



Review article

Experiences of adults providing care to a partner or relative with depression: A meta-ethnographic synthesis



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ABSTRACT

Background: International interest in the informal carer role has grown in part because of the relationship between caring and caregiver burden. It has been suggested that living with someone with depression is comparable to that of other serious mental health problems, such as schizophrenia or dementia.

Methods: This meta-ethnography included 15 studies exploring experiences of living with a relative or partner with depression. Studies were heterogeneous regarding types of relationship with the depressed individual.

Results: The synthesis revealed a cyclical, psychosocial process that family caregivers undergo whilst providing care to a person with depression. The process consists of four phases: making sense of depression; changes in family dynamics; overcoming challenges; and moving forward. The findings illustrate that care giving is not a static process and that the needs of the depressed person are constantly changing.

Limitations: Some of the studies presented in the review represent caregivers recruited via support groups and so the person cared for may not have had professional diagnoses of depression.

Conclusions: This synthesis indicated the need for professional support to be available to caregivers for their own mental health needs. The model put forward suggests that different types of support may be useful for caregivers at different stages of the process including couples or systemic therapy at the initial stages of management, addressing stigma to help those overcoming challenges of caring for their partner or relative and self-compassionate approaches for caregivers who may need support to look after themselves, avoid feelings of guilt and move forward towards acceptance.

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1. Introduction

The concept of 'care' has received more attention in recent years across the UK, US, Australia and Europe in terms of legislation, policy and practice (e.g. the Care Act (DOH, 2014); Carer Recognition Act (Australian Government, 2010)). Approximately 6 million people in the UK, 2.5 million in Australia and 65 million in the US provide unpaid care to a family member (Office for National Statistics, 2011; Australian Bureau of Statistics, 2003; Caregiver Action Network (nd)). The growth of interest in the carer role has helped establish the idea that the provision of informal care warrants attention because of the relationship between caring and burden (Henderson and Forbat, 2002; Lloyd, 2000).

Twelve month prevalence estimates for depression vary between 6.7% in the US (Kessler et al., 2005) and 3.2% worldwide (Moussavi et al., 2007). Researchers generally agree that chronic mental health problems such as depression represent a burden to the patient and their family (Loukissa, 1995). Burden refers to the significant amount of strain experienced by relatives, including a range of emotional, psychological, social and financial problems (Loukissa, 1995). Factors associated with higher levels of burden are living with the patient and being closely related to them (Ostman and Hansen, 2004). It has been suggested that partners experience the most burden compared to other relatives (Ostman et al., 2005). There are mixed findings regarding the relationship between type of diagnosis and burden strength. Some studies suggest that the burden of depression is comparable to schizophrenia (Van Wijngaarden et al., 2009) or dementia (Yeatman et al., 1993). Others argue that caring for a relative with depression produces less burden than caring for a relative with bipolar affective disorder or dementia (Chakrabarti et al., 1992; Rosenvinge et al., 1998).

The increased interest in the carer role has led to a more formal identity of 'carers' or 'caregivers' and they are often viewed as part of the 'care team'. Some welcome this identity (e.g. Szukler and Holloway, 2001), arguing that informal carers can support progress through the supervision of medication and encouragement to attend treatment interventions. However, services that construct family carers as being an extension of the professional care team have been criticised for polarising the roles of the carer and cared for and overlooking the fact that many informal carers do not define themselves as such (Henderson and Forbat, 2002). By professionalising caregivers, it perpetuates the myth of the carer/cared for taking diametrically opposed positions and ignores the intimate and complex relational aspects of informal care. Furthermore, the shifting balance of care relationships are not recognised and little view is given to the reciprocal and multi-dimensional aspects of interpersonal relationships (Henderson and Forbat, 2002; Lloyd, 2000).

A small body of qualitative research has emerged focusing specifically on the subjective experiences of adult caregivers for people with depression. This research has not previously been

subjected to a synthesis; therefore, the aim of this paper is to conduct a meta-ethnography of the literature exploring the experiences of family members caring for a partner or relative with depression and to consider the findings in light of the impact on family relationships and how policy and practice might seek to best support caregivers in their role.

2. Method

2.1. Design

The diversity of approaches to synthesising qualitative research has grown steadily over recent years and has itself become a topic for review (e.g. Campbell et al., 2011). A key point of difference between methods is their varying epistemological positions (Gough et al., 2012), ranging from a highly relativist view of knowledge (e.g. meta-narrative methods) to a scientific realist viewpoint (e.g. ecological triangulation). Meta-ethnography (Noblit and Hare, 1988) is informed by objective idealism, which sits between these two poles. Its interpretative nature implies a degree of relativism; however it does not uphold the relativist idea of multiple realities. Instead, the emphasis is predominantly on examining commonalities across accounts, ultimately seeking to provide a 'whole' which has greater explanatory power. Meta-ethnography is particularly useful for synthesising research which seeks to understand individuals' experiences of illness and care (e.g. Campbell et al., 2003).

Meta-ethnography has been increasingly applied to larger sets of studies (Pound et al., 2005) and to non-ethnographic sets of studies (Atkins et al., 2008; Britten et al., 2002; Campbell et al., 2003). A meta-ethnographic synthesis refers to a process that takes individual components of a study and organises them innovatively to form a holistic representation (Noblit and Hare, 1988). Interpretations and explanations in primary studies are treated as data and key themes and metaphors are translated across several studies to produce a synthesis (Noblit and Hare, 1988). Within a meta-ethnographic synthesis, studies may be directly comparable as reciprocal translations; they may conflict in which case a refutational synthesis can be produced; taken together they may also represent a line of argument. Noblit and Hare (1988) outlined seven iterative phases of meta-ethnography which were followed in the present meta-ethnography: getting started; deciding what is relevant to the initial interest; reading the studies; determining how the studies are related; translating the studies into one another; synthesising translations; expressing the synthesis.

2.2. Article selection

All published, peer reviewed articles that used qualitative methods to explore the experiences of adults providing care to a

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