Making the relationship work

- F and M have similar ideas about the factors that are important in making their relationship work – i.e. listening, sharing, feeling able to be vulnerable.

- M emphasises the importance of good communication in building trust between partners – something that he has learned from his previous experiences in relationships. For M, communication enables partners in a relationship to make choices.

- Another important factor for M in maintaining a good relationship is each partners' access to a wider support network.

16. Ideas about helping a depressed friend

- F considers that her experience of living with and trying to help a friend with depression has provided her with some insight into M's experience.

- In trying to help someone else with depression, F would share own experiences, as a way of showing that she understands and providing reassurance (e.g. about taking antidepressants). She would also encourage the person to seek professional help.

- M agrees with these ideas but emphasises the importance of additionally finding a helpful and available person in one's natural support network. A useful helper for M would be someone who is non-judgmental and can be trusted, as well as perhaps older, wiser and with similar experiences.

17. What causes depression?

- For F, the key factors in explaining why people become depressed relate to their upbringing and lack of exposure to bad events (and therefore lack of coping experience).

- M thinks that people become depressed when they fail to see a way of coping with something and cannot engage with their difficulties in a solution-focused way. He is not sure whether such a predisposition is inherited, learned, or connected with past traumatic experiences.

Appendix VIII:

Extract from transcript of a follow-up interview

Follow-up interview with Couple 1

Bold – Interviewer (I)

Italic – Female partner (F)

Plain – Male partner (M)

Um. Right, so I, as I, sort of, started to say, I guess the jumping off point is probably to hear your reactions to, um, my attempt at a summary of our first conversation. Um, but I'm very happy to, sort of, go in whatever, ever other directions you feel would be, sort of, useful or informative, really. Um, I've got a few things that I'd perhaps want to follow up a bit more, which are kind of related to the points here, but may not neatly fall in to any of the categories necessarily. Um. I suppose, you know, we were saying that it was back in August that we had our first conversation, so, er, I suppose round about five months ago, um, and with that mind I was wondering what it, what it was like, er, to, sort of, get a summary of that interview before. I wonder how you, how you, sort of, found that in a way, um...?

After you!

Um. I actually found it quite useful to remember kind of where we were at that point. It was quite nice to have a stake in the ground, um, as it were, to kind of, er, and have it kind of detailed, er, written down *[Mm]*, kind of where we were in developing our relationship and our kind of mechanisms for coping with, um, the kind of various, um, episodes, I suppose you could say. Um, and we've had, you know, four, five months since then, um, and looking back and being able to kind of compare where we are now to where we were then is probably quite a good *[Mm]*, a good thing for us to be able to do. I mean, we don't normally **[Yeah]** kind of take that kind of stock really. We kind of every now and again say something like, I don't know, you know, "When we first met" or "Six months after that" or "Last Christmas". The kind of the big highlights **[Mm]**. But they're all based on, kind of, what we thought we remember of the time and not really anything, kind of, written down. Where it's really good to get a, an external view of where we were and kind of see it all again and say, OK **[Right]**, this is fact or fiction or, you know, an external view of how we thought we were doing **[Mm]** and it's just good to be able to see that. So for me it's a, it's quite eye opening to, kind of, think, "Oh right, OK. That's where we were". And then, kind of, think forward to today and this is where we are now and what the differences are.

Sure. So, a, sort of, kind of, historical document almost. Er...

Yeah, but it's not, it's not just, it's not just historical for the sake of it just being a point in time. And I think I can hopefully say for both us, certainly for myself, that there's been some progress **[Mm]** from there to here, which may have perhaps been facilitated a bit by the experience we went through and also having to, kind of, sit and think about it and talk about it **[Mm]** in much more clinical black and white terms, rather than just kind of dealing with it. Um...

