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Coping with patients suffering from overactive bladder: experiences of family caregivers in Hong Kong

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What is known about this topic

- Caring for sick family members often creates emotional stress for family caregivers.
- Social network breakdown and social impairment are common among family caregivers.
- Supportive family relationships facilitate the coping and recovery of patients with chronic illnesses.

What this paper adds

- The low social visibility of overactive bladder (OAB) hindered family caregivers seeking information on OAB and care-giving approaches, thus causing their care-giving experiences to be more difficult.
- A lack of communication between study participants and their family members with OAB worsened the emotional state and experiences of the caregivers.
- Gender expectations in traditional Chinese culture and the related triple burden experienced by many participants potentially cause physical and emotional burnout.

Abstract

This article examines the experiences of family caregivers working with patients affected by overactive bladder (OAB) in Hong Kong. Chronic diseases create physical and emotional burdens not only for patients but also for family caregivers, who often experience physical and emotional burnout and social impairment. Extensive literature has pertained to caregiver experiences in western and non-western settings; however, few studies have addressed the livelihoods and experiences of family caregivers of patients with OAB in ethnic Chinese communities. Because of the increasing prevalence of OAB worldwide, this study investigated the experiences of such caregivers in Hong Kong, examining their emotional and social needs. A qualitative research design with individual semistructured interviews was adopted, and snowball sampling was used to recruit 35 family caregivers who were referred by patients with OAB. The participants were interviewed individually from May to August 2013. A phenomenological approach was adopted in the data analysis. The data revealed that all participants had unpleasant experiences in caring for family members with OAB. A sense of powerlessness, helplessness, confusion and guilt, as well as grievances and social withdrawal, was prevalent, causing great physical and emotional suffering and subsequent physical and emotional burnout. These negative experiences were often caused by confusion regarding caretaking duties. The negative emotions of the participants and their family members also caused a lack of communication and mutual understanding about the disease, causing care-giving to be even more confusing and difficult. Furthermore, because of traditional Chinese cultural values and gender expectations, male participants experienced the triple burden of employment, domestic duties and care-giving. More holistic social and healthcare support services should be provided for care-giving family members of patients with OAB patients, empowering such caregivers to attend to family members and care for their own emotional well-being.

Keywords: care-giving, chronic care, experience, family caregivers, Hong Kong, overactive bladder

Introduction

Chronic health conditions have been documented to reduce the quality of life and worsen the emotional state of patients (Gravely-Witte *et al.* 2007, O'Neil *et al.* 2013, Purdy 2013). Therefore, helping chronically ill patients to achieve a positive emotional state is vital for enhancing their ability to manage chronic conditions more positively (Lindsay 2010). To achieve this, the care and support of family members is critical (Grapsa *et al.* 2014). However, family caregivers often experience emotional stress caused by the caregiving process (Karahan *et al.* 2014). Low income, patient gender, poor health, problems in managing patient symptoms, and the interaction between health and problems in managing patient symptoms were all associated with higher rates of depression among family caregivers (Cummings & Kropf 2014).

Overactive bladder (OAB) is a common chronic bladder dysfunction worldwide. Population-based studies conducted in six European countries and in Canada estimated that the overall prevalence of OAB in adults aged 40 years or older was 16.6% (Milsom *et al.* 2001) and 13.9% (Herschorn *et al.* 2008) respectively. In Hong Kong, approximately 15% of the population was estimated to experience OAB symptoms (Oriental Daily 2009). OAB is defined as urinary frequency, urgency and incontinence (Easton 2010) in the absence of urinary tract infection or other obvious pathology (Haylen *et al.* 2010). Treatment and management of OAB include lifestyle modifications, behavioural therapy, pharmacotherapy, neuromodulation, botulinum toxin therapy and surgical interventions (Allahdin & Oo 2012).

