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Dualistic Perspectives on Illness Coping Experiences of Individuals with Depression and Their Spouses: A Qualitative Study

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Abstract

Dyadic coping approaches are known to ease emotional distress in patients and families dealing with chronic illnesses. However, most coping research in depression has centered on individuals rather than couples. This study explored how people with depression and their spouses experience coping, applying a dyadic lens to inform the design of tailored couple-based interventions. We conducted semi-structured, in-depth interviews with patients diagnosed with depression and their spouses. Data were analysed following Colaizzi's seven-step phenomenological method. Participants' experiences were grouped into four overarching themes and twelve subthemes: (1) delays in seeking and receiving care (delayed decision-making, delays in hospital care), (2) spousal challenges in adjustment (illness-related stress, role strain, negative emotions), (3) dual nature of dyadic coping (joint coping efforts, supportive communication, emotional support, alongside negative communication and overprotectiveness), and (4) uncertainty and unmet needs (fears about illness progression, desire for continuous care). To improve depression care, healthcare providers should encourage constructive dyadic coping within couples, enhance patients' and spouses' understanding of the condition, address spouses' mental and physical well-being, develop couple-focused intervention strategies, and strengthen continuity of care across the health system.

Keywords: Dyadic coping, Depression, Spouses, Caregiving, Qualitative research

Introduction

Depression, categorized as a mood disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), is a multifaceted condition marked by persistent sadness, loss of interest or pleasure, and impaired daily functioning. It is further distinguished by its high prevalence, recurrence, and strong association with suicide risk [1-3]. Globally, an estimated 280 million people live with depression, with lifetime prevalence ranging from 3% to 17% depending on the region [4]. According to the Global Burden of Disease Study [5], depression is a leading cause of disability worldwide, reflecting its major public health impact.

Suicidality is a critical concern, with approximately two-thirds of individuals with depression reporting suicidal ideation, and around 15% of those with severe symptoms dying by suicide. This translates to nearly one million deaths per year attributable to depression [6]. In China, community surveys in 2019 indicated a lifetime prevalence of 3.4% among adults over 18, yet only 0.5% of affected individuals received adequate treatment [2, 7]. Beyond its link to suicide, depression exerts long-term effects on occupational functioning, social relationships, and family stability [8, 9]. Spouses, often the primary caregivers, frequently develop "caregiver role fatigue"—a state of emotional exhaustion, declining caregiving capacity, and increased vulnerability to mental health problems [10]. Evidence shows that caregiving for a partner with depression heightens stress, anxiety, and even depression in spouses themselves, thereby intensifying the broader social burden [11].

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The origins of depression remain incompletely understood, though biological, psychological, and social factors are all implicated [12, 13]. Risk factors include spousal unemployment, marital discord such as infidelity, substance use, and comorbid somatic illnesses [14, 15]. In China, treatment involves both pharmacological and non-pharmacological approaches, including psychotherapy and physiotherapy [16]. However, adherence to medication is often poor, though family oversight can help improve compliance. Psychotherapy typically includes interpersonal therapy and cognitive-behavioural therapy [17].

Marital relationships play a crucial role in shaping how depression is experienced and managed. Spousal stress and coping are interdependent; one partner's distress often influences the other [18]. Moreover, spouses' perceptions and attitudes toward illness affect patients' willingness to seek care [19]. As primary caregivers, spouses bear considerable physical, psychological, and social burdens [20]. Research suggests that spousal stress negatively impacts patients' well-being and recovery, whereas couple-based interventions can reduce stress and improve coping outcomes [21]. Despite this, much of the existing literature on depression coping has concentrated on individuals rather than couples.

Dyadic coping and study objectives

Bodenmann's [22] dyadic coping theory highlights how couples jointly manage stress when faced with adversity. Research across a range of health conditions—such as breast cancer and haematological malignancies—has demonstrated that interventions based on this framework can relieve emotional distress, enhance quality of life, and improve treatment outcomes [23-26]. Despite this evidence, applications of dyadic coping have mainly been restricted to chronic physical illnesses, with limited exploration in the context of depression. Given the reciprocal nature of stress between patients with depression and their partners, dyadic coping may serve as an effective means of reducing caregiver burden, strengthening adherence to treatment, and alleviating psychological strain.