That would certainly be very interesting to hear about if that was OK. But, um, perhaps I'll ask the same question to F about how you found//

Yeah. Similar **[Getting that. Yeah]***, um. Um... I wouldn't, without this I wouldn't have been able to remember much of what we said* **[Mm. Mm]***. Um. But reading it now I think oh, you know, it's all coming back to me. It's not like, um, you know, I think it's fairly accurate* **[Right]** *summary of the conversation, the interview that we had* **[Right]***. But yeah, same as M, I just think God, it's... I think that's why I thought it must be such a long time ago because* **[Mm]** *it's almost not relevant now.*

Because it feels like things have changed so much?

Yeah. And that's for me on a personal level, obviously **[Yeah]**, *because I'm now off my anti-depressants* **[Right]**, *um, and feel, you know, ten times better in myself. But also, as you've said, from the point of view of our relationship, it's really good to, kind of, think, God! It almost seems like we were really naive and (laughs) and kind of really young with each other then, but I feel like we've moved on a lot since then. So I mean exactly the same as M* **[Mm]**, *I just think it's a really nice stake in the ground.*

Yeah, yeah. Was there… did you, I suppose it's perhaps slightly difficult to know in some respects, I mean, there's a sense of things having changed for you, um, so some of this may not represent how things are now *[Mm]*. **Did you read any of this and have a sense that, that I'd got it wrong, in a way, that in trying to, sort of, summarise or bring out bits that didn't, it didn't map with what you thought, with your memory of what you were saying at the time?**

Not that I can remember, no.

No.

Er, no, not for me either. I mean it, as I said before, it's a really good, kind of, black and white written down synopsis of, kind of, how we were feeling and what we were doing at the time. So it's, I don't, I don't, you know, nothing here, um, seems, kind of, odd or sticks out as being, "Oh, I didn't say that. I don't remember feeling like that" *[No]* **[Mm]**. It's, it's a really good representation I think.

It made me laugh! (laugh)

Right!

Why did it make you laugh?

Well, I can remember really clearly saying things like, um, the having a go thing **[Yeah]**. *I don't know, it's just funny now. I mean, I don't disagree with that. I would still say the same thing* [Mm]. *I would describe it in the same way. I suppose, you know, had you come round today and our relationship wasn't going so well or whatever, then this might actually be quite difficult to look at. But because things have been going well* **[Sure]** *it feels quite good//*

It was quite sort of *[to read it]* **positive…**

Yeah. And I think it was a good experience for us to have gone through [Mm] *just the actual physical sitting down with you and talking* **[Right]** *and having that opportunity, which we don't, well, I suppose we could make it ourselves, but we haven't done. Um, I think that was a really helpful process for us to go through.*

But I don't think since August we've just, kind of, we went to sleep the evening of being interviewed by [I] woke up today and it was all hunky-dory *[No]*. I think there's been *[Yeah, you know, we've worked at it, but]*, there's been, yeah, there's been… It'll still be part of a journey.

Mm. Mm

And it still is. We're still on it.

So, that's quite a, it's quite good to be able to say well, you know, "There's, here's another station, here's another station" or *[Mm]* "We're going backwards a bit" or whatever. So it's good.

Great. Um, I'm thinking that some of my questions might be more difficult to answer given that things have changed from where they *[Mm]* **were now. I mean, I'll perhaps explore some of them with you in any case, but, um, maybe a more sensible starting point is then for us to talk about, um, how things have changed in relation to perhaps**

to some of the things here, or, um, maybe in more, in more general terms. I, sort of, hand that over to you, to you really, however you want to, to answer that. Um…

How do you mean? Do you mean in terms of, um, episodes, in terms of coping, in terms of… Is there, is there a structure, or do we just…

Well, I [talk, talk round things?], I don't know whether… There's a sense that some of these things represented, um, your ways of managing things, say, five months ago, and that, um, either some of them have become irrelevant now, um, I don't know because perhaps F is feeling better, or because you found other ways of managing things. I'm not, I suppose I'm, that would be something to…