Patients with OAB often require long-term treatment, and the disease can severely affect their physical, psychological, social and sexual well-being (Coyne *et al.* 2011, Nilsson *et al.* 2011). Compared with patients with other types of incontinence, such as stress incontinence, the quality of life of patients with OAB has been documented to be poorer (Duggan 2011). The symptom of urinary urgency, in particular, is closely related to the adaptive behaviour of patients (Minassian *et al.* 2010). The embarrassment caused by symptoms forces many patients to feel that they cannot leave their homes (OAB Concern Group 2008). Furthermore, OAB often leads to reduced work productivity, unemployment and activity impairment (Coyne *et al.* 2011, 2012). OAB is also closely correlated with mental distress, depressive symptoms and alcoholism (Ikeda *et al.* 2011). Because of these negative effects on patients, the emotional stress on family caregivers is estimated to be severe.

Significance

Family members often serve as the immediate caregivers of patients with chronic illnesses. A supportive family relationship facilitates the coping and recovery of patients with chronic illnesses (Untas *et al.* 2012). Chronic diseases create physical and emotional burdens not only on patients but also on family caregivers (Chang *et al.* 2010). Some family caregivers experience physical and emotional burnout or impairment (Vilchinsky *et al.* 2014) as well as social network breakdown and social isolation (Bahrami *et al.* 2014). Although extensive literature pertains to the experiences of family caregivers of patients with chronic illness, few studies have examined the livelihoods and experiences of the family caregivers of patients with OAB in ethnic Chinese communities. Therefore, because of the increasing prevalence of OAB worldwide, this study fills the gap in the literature by examining the experiences and needs of such family caregivers in Hong Kong.

Methods

To understand the experiences of family caregivers of patients with OAB, a qualitative approach to data collection was adopted, individual semistructured interviews were performed and phenomenological data analysis was conducted.

Ethical considerations

This study was approved by the Committee on the Use of Human and Animal Subjects in Teaching and Research at Hong Kong Baptist University. Participation in the study was voluntary. Before the interviews, all participants were provided with information sheets explaining the purpose and nature of the study. To ensure the understanding of the participants, the information sheets were written in traditional Chinese (their native language), and verbal clarification was provided. Each participant provided written consent before the interviews, and participants were assured of their rights and freedom to withdraw from the study. To ensure participant privacy, no identifying details were recorded in the audio records or coded data. All participants were designated with codes in the interview transcripts, and data, which were stored in locked files, were strictly confidential. The audio records of the interviews were destroyed after the content was transcribed.

Data collection

In this study, a qualitative data collection approach involving in-depth individual semistructured interviews was adopted. The 35 participants sampled using snowball sampling were family members of patients with OAB who referred the participants during fieldwork. All participants agreed to participate.

The participants were interviewed individually from May to August 2013. All interviews were conducted by the researcher to ensure quality and consistency and reduce the possibility of insufficient data and data flaws, which might have occurred if another interviewer was introduced. All interviews were conducted in Cantonese Chinese (the native spoken language of the participants and researcher) to ensure that the participants could express themselves without language barriers.

Before the interviews, an interview question guide was developed according to data from a previous study by the researcher on the illness experiences of OAB patients (Siu 2014) and previous studies by other scholars on family caregivers. The sampled patients in an earlier study by the researcher expressed strong feelings of sadness and guilt regarding how their illness affected family members. They also reported regularly experiencing poor communication with family members that led to frequent misunderstandings. Some interview questions were developed to follow up on these findings. In addition, according to the literature on family caregivers of patients with chronic illnesses, interview questions were developed to investigate the experiences of the participants in caring for family members coping with OAB. The interview question guide thus ensured that the interviews covered the research questions, which were designed to elicit answers from the participants regarding perceptions of OAB, experiences and difficulties in caring for and communicating with family members with OAB, and understanding of and feelings towards these family members. To overcome a potential bias present because the interview question guide was developed by a single researcher, the guide was piloted with five people who had cared for family members with chronic illness. The questions were open-ended, and the participants had a high degree of flexibility in expressing views, feelings and experiences (Bernard 2002).

The interviews were conducted in an empty classroom at Hong Kong Baptist University. Each interview lasted 1.75–2 hours and was audio-recorded with participant consent. As an incentive, each participant received a supermarket cash coupon of HK$100 upon completion of the interview.

