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Through their eyes: Exploring the experiences of individuals living with a person with depression

Blaze Kidron-Style, Kerem Kemal Soylemez *, Joanne Lusher and Ana María Carretero-Resino

Regent's University London, Inner Circle, Regent's Park, London NW1 4NS United Kingdom.

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Abstract

Those living with individuals with depression often have an important role to play in providing care to a family member. This can impose stress and burden on the caregiver. Despite an abundance of research focusing on individuals with depression, there is little research available in the literature on individuals living with a person with depression. The purpose of the current study was to explore the lived experiences of these individuals. A qualitative design using an Interpretative Phenomenological Analysis was employed to address this area of inquiry. Semi-structured, in-depth interviews were conducted with five individuals living with a person with depression who were recruited using purposive sampling. Three superordinate themes with several subordinate themes were identified from the collected data. The superordinate themes were: 1) the change in perspectives about depression and the person with depression; 2) the impact on personal, social, and professional lives; 3) coping strategies and resilience. These findings underpin how living with a person with depression can significantly impact personal relationships and daily lives of those around them and the range of emotional and social challenges faced by family members. Caregivers must develop strategies to cope and find inner resilience. This study contributes a richer understanding of the perspectives of caregivers and identifies a need for proper widespread support. Future research could aim to develop tailored interventions that address the challenges faced by caregivers of people with depression.

Keywords: Depression; Mental Health; Caregiving; Qualitative

1 Introduction

Depression is a common and often debilitating mental health illness [1]. The World Health Organisation ranks Major Depressive Disorder (MDD) as the fourth leading cause of disability worldwide [2]. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5; [3]) outlines the criteria for a depression diagnosis. A patient must display at least five of the following symptoms, one of the first two symptoms listed must be present for diagnosis: 1) Depressed mood most of the day nearly every day, 2) Diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, 3) Diminished ability to think or concentrate. 4) Feelings of worthlessness or excessive or inappropriate guilt, 5) Recurrent thoughts of death/ suicidal ideation, 6) Insomnia or hypersomnia, 7) Significant weight loss when not dieting or weight gain, 8) Psychomotor agitation, 9) Fatigue or loss of energy. For a diagnosis, a minimum of five symptoms must occur at the same time within a two-week period, indicating a change in previous functioning. These symptoms must significantly disrupt the individual's life in social, work, or other important areas for a positive diagnosis. Additionally, symptoms should not be the result of a substance or another medical condition. The severity of depression is based on the number and intensity of these symptoms [3].

Depression can affect an individual's life in a number of ways. A notable functional impairment for people with depression is a decrease in work productivity, stemming from absenteeism [4] as well as presenteeism as individuals with depression may develop poor job performance due to the concentration impairment and feeling fatigued due to

* Corresponding author: Kerem Kemal Soylemez

the depression [3]. It is also linked to impairments in several areas affecting quality of life, including perceiving stressors as worse, and less perception of events being positive or uplifting [5]. As a result, those with depression tend to have lower overall quality of life.

Informal caregiving can be defined as providing care to a person with an illness or disability, and not a paid job [6]. Individuals living with the care receiver tend to have higher demands placed upon them. Those living with a Person With Depression (PWD) often result in these informal caregiving roles. In 2021/22 in the UK alone, 7% of the population provided informal care and around 60% of those were women [6]. Around 90% of individuals with severe mental illnesses are assisted/cared for by a family caregiver every day [7]. However, there is a lack of availability of clear statistics on how many people care for individuals with depression.

Coyne's [8] Interpersonal theory of depression suggests that individuals with depressive symptoms engage in maladaptive interpersonal behaviours. Although these behaviours aim to moderate distress, they often end up pushing away social support, thus intensifying depressive symptoms. Key behaviours identified by this theory include excessive reassurance seeking, negative feedback seeking, and conversational self-focus [9]. These behaviours and communication patterns can eventually lead to a cycle of negative interactions with those they live with and may affect not only the quality of these relationships, but also can exacerbate the depression itself. This theory highlights the reciprocal nature of interactions in the home where depression is present. Individuals living with a PWD may find themselves in a complex situation where their attempts to provide support are met with the depressed individual's patterns of negative feedback seeking and excessive reassurance seeking. This may lead to exhaustion within the relationship as the caregiver has to navigate the many maladaptive behaviours of the depressed person [10]. However, this theory does not come without criticism. There is a debate around whether social skill deficits and interpersonal problems may be consequences rather than the cause of depressive symptoms, thus challenging the directional assumptions of Coyne's model [11].