I don't think they've become irrelevant. I think one of the good things I've noticed that F needs less of, kind of, prompting, if that's a phrase to describe kind of my role previously **[Right]** in taking the step to do something **[Right]**. So if we take an example of we went to visit your mum and dad and, you know, what your mum said and *[Mm]*, you know, you were, not visibly, I would say, upset by it, but there was something in there *[You knew I was]*. Yeah, I knew you were. But you weren't kicking everything or anything like that! You were fine about it, or not visibly upset, rather. Um, and then you came back and you… what seemed to me as you, kind of, thought about it and decided what your plan of action was going to be, then you just did it, is, is different to how maybe *[Mm]* it would have been before. I think maybe before something that might have triggered something for you to, kind of, get, to take what happened *[Mm]* and, and do something with that inside yourself and then cause something else to happen to you externally, which I'm then thinking, well, I don't really know what's going on *[Mm]*. And then start one of these, you know *[Yeah]*, one of these types of episodes. So I think you, you just dealt with that without, you now… You, kind of, checked with me to, kind of, say, "Well, I'm, kind of, feeling this" or "I didn't feel so good about that". Um, "This is what I'm going to do about it. What do you think?" Which is, and I'm just like, "Well, yeah, that's cool". So, do you see what I'm saying? *[Mm]* So that's I think that's different to how maybe it might have been *[Yeah]* previously. And part of that's maybe due to, um, speaking to your, your HD about those kinds of issues//

HD is [Head Doctor] Head Doctor.

Right!

Sorry!

I'm not allowed to call him a shrink!

Yeah, so we call him, call him head doctor! (laugh) Speaking to HD about it on a regular basis and then just formulating, you know, yourself just a way of, kind of, getting on with it. So I think that's, that's changed, um, which I'm, you know, I'm impressed. I think that's really good.

What's your sense of that, F?

Yeah, I agree. Um. God, it's a really difficult question to answer because actually so much has changed.

Yeah. Sure.

Um. I mean, I've learnt a lot more about how to deal with things myself so that perhaps it doesn't get to the stage where M needs to do the kind of things that we were mentioning before **[Yes]** *I mean I, the big thing for me in this was the discomfort of getting a slap around the face, but* **[Mm]**, *a mental slap around the face* **[Mm]** *but, um, the kind of impact that that had was really good* **[Yes]**. *But I don't feel that I've needed that so much, partly because… partly because I haven't been feeling so low anyway* **[Mm-hm]**, *um, maybe because I haven't… I've been able to control that process a bit better because I recognise it a bit more. So I can, kind of, stop it before it get, you know, before I start to kind of plummet too much. Um* **[So]**, *but also* **[Yeah]** *I think I, you know, have learnt to trust you more and*

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more as well. So I can, it's easier for me to say, you know, "This is a, this is pissing me off and I want to do something about it". That, I don't know, just comes much more naturally.

That, that reminds me of something that, um, M said in the first interview, um, it may even be written down in one of these sections somewhere here, um, about hoping that you'd be able to get to a stage *[Mm]* where you could say that this is, you know, this is pissing me off *[Yeah]* or, um, without, sort of, things needing to move, sort of, so *[Yeah]* so far along. Is that...?

Yeah. **[Is that...?]** *I won't say we're there 100% but...*

No. I think, I think that's, that's the biggest change for me, um, in being, I mean, reflecting what F is saying, in being trusted that I'm not going to explode necessarily or I'm not going to, you know, just have a big issue with something you're saying, when you've got as much right as anybody else to say, "Well actually this is how I think or feel" or don't or whatever *[Mm]*. And we should, and we, kind of, just kind of get on with that. Um, and we don't kind of hold any grudges or take it out on each other too much or anything, which is going to be, kind of, have a lasting, kind of, effect *[Mm]*. I mean, we kind of get a bit, I mean, you know, I think I said to you (inaudible) I just, just go really quiet and I shut up for a bit and then it'll be fine. But it's not a big, you know, we don't, kind of, exhibit that kind of behaviour where we're very, um, I don't know, disrespectful of each other **[Mm]**. And if one of us is in a mood or unhappy or whatever, then that's fine. It's OK to be in a mood and unhappy, it's not a big deal. You know, as long as it's not, er, a symptom of something else or a long lasting thing which has to be kind of more looked at. But if it's just, you just, kind of, wake up and you're feeling a bit, well, you've eaten something, or you just feel tired today, whatever it is, then you just, so what? It's like, so what? No big deal. Um, and we'll kind of both allow each other, you know, "I don't want to get out of bed today" or "I don't really want go to trapeze today" or **[Yeah]** whatever it is. And it's kind of allowing each other to, kind of, get on with it, I think.