The overall aim of this study was to examine how individuals with depression and their spouses experience dyadic coping, with the goal of guiding the design of tailored couple-focused interventions. Specifically, the study sought to: (1) identify and categorize coping experiences of patients and spouses, (2) explore how stress perceptions, coping strategies, and support mechanisms operate within these dyads, (3) assess the unmet needs and challenges encountered during the coping process, and (4) generate evidence-based recommendations for healthcare professionals to develop and implement dyadic interventions for depression.

Materials and Methods

Study design

Because this study aimed to investigate the lived experiences of patients with depression and their spouses, a qualitative design grounded in phenomenology was adopted. This approach was appropriate for capturing the subjective perspectives of both groups and aligning with the study objectives. Data were analysed using Colaizzi's seven-step method, which provided a structured and systematic framework for extracting themes and ensuring analytical rigor.

Participants

Participants were recruited through purposive sampling from the psychiatric department of a tertiary hospital between September 2022 and May 2023. Eligible participants included individuals with depression and their spouses, both of whom took part in semi-structured, in-depth interviews. Although limiting the sample to hospitalized cases narrowed the scope, this strategy enabled a focused exploration of dyadic coping. The sample composition—predominantly female patients with male spouses—was acknowledged as a limitation that may influence generalizability. Data collection continued until thematic saturation was reached.

Inclusion and exclusion criteria for patients

Inclusion criteria required patients to have a confirmed diagnosis of depression, adequate cognitive and expressive ability, informed consent, and to be married and cohabiting with a spouse who served as the primary caregiver (≥40 hours of care per week). Exclusion criteria were withdrawal of consent, diagnoses of schizophrenia, paranoia, mania, or other psychotic disorders, and serious medication-related adverse effects that impaired participation.

Inclusion and exclusion criteria for spouses

Spouses were included if they were married to and living with the patient or serving as the primary caregiver, possessed sufficient understanding and communication ability, and gave informed consent. Exclusion criteria were communication or cognitive impairments and a history of mental illness.

Both members of each couple had to meet eligibility requirements. In total, 10 couples were enrolled. Among patients, 7 were women and 3 were men, aged 33–66 years (mean 53.2 ± 9.5). Education levels ranged from elementary school to bachelor's degree. Spouses were aged 35–71 years (mean 54.9 ± 9.75), with a similar educational profile. Patients were coded A1–A10, and spouses B1–B10, corresponding to interview order. Demographic details are summarized in **Table 1**.

Table 1. General information of the study population ($n = 10$)

Patient											**Spouse**			
No.	**Gender**	**Age/yrs old**	**Degree of education**	**Professional status**	**Course of a disease/yr**	**Medical insurance**	**Combined with other chronic diseases**	**Length of marriage/yrs**	**Place of residence**	**Per capita family monthly income/yuan**	**No**	**Age/yrs old**	**Degree of Education**	**Professional status**
A1	Woman	33	University or college	Incumbent	2	Employee medical insurance	Yes	8	Cities and towns	8000	B1	35	University/college	Incumbent
A2	Woman	56	Undergraduate course	Incumbent	3	Employee medical insurance	Yes	35	Cities and towns	5000	B2	60	Undergraduate course	Retire
A3	Woman	46	Primary school	Incumbent	1	The new rural cooperative medical insurance	Yes	20	Village	2000	B3	46	Primary school	Incumbent
A4	Woman	50	Senior high school	Wait for employment	1	Employee medical insurance	No	26	Cities and towns	5000	B4	53	Senior high school	Incumbent
A5	Man	59	Senior high school	Wait for employment	1	Urban resident insurance	Yes	35	Cities and towns	800	B5	60	Primary school	Wait for employment
A6	Man	61	Senior high school	Retired	20	Employee medical insurance	Yes	36	Cities and towns	4000	B6	61	University/college	Retire
A7	Woman	47	Primary school	Wait for employment	4	Urban resident insurance	Yes	21	Cities and towns	2000	B7	50	Primary school	Wait for employment