Badger [12] further sets out a three-stage framework for the social psychological process of family transformation when a family member has depression. The process encompasses the cognitive and behavioural changes happening within a family from the onset of a member's depressive symptoms through to their recovery and remission. As family members navigate through the three stages of family transformations, everyone in the family undergoes changes, leading to alterations in how the family operates. The first stage is *acknowledging the strangers within*. When family members initially recognised the significant changes in the member with depression, as well as in other family members and the overall functioning of the family. The second stage, *fighting the battle* refers to the daily efforts of family members to cope with changes in the family's interactional dynamics that emerged in the initial stage, which were seen as different from the patterns of interaction before the depression. These altered dynamics were viewed as harmful to every facet of family functioning, including communication and problem-solving. Finally, *gaining a new perspective*, involves redirecting attention from the member suffering from depression towards themselves and other family members, as well as altering the dynamics of interaction between the family and the individual with depression. As family members transition into this stage, they were reported to have experienced a sense of losing themselves and mourning the person they once knew. This stage of gaining a new perspective was characterised by efforts to preserve well-being, shifting focus onto others, reshaping the relationship, and cultivating a sense of hope. Whilst this model provides a useful framework to understand the process of family transformation when a family member has depression, it does not consider cultural differences in family structures and coping mechanisms. However, cultural factors can have a significant influence on how a family understands and manages depression within the family and therefore a one-size fits all approach is not suitable for all family contexts [13].

Furthermore, presence of depression in a family can deregulate normal familial roles. For example, depression of children and adolescents can impact family functioning and change the family dynamic. Research suggests that parents of depressed youths report higher levels of parenting stress and lower parent wellbeing [14]. Furthermore, Seeber, et al., [15] found that when observing videotaped problem-solving interactions, parents of depressed adolescents made significantly more negative attributions for their child's behaviour than those of non-depressed children. These attributions tended to be associated with more aggressive and less facilitative parenting behaviours. During depression, families often go through transformation trying to understand what is happening, and they develop protective and coercive strategies, as well as finding new ways to relate to the depressed person [12]. Badger [12] and Nosek [16] identified that relatives of depressed people develop a constant vigilance that intensifies or decreases in or between depressive episodes.

The dynamics of relationships can be profoundly altered by living with a person with depression. This may be particularly prevalent in romantic relationships. For instance, there may be a decline in intimacy levels when one of the partners has depression [17]. Additionally in problem solving situations, couples where depression is present

demonstrate more negative behaviours such as complaints and self-derogatory statements [18]. Harper and Sandberg [19] examined 614 couples in long-term marriages, lasting on average 36 years, to determine whether depression in one or both partners links to poor affective and problem-solving communication. The results of this study indicated that when husbands and wives were more depressed, both affective communication and problem-solving processes were impaired for the couple. However, it is not possible from this study to conclude whether poor affective and problem-solving communication processes lead to the depression or whether the depression subsequently leads to these issues. Nonetheless, it suggests it is likely that there is a reciprocal relationship where depressive symptoms and poor communication dynamics within a marriage mutually reinforce one another.