It's, kind of, bit... communicating your sort of emotional experience but being quite dependent on trusting the other person's reaction [Mm] *[Mm]* in relation to that, that it won't become, um, sort of more than an issue that it is [Mm] in a way. That it's...

Sometimes we find we actually feel the same, but we just haven't said it to each other. We both, kind of, don't want to say. I mean, you know, every, every week we tend to go to a particular, to a particular type of sport, trapeze, for instance on a Sunday. And then I'll get up on a Sunday morning and think, "Oh god I really can't do this" but I don't want to let F down **[Mm]** so I'll just kind of go along with her, "Right, we're getting ready" **[Mm]**. And F, you know, we'll get to, I don't know, quarter to two, we've got to leave by two, and F will go, "I don't really want to do this" and I'll go, "Oh great! I don't want to do it either!". And we just don't do it! But we haven't, do you know what I mean? But it's, and it's not a big deal **[Sure]** but you still, kind of, feel, or I still, kind of, feel a bit, sometimes, I want to... don't want to let her down **[Mm]** but it's easier for me to say, "I don't really want to do this". And if she says we are going to do it, we're not going to do it, then we just, you know, we'll cope with it at the time. It's not a big saga. It's not a big drama.

We don't have dramas.

Yeah, damn! We should have a few more dramas! (laughter) Well, we do//

Well, yeah, we've had a few whoppers but [Yeah, we've had, yeah] *not recently!*

(inaudible) Well, (inaudible), I mean there's been some things happen... there is, kind of, the other side of this is *[Yeah]* in, in, there's been some things happening in my family life, so my sisters and my mum and dad and stuff, my brother, which F has been the support person for me in those circumstances. Whereas **[Sure]** maybe four five months ago there were some things happening for F which I was helping her with. So that's kind of *[Mm]* enabled a balance to be struck or **[Sure]** re-established rather, which I found really, really

useful for me. Not, I think it says in one of these things, not wanting to, kind of, be seen as, um, or F was, kind of, saying that she didn't want to, kind of, see it all being F's **[Mm]** in the, in the, F in a spotlight and me just kind of helping. It's kind of turned it the other way round as well. So I think that's been quite a useful re-balancing of the whole, the whole thing.

Yeah, definitely.

Sure. Sure. I mean, ah, there does… and I think, um, one or other or perhaps both of you said at the end of the last interview that communication seems to be fairly near the top of the agenda *[Mm]* **for help and support, really, in relation to times when you've felt depressed. Um. There's a sense that, that things have, things are better now, um, in relation to F's depression, that's sort of retreated so, but if I ask you to sort of think about, um, it sounds like there's something about being depressed that disrupts communication** *[Mm]* **that makes it more difficult. Um. And I don't, I don't know, maybe, maybe you could say a little bit about what your sense of that is. I mean, I know we've, we've probably touched on it in a number of ways already. But I don't know whether, I don't know, what are your thoughts now in relation to that?**