A8	Man	59	Primary school	Wait for employment	8	The new rural cooperative medical insurance	Yes	26	Village	900	B8	57	Primary school	Wait for employment
A9	Woman	66	Primary school	Retired	1	The new rural cooperative medical insurance	Yes	41	Village	1500	B9	71	Primary school	Wait for employment
A10	Woman	55	Primary school	Retired	3	The new rural cooperative medical insurance	Yes	24	Village	2500	B10	56	Primary school	Incumbent

Ethics

Given the emotional sensitivity of individuals with chronic mental health conditions and their caregiving spouses, strict ethical safeguards were applied. All participants were informed of their right to withdraw from the study at any stage without any negative repercussions. Prior to the interviews, the research team explained the study's purpose and importance, stressed the principles of voluntary participation and confidentiality, and obtained written informed consent. Participants were assured that audio recordings would remain anonymous, names would not appear in any publications, and recordings would be permanently deleted after the study concluded. These measures ensured that the research was conducted with respect and sensitivity to participants' well-being. Participation was entirely voluntary, and refusal or discontinuation carried no risk or penalty. Ethical approval for the study was granted by the Ethics Committee of the First Affiliated Hospital of Chongqing Medical University [Project ID: K2023–084].

Data collection

Developing the interview guide

A multidisciplinary research team was assembled, comprising a psychiatrist, counsellor, nurse manager, and two graduate nursing students. Guided by the study's objectives, the team conducted a literature review on depression treatment and the concept of dyadic coping to design an initial interview guide. Following group discussions, the outline was refined, and a pilot test was carried out with two patients with depression and their spouses. Based on feedback from these preliminary interviews, the final interview guide was established **(Table 2)**.

Table 2. Outline of interviews

Patient's Interview Outline	**Spouse's Interview Outline**
1. What were your thoughts, attitudes, and emotions when your doctor informed you of your depression diagnosis?	1. What were your thoughts, attitudes, and emotions when you learned about your loved one's depression diagnosis from the doctor?
2. What challenges have you faced in work, daily life, and social interactions due to your illness and its treatment?	2. How has your loved one's depression impacted your work, daily life, and social interactions?
3. Have there been changes in your relationship with your loved one since your diagnosis? If so, what are they?	3. Have there been changes in your relationship with your loved one since their diagnosis? If so, what are they?

4. What steps have you and your loved ones taken to adapt to the changes caused by your illness? What have been the outcomes?	4. What steps have you and your loved one taken to manage the changes caused by their illness? What have been the outcomes?
5. What kind of support have you received from your loved one during your treatment, or what support do you wish to receive?	5. How have you supported your loved one throughout their treatment process?
6. What are your future goals or plans for yourself and your loved one?	6. What are your future goals or plans for yourself and your loved one?

Data collection methods

Interview times and locations were arranged in agreement with participants, and individuals with depression and their spouses were interviewed separately. Alongside audio recordings, detailed field notes were kept to capture non-verbal cues such as facial expressions and body language, as well as the interviewer's reflections. The interview guide served as a framework, but the researcher adapted the order and style of questioning to the interviewees' circumstances, following up on relevant issues when appropriate. Care was taken to avoid leading questions or evaluative comments. Data collection continued until thematic saturation was reached, meaning no new insights emerged from further interviews.