Data analysis

A phenomenological approach was adopted to examine the lived experiences of the participants and how they described these experiences (Nieswiadomy 1987). The interviews were transcribed verbatim and then translated into English. The transcriptions were segmented into meaning units and then collapsed into categories and eventually themes through abstraction and constant comparison. Coding schemes were developed (Liamputtong & Ezzy 2005) according to an inductive coding process by allowing for the discovery of behaviour and thought patterns (Bernard 2002). Recurrent codes and themes were noted and highlighted, and new thematic codes that emerged from the data were added to the coding list. A coding table used to identify themes, categories and codes with supporting interview quotes was constructed. Memos were used to record ideas and commentary during the interview and coding process. A codebook was maintained for recording special data (Bernard 2002). The analytic procedures, coding and findings were documented in the codebook to ensure the consistency and accuracy of the collected data. Because the data collection and analysis of this study was conducted by a single researcher, recoding was performed 1 month after the first coding as a cross-analysis to eliminate possible subjectivity, bias and overlap, thereby enhancing the validity and reliability of the coded data.

Data credibility was established by performing validity checks with the participants, who verified the accuracy of the interview transcriptions. Direct interview quotations from the participants were included in the analysis to ensure that their ideas were clearly represented. Data neutrality was established because the findings were grounded in the interview data, not in the bias, motivation or interests of the researcher.

Results

Participant demographics

Table 1 presents the participant demographic data. All 35 participants were family members of patients with OAB and served as the primary caregivers. The sample comprised 25 men and 10 women aged 30–68 years. All of the men were caring for spouses with OAB. Of the 10 women, six were caring for spouses with OAB and four were caring for sisters with OAB. Five of the women were homemakers, and the other 30 participants were employed in various sectors, including administration and management, education, commerce and finance, information technology, food and catering, healthcare and social welfare.

All of the participants had been caring for their family members for at least 4 years (some for 14 years) after the onset of OAB symptoms. Providing emotional support was the most critical care-giving

Table 1 Demographics of the participants

Informant code	Sex	Age	Years of marriage	Relationship with patients	Job employment	Years in care-giving role
P1	M	30	1	Husband	Yes	3
P2	M	68	30	Husband	Yes	14
P3	M	35	10	Husband	Yes	3
P4	M	42	10	Husband	Yes	3
P5	M	44	11	Husband	Yes	4
P6	M	45	12	Husband	Yes	10
P7	M	49	10	Husband	Yes	8
P8	M	47	13	Husband	Yes	5
P9	M	46	20	Husband	Yes	7
P10	M	47	17	Husband	Yes	6
P11	M	57	16	Husband	Yes	9
P12	M	55	16	Husband	Yes	9
P13	M	42	8	Husband	Yes	5
P14	M	41	14	Husband	Yes	4
P15	M	38	9	Husband	Yes	3
P16	M	54	20	Husband	Yes	6
P17	M	56	25	Husband	Yes	6
P18	M	57	23	Husband	Yes	10
P19	M	52	21	Husband	Yes	8
P20	M	54	22	Husband	Yes	7
P21	M	53	20	Husband	Yes	4
P22	M	49	10	Husband	Yes	4
P23	M	58	30	Husband	Yes	9
P24	M	62	34	Husband	Yes	11
P25	M	61	35	Husband	Yes	7
P26	F	47	20	Wife	Yes	5
P27	F	56	30	Wife	Yes	9
P28	F	51	10	Wife	Yes	4
P29	F	52	15	Wife	No	5
P30	F	43	15	Wife	Yes	4
P31	F	46	16	Wife	No	6
P32	F	55	0	Sister	Yes	8
P33	F	53	0	Sister	No	9
P34	F	49	0	Sister	No	7
P35	F	50	0	Sister	No	8

task according to the participants. Furthermore, providing supportive care, such as cleaning and preparing clean trousers, buying sanitary wipes and pads, and accompanying family members to medical appointments were the other common care-giving tasks reported by the participants. The participants also performed domestic duties for their family members.

The patients included 29 women and six men aged 28–55 years: 23 patients (all women) were homemakers; 10 patients were employed in administrative, clerical, or sales or retail jobs; and two patients (both men) were unemployed. All patients could care for themselves physically but required their family caregivers to provide emotional support and supportive care. Most patients received routine follow-up treatment in the urology clinics of public hospitals, and a few patients received follow-up treatment with private-practice urologists. Urinary urgency and incontinence were slightly improved through constant medical management, decreasing from at least 10 and six times a day, respectively, to eight and three times a day, respectively, in the most severe case, according to the participant observations.