The experience of depression is still very isolating **[Yeah]**. *I mean, thankfully I haven't felt particularly bad in the past few months. Um, I mean, it's difficult sitting here now to know that if next week was a bad week and I felt bad, you know, how we would deal with that. We haven't actually had to deal with it for quite a long time* **[Yeah]**. *Um, I don't know, I mean whenever I'm feeling good I always hope that the next time I feel bad I would be able to communicate about it better* **[Mm-hm]**, *and there wouldn't be anybody else I would talk to apart from M about it, and my head doctor. And I know that I can, you know, in my head I know that I can trust M and he's not going to run away and he's not going to reject me because I'm feeling bad or whatever. I still think I wouldn't find it all that easy* **[Yes]** *but I would hope that I would be able to, you know, given everything that we've been through in the time that we've been together now and the understanding that we have of each other, and your track record, I would hope that, you know, I would, it would be easier* **[Sure]** *but I'm, I still don't, you know, it still wouldn't be… the easiest thing, I don't think.*

Sure. So, feeling depressed and finding it hard to, to communicate something of that are quite//

Well that's the, yeah **[sort of, they're quite interwoven]**. *Yeah, and that's probably the biggest problem* **[Yeah]** *is, I mean, it's, sort of, catch 22 that the hardest thing to do is the thing that would, you know, pretty much take the problem away* **[Yeah]**. *And I know that in my head* **[Yeah]**. *But I don't know what it is about depression but it is… I don't know, I suppose you get so caught up in what's going on in your own head that it's difficult to get that out in some way* **[Yeah]**, *particularly, you know, once you've, sort of, allowed yourself to go quite a long way into it.*

Sure. So, something about the difficulty of putting the experience into words that, that perhaps words aren't quite adequate to… yeah *[Yeah]* **to get across what that experience is, in a way (inaudible).**

Which I th…, I mean, is linked to, um, the issue I have anyway generally about dealing with emotion, and being fairly unable to express that verbally or otherwise, or even just allow it to be there **[Mm]**. *I mean, that's, that's, I don't know whether that's common amongst people with depression but that's certainly my problem* **[Sure]**. *And when the emotion is that extreme then it's even more difficult to, you know, do whatever, do something with it* **[Yeah, yeah]**, *so you just end up, kind of, stuck with it.*

Yeah. What are your thoughts, M?

Um. I think my thoughts are, there's probably two or three things in there. One of them about the communication side is, I think my, my take on it is as the person who's outside of

the, kind of, outside of the experience, it's kind of my job to be, to open as many communication channels as possible, so that whichever you decide is comfortable for you, then you can take it. So if that is to talk, or if that is to write something down, or if that is to, you know, whatever it is, you know, then my job is to make sure that *[Mm]* none of those are closed and that you can choose whichever one you want which makes you comfortable at the time. Because, I mean, you may not want to talk, but you may want to write it down, you may not want to...

I can think of two instances when that has worked for us. I don't know if you've been aware of how significant (laugh) they've been [No]. *When, um, we didn't win a piece of business before Christmas, I think it was the, I can't remember which one it was* [The one with (name)]. *Yeah, and it just so happened that M was at home that day. I don't know why you weren't at school? I can't remember* [I was probably too lazy! (laugh)] *But we were both in the same place, so he was there when I got the e-mail to say that we hadn't got this piece of business* [Yeah]. *It was the Giving Campaign, because it was the second* [Ah, OK] *in one week that we didn't win. Um, and I was just really pissed off about it, and I knew that, the first one we didn't win the previous weekend, I'd felt pretty bad that weekend. And, you know, here it was again the ne..., the very next Friday – I'm being told again that we haven't won a piece of business. But because you were there, you just told me to stop work and we just went and lay on the bed for an hour and cuddled. And I had a chance to say whatever, I don't think we even particularly talked at length. But just the, because I'd been allowed an opportunity to express how I felt* [Mm, mm] *then it didn't, you know, I managed to get rid of, well not get rid of it, I don't... well yeah, get rid of it, so that it didn't become a burden* [Sure] *longer term.*

A sort of intervention at the right time.

Yeah. But it wasn't, you know, let's sit down and have a really logical, kind of [Sure], *I mean, I don't why you, how you sensed what it was that I needed.*

Um. Part of that is over time getting used to you.

(Interview continues)

(Transcript extract covers first 22 minutes of 78 minute interview)