Data analysis methods

Collected data were systematically organized, numbered, and securely stored. Audio recordings were transcribed verbatim within 24 hours, incorporating both spoken content and observed non-verbal behaviours from field notes. Analysis followed Colaizzi's seven-step method: (1) repeated reading of transcripts to gain an overall understanding; (2) extraction of significant statements relevant to the study; (3) summarization of key meanings; (4) clustering of similar concepts into themes and categories; (5) relating themes back to the phenomenon under study; (6) integrating findings into a comprehensive description; and (7) validation of results through participant confirmation. Two researchers conducted the analysis independently before comparing results. Any discrepancies were discussed, and if unresolved, clarified with participants to ensure accuracy. To enhance rigor, the study applied credibility, transferability, dependability, and confirmability criteria. Strategies included member checking, triangulation of analysts, maintaining an audit trail of decisions, and adherence to the COREQ checklist for transparency and completeness in reporting.

Results and Discussion

Analysing the study results, we identified four themes and 12 subthemes **(Table 3)**.

Table 3. Dualistic perspectives on the illness coping experiences of patients with depression and their spouses

Themes	Subthemes
Delays in medical care	Delays in medical decision-making
	Delays in in-hospital care
Spousal maladjustment	Perceived stress of the illness
	Role conflict
	Negative emotions
Coexistence of positive and negative dyadic coping strategies	Shared coping
	Positive communication
	Emotional support
	Negative communication
	Overprotectiveness
Confusion and needs	Fear of illness prognosis

	Desire for continuity of care

Theme 1: delays in medical care

Delays in medical decision-making

Delays in medical decision-making refer to the time between the onset of symptoms and seeking treatment. Many participants experienced delays due to limited knowledge, stigma, and attempts at self-healing. Patients and spouses often lacked reliable channels and professional guidance, which led to insufficient understanding of depression. One patient explained that they had “no idea what this disease was” and, after consulting online sources and friends, had even contemplated suicide. Another believed the symptoms were caused by menopause, while a spouse admitted they had not realized that psychiatric care was necessary for depression.

Accepting the diagnosis also proved challenging for some individuals. Several avoided psychiatric care due to fear of discrimination or social judgment. One participant visited multiple hospital departments before finally seeing a psychiatrist, initially thinking their symptoms were simply a lack of energy, and resisted psychiatric care because they believed only “crazy people” sought such treatment. Another spouse described how their partner initially refused treatment, worried about being publicly known as having depression. Similarly, one husband recounted that his wife’s mental illness was initially difficult to accept, as he had always associated illness with physical organ dysfunction, and he noticed that friends began to perceive her differently.

Some patients and their spouses attributed depression to mindset or stress and attempted to manage it independently. One patient suffering from low mood and insomnia recalled that their son advised them to endure the condition, suggesting it was not serious and did not require treatment, yet they continued to feel unwell daily. Another spouse assumed that proper rest and a positive attitude would naturally improve the condition. Similarly, one husband noted that when doctors suspected his wife had depression, he encouraged her to rest at home instead of working, believing stress was the main cause, though her symptoms persisted intermittently.

Delay in In-Hospital care

Delays in receiving in-hospital care were often caused by misdiagnosis or underdiagnosis. Several participants described prolonged journeys through different hospital departments before obtaining specialized psychiatric care, leaving them physically and mentally exhausted. One patient explained that local hospitals initially provided only sleeping pills, and it was only after a visiting psychiatrist from a larger hospital assessed them that depression was recognized and referral to a psychiatric department was recommended. Another spouse recounted that symptoms began in January, but the formal diagnosis of depression was not made until July. Others described repetitive consultations with multiple departments, with some doctors attributing symptoms to menopause, resulting in repeated cycles of unrecognized illness.

These delays illustrate systemic gaps in mental health education and services, particularly in rural areas where stigma and misdiagnosis are common. The narratives also highlighted the crucial role of spouses in navigating these barriers, providing key opportunities for interventions that engage both partners in the treatment process.

Spousal maladjustment

Spouses of individuals with depression often experience dynamic stress, which fluctuates alongside the patient’s health. Some spouses reported feeling less stressed as the patient improved, whereas stress intensified during periods of worsening symptoms. One spouse noted feeling happier when their partner’s condition improved, while another described severe anxiety and helplessness when the patient’s illness appeared unmanageable, though stress diminished as recovery progressed. Sleep disturbances were also common, with spouses monitoring the patient throughout the night to ensure their safety.