Moreover, the roles in households need to be reorganised to adapt to the needs of the person with depression [20, 21, 22]. This includes the need to take on extra responsibilities, including those that typically belonged to the person with depression. For example, when a child has a parent with depression, they may end up being the one looking after the parent and the parent ends up taking a child-like role [22]. The children may also end up taking on responsibilities that wouldn't generally be theirs, such as looking after younger siblings or helping more around the house [20]. For romantic partners, this role reformation can come in the form of going from equals to the depressed partner taking on a child-like role and the other a parental role [23]. This change is often accompanied by a reduction in both emotional and practical support from the partner who is depressed [24]. Oliffe, et al., [25] found three key couple patterns between heterosexual couples with the male partner having depression. The predominant theme identified was *trading places*, which highlighted how couples frequently adopted unconventional gender roles as a means of coping with depression. The *business as usual* approach was driven by a tacit agreement to maintain traditional masculine and feminine roles to mask the presence of depression. Meanwhile, the "edgy tensions" scenario exposed a disparity in gender role expectations, leading to feelings of bitterness and strains in the relationship. All these changes in relationship dynamics may cause dissatisfaction in the relationship.

Those living with a person with depression often become unofficial or informal caregivers. This is especially relevant in the UK where policy places preference on caring for mental and physical illness in the community, putting more pressure on those living with ill people and leading more to become unofficial caregivers [26]. Following the process of deinstitutionalisation, it has been observed that in the West, family members have become the primary provider of care to those with mental illness [27]. Compared to the general population, caregivers for individuals with a chronic illness have been found to bear a significantly higher burden, both economically and in terms of quality of life [28]. This burden intensifies even further for those caring for adults with depression [29]. This highlights the extensive impact depression has not only on the patients themselves but also on their family members who provide care for them. The emotional burden often experienced by these caregivers may stem from the unrelenting vigilance required when living with someone suffering from depression [16].

Caregiving can also affect work participation due to caregiver hours because of various factors, such as the amount of time the person with depression needs caring for, as well as the dependency of the person with depression on the caregiver [30]. This may lead to economic burden to the caregiver due to reduced hours at work as well as impact on quality of work impacting on their career [31]. The intensity of caring commitment may also influence the level of economic burden felt. Carmichael and Charles [26] found that informal caregivers caring for people for over 20 hours a week were less likely to undertake informal employment than those working less than 20 hours, and when they did, they tended to earn less per hour and worked less hours per week. However, some research has suggested improved work participation as a respite from their caring duties. The severity of symptoms because of a mental disorder often is reported as the main factor that places burden on the relatives [32]. However, according to Östman, et al., [33] the factor that is more important than the level of diagnosis is if they are living with and are close to the person with a mental illness.

Relatives have reported experiencing not being taken seriously and being disregarded by healthcare professionals [22], and they expressed being left with all the responsibility for the care of the depressed person [21]. Such experiences with healthcare services are said to exacerbate the challenges encountered by family members [34]. Therefore, it is crucial that family members receive support for their own well-being. [35].

Despite the significance of caregiving consequences, there are few qualitative studies focusing on the individuals living with a person with depression [36]. Most studies focus directly on the person with depression themselves or on caregivers of people with physical illness or disability. Where mental illness is the focus of research, much of it focuses on schizophrenia and bipolar disorder [37, 38, 39]. Where qualitative study on the caregivers of depression has been conducted, it is often focusing on one relationship like romantic partners [25, 24]. As such, there is limited research exploring the experiences and points of views of the individuals who live with a loved one with depression. The aim of

this study is to explore and understand the lived experience of individuals living with a person with depression. It aspires to uncover new knowledge in this area that has been under-researched.

The present study aimed to explore and understand the lived experience of individuals living with a person with depression and to uncover new knowledge in this under-researched area. The overarching research question in the current study was: *What are the lived experiences and emotional impacts of individuals living with a person with depression?* The key objective of the present study was to gain insight into the experiences of those who live with a person with depression.

2 Material and methods

2.1. Design

Qualitative research allows researchers to delve deeper into real-world problems and provides richer insights into people's behaviours, attitudes, and experiences. These phenomena may be difficult to accurately capture quantitatively, whereas qualitative research allows participants to explain what they are thinking and feeling and why [40]. Unlike quantitative methods that rely on numerical data, qualitative research uses open-ended questions, to facilitate a dialog that allows individuals to express their inner thoughts, feelings, and perceptions in their own words [41]. This method of study gains a wealth of data that is rooted in the participants authentic experience. Interpretative Phenomenological Analysis (IPA) was selected as the research approach for this investigation. IPA allows qualitative researchers to investigate how people make meaning of significant life experiences [42] and offers a detailed investigation of a particular subject. IPA was chosen for this study in order to gain an in-depth understanding of how individuals living with a person with depression make meaning of this experience.

2.2. Participants

A sample of five adults who currently live with a person with depression were interviewed for the current study. All participants were given pseudonyms in order to protect their anonymity. Smith, et al., [42] suggest a small sample size for IPA to allow for a detail study of each individual case and focuses on depth of understanding as opposed to breadth.

2.3. Data Collection and Ethical Considerations

Ethical approval was obtained from the University Research Ethics Committee. Diligent efforts were made to comply with the ethical policies of the University and adhere to the strict guidelines when conducting research set by the British Psychological Society [43] Code of Ethics and Conduct. Interviews were conducted online via video chat to facilitate remote participation and make it more convenient for participants. Throughout the interviews the interviewer took notes to capture additional observations. Video and audio recording was utilised to capture the interviews to allow for more accurate data collection. All participants were given information sheets prior to interviews and debriefed after interviews.

2.4. Data Analysis

Guidance for IPA [44] was followed throughout the analysis. This approach allowed for an in-depth exploration of participants' lived experiences and subjective interpretations of living with a person with depression. First the researcher read and reread each transcript whilst simultaneously listening to the recording to become familiar with the data. Whilst doing this, initial notes were taken to capture any first thoughts or impressions. Next, analysis involved engaging in line-by-line coding. This detailed coding identifies significant statements in the text. These initial descriptive codes focused on describing the content without interpreting their meaning. Following this, codes were grouped into clusters based on shared characteristics or meanings. Themes were then identified and developed from the initial notes and listed in the margins. Connections were formed between the emergent themes, to uncover some of the most interesting and important aspects to develop subordinate themes. These steps were then repeated for all interviews one by one. Patterns across all cases were identified to establish superordinate themes.

3 Results and discussion

Analysis of the data led to three superordinate themes being developed with additional subordinate themes (See Table 1).

Table 1 Themes

Superordinate themes	Subordinate themes
I used to think depression was... but in reality...	False impressions about depression The cost of depression on relationships
Living with them is a bit of a rollercoaster	Impact of others' depression on me Being faced with social isolation Negotiating professional lives
There is no manual, I wish there was	Clinging onto a support system Coping mechanisms I didn't know my own strength

3.1. "I used to think depression was... but in reality..."

This theme was derived from the participants expression of how living with a person with depression has changed their view of both depression as well as the person they live with. Individuals who are living with a PWD often go from a superficial understanding of depression to a more nuanced understanding as a result of their lived experience [45]. This theme depicts that shift from the initial misconceptions or oversimplification of what depression is, to a more nuanced understanding after having lived with a person with depression as well as the shift in their personal relationship with the PWD.

3.1.1 *False impressions about depression*

Participants described how living with a person with depression had changed their view of what depression was, or that it manifested in a way that was different from what they expected. Some common misconceptions about depression include the beliefs that the person should "snap out of it", or that it is because the person has no willpower [46]. These misconceptions can lead to stigmatisation and discrimination of people with depression [47].

Participants highlighted how they had previously perceived depression as a milder emotional state, something that quickly passes on, similar to feeling sad or down. This is a view that is common among those who have either not experienced depression themselves or don't know others with depression and contribute to stigma towards depressed people [48]. However, this had changed since living with a person with depression.

Other participants acknowledged how they had gained a better understanding of depression, suggesting their initial understanding was limited or based on misconceptions, which is common when people first encounter mental health issues. Despite this increase in understanding they also admit to the realisation of how little they still know. This highlights the complexity of the condition, countering the common misconception that depression is a simple one size fits all condition [49].