The onset of depression also led to role conflict for spouses, who often faced the dual pressure of caring for the patient while managing family responsibilities. One husband explained that he had to take over his wife’s role in managing their child’s education, despite feeling inexperienced and frequently encountering conflicts. Another spouse described delaying work commitments to care for the patient, while yet another reported that caring for the sick partner left grandchildren unattended, causing strain on the family. Some spouses also faced economic challenges, as work absences to provide care reduced household income, yet medical appointments and treatment remained necessary. These examples demonstrate the complex interplay between caregiving responsibilities, family dynamics, and personal stress experienced by spouses of individuals with depression.

Negative emotions

Spouses, as the primary caregivers, were deeply affected by the patient's symptoms, family circumstances, and their own negative emotional responses, which included helplessness, worry, anxiety, sadness, and depressive feelings. One spouse described feeling powerless while worrying that his wife might attempt suicide. Another recounted their initial difficulty in accepting the diagnosis, frantically seeking information online and from friends, and experiencing emotional breakdowns. Some spouses were visibly overwhelmed during discussions about the patient's condition, describing feelings as if "the sky was going to fall." Others acknowledged that the onset of illness left them with no choice but to accept the situation, while some experienced physical manifestations of stress, such as premature graying of hair.

The emotional strain observed in spouses highlighted the reciprocal nature of stress within the couple, emphasizing that interventions should consider shared emotional regulation. Role conflicts arose from the tension between traditional caregiving responsibilities and the demands of managing a mental illness, suggesting that structured role reassignment or support could alleviate some of the pressure. The prevalence of negative emotions, often stemming from limited knowledge or resources, underscores the need for targeted counselling and spousal support mechanisms.

Coexistence of positive and negative dyadic coping strategies

Shared coping

Despite the significant shock that depression imposed on families, many couples chose to confront the challenge together, sharing the burdens and responsibilities. One patient noted that although their spouse had previously helped with household chores, after the onset of illness, their partner took on nearly all household responsibilities. Another patient acknowledged that her husband absorbed most of the stress during this period. Spouses also expressed commitment to remaining actively involved in treatment, accompanying patients to medical appointments, and taking on responsibilities for family members to ensure care continuity.

Positive communication

Some patients actively shared their experiences of illness with their spouses, prompting changes in communication styles that relieved mutual stress and strengthened intimacy. One patient described how her husband became more attentive, offering verbal encouragement, promoting positive thinking, and taking her for walks, all without complaint. Another couple reflected that the illness prompted a reevaluation of their communication and relationship, ultimately improving their bond. Spouses also demonstrated proactive involvement in treatment, persuading resistant partners to seek care and fostering closer interaction than before the illness.

Emotional support

Depression, as an affective disorder, requires substantial emotional support, and spouses played a crucial role in providing this support during treatment. One patient described how her husband's constant presence, physical comfort, and encouragement helped her muster the strength to cope with the illness. Similarly, another participant emphasized that her wife's patient, attentive, and nonjudgmental presence provided significant emotional relief. Spouses also adapted to logistical challenges, using phone calls and extended conversations to maintain connection and provide reassurance when physical proximity was not possible.

Negative communication

Some patients and their spouses experienced negative patterns of communication, which, combined with the stress of depression, led to reduced intimacy, limited interaction, and frequent complaints. One patient tearfully recalled that her husband often dismissed her concerns and minimized her feelings whenever she shared her struggles at work or with her illness. Another participant mentioned that she rarely discussed work-related stress with her spouse, and spiritual or emotional communication was essentially absent. Spouses also expressed difficulty in knowing how to provide care, with some reporting frustration and conflicts arising from behaviors they found hard to accept after the onset of illness.