3.1.2 *The cost of depression on individual relationships.*

Participants discussed how depression had affected their relationship with the PWD. As highlighted by Coyne's interpersonal theory of depression [8], it can have an adverse effect on relationship dynamics because depressive behaviours can elicit a negative response from others, which may create a self-perpetuating cycle where the behaviours of the depressed person lead to an increase of interpersonal conflict. Findings from the current study showed romantic relationships were affected by a role reversal, with participants describing their partner taking on a childlike role rather than that of an equal.

Participants talk about the way this change in dynamic had shifted the way they viewed their partner, less as a romantic partner and more as someone they needed to supervise. Additionally, participants indicated that as a result of these relationship shifts, the intimate or romantic side of the relationship was no longer present. Lack of intimacy is attributed by one participant to the medication and mood and lack of interest of the depressed person. Research into antidepressants supports this assumption as all antidepressants have a negative effect on sexual functioning including a lack or loss of sexual desire [50]. Others attribute the lack of intimacy to the way they view their partner differently and their loss of attraction [17]. Lack of sexual functioning can be a result of a chemical imbalance as well as the strain that depression puts on a relationship [51].

Interestingly, for mothers, the shift in dynamic manifested in challenges around how to perform the role they already had rather than a reversal of roles. Mothers felt like their job was to look after their children or even “fix them”. This instinct to over protect may come from a fear about the child’s well-being leading to the mothers being over involved in their child’s life. Mothers of depressed children may fear they will hinder their child’s development by overprotecting [52].

Participants with depressed children talked about the complexity of parenting them. This involved reconsidering their parenting style by adapting to meet the child’s needs. Research suggests that overprotective parenting does have a positive effect on increased depressive symptoms in children [16] supporting the reflections by participants on their parenting challenges and adaptations. Relationship changes between parent and child involved more introspection about how the parent may be affecting the change. Whereas with a partner, the responsibility was placed on the person with depression. This may be because mothers feel it is an extension of a role that they already have rather than a shift in dynamic [53].

3.2. “Living with them is a bit of a rollercoaster”

Living with a PWD meant a change in lifestyle, this included personally, socially, and professionally. Radfar, et al., described these changes as a “turbulent life” reflecting the burden put upon family of a person with depression [54]. Many studies have highlighted the burden put on caregivers including the emotional [35], feelings of social isolation [55] as well as professional and economic burdens [56]. This theme encapsulates how participant’s experience these burdens and the impact it has on their personal, emotional, social, and professional lives.

3.2.1 Impact of others’ depression on me

Feelings that participants had to always put the other persons needs ahead of theirs were often conveyed in the narratives. This came in two forms, firstly, constant availability to the person and constant vigilance. Similarly, previous research suggests that people with depression felt they were “not living their own lives” and that the stress of constant availability and constant vigilance was like a constant shadow of their heads [57]. Participants in the current study describe the emotional toll this takes on them. The participants talked about a range of emotions such as fear and anxiety as well as feeling overwhelmed.

Expressions of readiness to leave whenever the other person wants them to, were voiced. This reflects the profound level of commitment to the wellbeing of the PWD. Similar findings were reported in the literature with participants describing being on call 24 hours a day [22]. It also underscores the unpredictable nature of depression and the demand it takes on the caregivers’ emotions and time. However, this dynamic may severely disrupt the caregiver’s life as it means they are constantly prepared to leave where they are to provide support.

The emotional impact of living with a person with depression was loudly heard in the interviews. Many studies have highlighted the emotional impact that caregiving has on caregivers which can lead to depression, anxiety, and stress [34]. The participants talked about a range of emotions such as fear and anxiety as well as feeling overwhelmed.

The daily demands of living with a person with depression do not only take up a lot of the caregivers time, but also their emotional reserves. This is in line with previous research that suggests caregivers of depression often experience a wide range of emotions including those of frustration, anger, responsibility, unhappiness, and despair [58]. This emotional burden is particularly prevalent for female caregivers [59] and as a result they have lower levels of life satisfaction [60].