Overprotectiveness

Both individuals with depression and their spouses sometimes engaged in overprotective behaviors, aiming to shield each other from emotional distress. Patients reported withholding their own stress to avoid worrying their partners, especially if the spouse had pre-existing health concerns. Spouses described adjusting their behavior to avoid triggering negative emotions in their partners, carefully controlling their own reactions and avoiding conflict. These interactions reveal the fluid nature of dyadic coping, where positive strategies such as emotional support can enhance intimacy and resilience, while negative patterns like excessive control or poor communication may undermine trust and relational quality. These findings highlight the potential value of interventions that encourage constructive conflict resolution and balanced emotional expression within couples.

Confusion and needs

Fear of illness prognosis

Both patients and their spouses reported increasing concern about the course and outcome of depression as they gained more understanding of the illness during treatment. Patients expressed guilt for the impact of their condition on family life and worried about prolonged recovery or recurrence, fearing potential limitations in their physical and mental capacities and future work performance. Spouses similarly voiced anxiety regarding the long-term effects of medication and uncertainty about the potential for recovery. These fears underscored the emotional burden shared by both partners and the perceived unpredictability of the illness.

Desire for continuity of care

Participants also highlighted confusion and anxiety about long-term disease management, particularly regarding accessibility to treatment and medications after hospital discharge. Those living in remote areas worried about traveling to larger hospitals, obtaining necessary prescriptions, and managing symptoms during periods of fluctuation. Spouses echoed concerns about follow-up visits and continuity of care. These experiences reflect critical gaps in healthcare accessibility and long-term support, emphasizing the need for dyadic interventions that incorporate education, care planning, and ongoing logistical and emotional support. A comprehensive approach addressing medical, psychological, and practical needs could strengthen coping strategies, reduce confusion, and improve long-term outcomes for both patients and their spouses.

This study revealed that people with depression often postpone seeking professional care, reflecting a common global pattern. Delays stem from limited awareness of the condition, fear of social stigma, and attempts to manage symptoms independently, such as attributing them to stress or menopause. Some participants shared experiences of confusion and reluctance, with one stating they “knew nothing about this disease … and thought about suicide many times” (A1), while another avoided psychiatric care due to the belief that “only crazy people see psychiatrists” (A7). These challenges were further compounded by systemic issues, including misdiagnoses in general hospital departments, leaving patients exhausted from repeated consultations before reaching appropriate psychiatric care. These observations align with broader findings that insufficient knowledge is a key barrier to treatment-seeking, particularly in regions like China, where awareness of depression is low and mental health resources are limited.

The study also highlighted the bidirectional nature of stress between patients and their spouses. Caregivers often experience intense emotional pressure, which can both affect and be affected by the patient’s condition. For example, spouses reported feelings of helplessness, worry, and emotional breakdowns in response to the patient’s illness. This reciprocal stress pattern underscores the significant impact that caregiver well-being has on patient recovery. The results show that role conflicts, such as balancing childcare, work responsibilities, and caregiving, often intensify this strain, emphasizing the importance of couple-centered strategies that address both emotional and practical challenges.

Couples employed a combination of positive and negative coping strategies to manage the impact of depression. Positive approaches, such as facing challenges together, open communication, and emotional support, fostered resilience and improved relationship satisfaction. These findings are consistent with research showing that mutual support and constructive dialogue enhance relational quality under stress. Conversely, negative strategies, including dismissive communication, complaints, or excessive overprotectiveness, often created tension and emotional strain within the relationship. Overprotective behaviors, while intended to shield partners from distress, sometimes limited autonomy and inhibited honest emotional exchange, ultimately weakening relational bonds.

Active involvement in caregiving and transparent communication emerged as particularly important for providing reassurance and security. Couples who engaged in shared coping and maintained open dialogue reported greater intimacy and emotional stability. At the same time, the burden of caregiving could lead to stress and feelings of being overwhelmed, illustrating the dual nature of dyadic coping. The study highlights the need for interventions that balance emotional support with practical problem-solving, enabling both partners to manage depression collaboratively without fostering dependency or emotional isolation.