A part of emotional burden that is particularly enhanced for those living with a person with depression is the fear around suicide and self-harm [52]. Participants highlighted the emotional toll of the individuals with depression bringing up thoughts around suicide or self-harm. This ongoing fear may stem from the unpredictable nature that depression has [61]. For caregivers, this can mean that they are always on edge, even in seemingly calm periods. Priestly et al. had similar findings with participants describing being on “red alert” and “on guard” at all times [17]. McLaughlin et al. found that living with someone with suicidal thoughts increased stress levels, feelings of helplessness and insecurity and fears of suicide attempts in the future [62].

3.2.2 Being faced with social isolation

Several participants highlighted the effect of living with a PWD on their social life. Living with a PWD can influence the caregiver’s social interactions and connectivity as they adjust their social life to accommodate the PWD’s needs. Given that one key symptom of depression is loss of interest in activities this can create a cycle where the caregivers social life is increasingly restricted leading to isolation and increased risk of mental health issues [63].

When the couples joint social life become hindered, it can impact their relationship and sense of well-being. These findings confirm observations by others that higher demands on family caregivers are associated with an increase in loneliness and a decrease in social contact [64]. Given that it is a common factor of depression that there is a diminished interest in socialising [8], it is likely these effects are even more exacerbated in caregivers for depression.

3.2.3 *Negotiating professional lives*

Adjusting professional lives in order to accommodate the needs of the person with depression and be present for them was something that came through strongly in the narratives. According to research, 60% of caregivers have to juggle unpaid caregiving with their responsibilities at work, with many forced to cut back hours, take leaves of absences, or leave their jobs altogether [65]. Participant's adjustments ranged from modifying work schedules and responsibilities to making significant career changes. Some participants left their jobs altogether, whilst others reduced their hours or commitments. These decisions exemplify the sacrifices that participants felt they were forced to make, which can in the long term affect their career prospects. Research into informal caregiving suggests that a professional and economic burden is put on the caregiver [66]. There is significant evidence that caregivers are more likely to work less hours than non-caregivers as a result of them adjusting their work hours [67]. Furthermore, not only are women more likely to be caregivers, but also female caregivers' wages and work hours decrease more as a result of the caregiving than male caregivers do [26]. While these sacrifices participants made were often felt to be necessary, they come with long-term consequences for the caregivers' careers and economic stability.

3.3. "There is no manual, I wish there was"

This super-ordinate theme explores ways of coping and getting through the challenges that come with living with a PWD. Previous themes have examined these challenges and how the experience of caregiving for someone with depression is complex and unpredictable. This theme encapsulates how the caregivers seek to maintain their own wellbeing. The insights the participants shared underscore the necessity of having support systems, coping mechanisms and personal resilience in finding a way through the challenges of living with a PWD.

3.3.1 *Clinging onto a support system*

The need for support emerged as a theme where participants spoke about looking for and relying on external support. This came in the form of family, friends, and professional support. Social connections can significantly influence caregiving outcomes and improve life satisfaction of caregivers [68]. Participants felt they appreciated when family and friends offered support or were willing to listen. Participants cited the importance of having a supportive friendship and family network. The act of intentionally seeking a support network highlights not only the importance that caregivers put on having one, but also the proactive steps they must take in order to feel like they are not dealing with it alone. Social support is one of the leading predictors of caregiver health [69]. Actively seeking out support networks is positively associated with caregiver mental health [70]. Caregivers of depression often seek out social support [22] while others avoid socializing to avoid stigmatization [21].

3.3.2 *Coping mechanisms*

A range of coping strategies were expressed in the interviews. Most strategies were practical, including getting out of the house, having coffees with friends, doing some things like art or spending time away from the depressed person. Caregivers must often take proactive steps to manage their own wellbeing as well as the "cared for" person's wellbeing [71]. Participants expressed that these coping mechanisms were not only important for their own mental health but also for them to feel they could be effective in their caregiving role. These participants highlight the crucial coping mechanisms of self-care. They emphasize that breaks are necessary and engaging in activities such as art, going for coffee with friends bring joy. Having space away from the caregiving duties can mitigate the emotional toll and burden that arises from their position. Ahlström, et al., similarly found that individuals living with a depressed person would find their own ways of coping with the situations [20]. Some participants found they needed to get their own professional help through their experiences of living with a PWD. They reflected on their own personal limits and how important seeking professional help was to their mental health. Similarly, participants spoke about knowing their own limits and knowing when to "step back". This exemplifies their feeling that the coping strategies were not just for their own wellbeing, but also to be able to properly look after the person with depression. This self-awareness helps caregivers to be conscious of their own stress levels and to make the necessary adjustments to avoid burnout. Research suggests that medical/psychological intervention for informal caregivers can have beneficial effects on subjective burden [72].

3.3.3 *I didn't know my own strength.*

Through caregiving for the person with depression, the participants discovered an internal strength and resilience. This theme explores personal growth that the caregivers experience as well as highlights their capacity to navigate and get through hard times. Resilience in caregivers has a positive effect on overall mental well-being [73]. Participants highlight the resilience that they found within themselves, unexpectedly, despite all the emotional and psychological challenges of living with a person with depression. The way they reflect suggests that they are surprised at their ability to stay level-headed despite the stress and emotional toll that living with a person with depression has taken on her. This realization comes as a result of the experience they have endured as a caregiver. Resilience is crucial for sustaining a caregiving role, by recognizing this it builds caregivers' ability to manage future stressors. This aligns with findings from Palacio G et al., who found that resilience was significantly associated with a positive impact on the quality of life in caregivers [73].

4 Discussion

The aim of this research was to provide new insight into the experiences of living with a person with depression. To do this, semi-structured interviews were conducted with IPA. This study aimed to achieve a deeper insight into this specific phenomenon, to learn what meaning the individuals living with a person with depression made of their experience, and to give them a voice to share their experience in an area they are often ignored.

For participants in the current study, their lived experience illustrated a shift in caregiver understanding of depression from initial misconceptions to a deeper, more nuanced understanding. This also highlights the profound impact of caregiving for a PWD on personal relationships, often resulting in role reversals and changes in dynamics. The emotional toll and social burden of caregiving for depression was emphasized, including constant vigilance, fear, and social isolation. Professionally, caregivers frequently make significant sacrifices, such as reducing work hours or having to leave their jobs. Despite these challenges, caregivers develop various coping strategies, seek support networks, and often discover unexpected resilience and personal growth. These findings enrich the literature on caregiving, specifically in the context of depression, and underscore the necessity of support for caregivers' well-being.

Like any research, this study was not without limitations that merit consideration. Firstly, the exclusion of individuals with mental illness may limit the scope and depth of these findings. This is particularly significant because those with depressed family members are more likely to have a mental illness themselves [74]. The absence of these perspectives may underrepresent the complexity of mental health that overlap with genetic and environmental factors. Furthermore, the study relied on self-reported data which might be subject to recall bias or personal biases, affecting the validity of material gathered. This limitation is inherent in studies using self-reported measures and cautious interpretation of results should be employed. The sample of this study also lacked diversity including only female participants, which may limit the diversity of experiences and perspectives captured. However, given the fact this is an IPA study, these issues are not of huge relevance or concern. Nevertheless, future research might wish to consider the socio-economic and cultural background as these factors could help to contextualize the participants' experiences and understand how these factors might influence experiences of living with and caring for a person with depression.

5 Conclusion

This study enhances understanding of the individuals' experiences of caring for someone with depression, which addresses a gap in the current literature. Through IPA, three main themes were identified: evolving perspectives on depression, the wide-ranging impact on caregivers' lives, and coping strategies. Caregivers often shift from misconceptions to a nuanced understanding of depression, face role reversals that strain relationships, and endure significant emotional tolls, including constant vigilance and fear of self-harm. Social isolation and professional sacrifices are common. Despite these challenges, caregivers use various coping mechanisms and support systems, showing resilience. The findings from this study have important policy implications for improving caregiver support and training healthcare professionals to collaborate closely with caregivers.

Compliance with ethical standards

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Disclosure of Conflict of interest

The authors declare that there is no conflict of interest.

Statement of ethical approval

Ethical approval was obtained from the University Research Ethics Committee.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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