Given the chronic trajectory of depression, ongoing post-discharge care remains critical. Symptoms and challenges related to social functioning continue to require attention, supported by consistent medication adherence and rehabilitation programs. Evidence also points to the effectiveness of online interventions in improving problem-solving skills and adherence to treatment. Overall, these findings reinforce the importance of fostering adaptive dyadic coping strategies that promote emotional expression, shared responsibility, and resilience within couples facing depression.

The study found that individuals with depression and their spouses often experience considerable uncertainty about how the illness will progress, which tends to grow as they learn more about the condition during treatment. This uncertainty frequently involves concerns about recurring symptoms, long-term impairment, and the possibility of relapse, leading to feelings of guilt, helplessness, and increased stress for caregivers. Participants highlighted the importance of structured psychoeducation programs to provide clear guidance on managing depression and coping with its challenges. Research supports that such educational interventions can reduce uncertainty and enhance coping skills for both patients and family members [27]. Addressing this uncertainty is essential, as unmitigated doubts can worsen psychological distress, reduce adherence to treatment plans, and strain family relationships.

Another challenge identified by participants was the limited access to consistent mental health care, particularly in rural areas. Difficulties in obtaining medications and attending follow-up appointments heightened anxiety about the future, while the lack of clear post-discharge care plans left many patients and caregivers unsure how to manage potential relapses. These findings are consistent with studies on integrated care approaches, such as collaborative care and telemedicine, which have been shown to improve treatment adherence and patient outcomes [28]. The results highlight the need for comprehensive care models that combine psychoeducation, digital support, and community resources to help patients and caregivers manage the illness over the long term.

Education about depression is a key strategy to improve consultation rates and reduce stigma. Efforts should target both the general population and the spouses of those affected. Public awareness campaigns should provide clear, accessible information through multiple channels, including videos, illustrations, and pamphlets tailored to different literacy levels. Primary healthcare providers should be trained to recognize signs of depression and screen patients presenting with physical complaints, with AI-assisted diagnostic tools potentially enhancing detection efficiency. Such approaches align with Thornicroft *et al*. [29], who emphasize the importance of primary care in mental health management and advocate innovative solutions to improve diagnosis and treatment.

The well-being of spouses is equally critical. Caregivers frequently report feelings of stress, loneliness, and helplessness when patients fail to understand or communicate about their condition. Involving spouses in the treatment process, encouraging them to participate in consultations, and maintaining open communication with healthcare providers can empower caregivers and foster collaboration, reducing emotional strain. Nurses and other professionals can provide additional emotional support through reassurance and encouragement, helping caregivers feel acknowledged and supported. Previous studies confirm that family involvement and emotional backing are associated with improved caregiver well-being and better patient outcomes [30, 31]. Implementing these practices can reduce caregiver burden and enhance the overall health and resilience of both patients and their families.

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This research adopted a qualitative approach, allowing a detailed exploration of the experiences of people with depression and their spouses. Although the study reached data saturation, its findings are specific to the participants and context, and may not reflect experiences in other settings. Future research could combine qualitative and quantitative methods, such as surveys or longitudinal tracking, to examine patterns of dyadic coping and their effects on treatment outcomes on a broader scale.

The current study focused only on patients and their spouses, without considering the views of healthcare professionals. Including clinicians' perspectives in future studies could provide a more complete picture of challenges and opportunities for implementing dyadic coping strategies in clinical practice. Moreover, while our findings indicate the benefits of positive dyadic coping, the practical impact of structured dyadic interventions still needs thorough evaluation. Subsequent studies should design and test interventions specifically for couples managing depression, evaluating how these programs influence stress levels, relationship quality, and mental health outcomes for both partners. Such research could help develop culturally sensitive and evidence-based approaches that support both patients and their families more effectively.

Conclusion

In summary, spouses have a vital role in recognizing symptoms, supporting treatment, and facilitating recovery for individuals with depression. At the same time, depression affects both partners physically and emotionally. Positive dyadic coping can improve relationship satisfaction, ease caregiver burden, and reduce depressive symptoms. These findings highlight the potential value of couple-focused therapeutic interventions as a supportive strategy for families dealing with depression.

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