Experiences of family caregivers of OAB patients

The experiences of care-giving to family members with OAB were consistently difficult for the participants. A sense of powerlessness, helplessness, confusion and guilt, as well as grievances and social withdrawal, was prevalent among the participants after the onset of the OAB symptoms in family members. Because of the chronicity of OAB, such feelings increased with time.

Powerlessness

When family members were diagnosed with the illness, 33 of the participants were unfamiliar with OAB, causing them to feel powerless to help their sick family members. They often felt a loss of control because they experienced difficulty in obtaining information about the disease and how they could care for their family members. Furthermore, many participants were reluctant to discuss the illness with their family members, increasing their uncertainty regarding how they could care for their family members. As one participant stated:

> I do not know what I can do to help her, because I have no idea of what overactive bladder is. I do not know much about this disease, except what I can observe from my wife. My wife is unwilling to talk much about her problem; therefore, I dare not ask her about her condition. However, this makes taking care of and supporting her even more difficult. I can only guess at how to help her. I feel so powerless because I do not know how I should care for my wife. It seems that everything is outside of my control. [P2]

The inability of participants to improve the physical and emotional condition of family members also contributed to feelings of powerlessness. As one participant reflected:

> Because of the disease, my wife's mood is bad and she always loses her temper. I feel very bad because I am unable to help her. I do not know what I can do to help her. Her mood is bad no matter what I do. She keeps losing her temper, and it seems that all the things I do are wrong to her. I have been searching for many possible remedies to help my wife. However, she does not make much improvement. I feel so powerless in helping my wife, even though I have tried hard to help her. [P5]

Helplessness

Of the participants, 31 felt helpless when searching for possible treatments, the limited efficacy of which often caused further frustration. As one participant commented:

> I have searched for many different remedies – western medicine, Chinese medicine, natural therapies and even folk remedies – for my sister to try. I keep any news or magazine reports about this bladder problem for reference. I also ask my friends whether they know anything that is good for the bladder and let my sister know. However, my sister fails to get any better after trying these remedies. My sister feels helpless, as do I. I have no idea where I can seek help. [P32]

A sense of helplessness was particularly prevalent among participants burdened with care-giving, employment and domestic duties. This feeling intensified when the emotions of the sick family members became unstable. One participant described the following:

> When I finish work, I have to go home immediately to take care of my wife. Although I am very tired after the office, I have to take care of home duties as well as of my wife's health and emotions. She cannot do many chores because she needs to go to the toilet frequently. Therefore, I must finish the remaining chores when I return home. I have to manage my emotions skilfully in response to her bad temper. I know my wife is suffering, but I really feel very tired and helpless. I must bear all this by myself. No one can help me; she is my wife, and I should be the only one to help her. I am under great pressure and am really afraid that I will break down one day. [P13]

Confusion

Overactive bladder was new not only to most of the participants but also to many people in their social circles. Therefore, the participants encountered difficulty in obtaining reliable information about the disease and caring for their family members. Twenty-five participants expressed feeling confused about the information and what they could do for their family members. As one participant shared:

> I feel confused about how to take care of my wife. If she has cancer, I think I am more confident in taking care of her because cancer is so common nowadays. However, I do not know anyone with overactive bladder or experience in taking care of these patients. The advice that I get from my friends is inconsistent; some friends recommend Chinese medicine therapy, whereas other friends say some Chinese herbs can harm the bladder. It is really confusing for me to know what piece of advice I should take. [P8]

A lack of communication between the participants and their family members regarding the disease was prevalent; the family members rarely mentioned their concerns or needs, and the participants also hesitated discussing such topics with their family members. This lack of communication frequently created confusion for the participants regarding what they should do to help their family members. As one participant noted:

> My wife does not want to talk too much about her sickness, so I dare not ask her too much. I often feel confused with what she needs. Sometimes she asks me to buy her sanitary pads; but if I buy them without her asking, she loses her temper. Without knowing her needs and feelings, it is difficult for me to help her. However, I have no way of knowing because she refuses to talk about it. Very often, I can only use my commonsense to help her, but I am confused whether what I have done is good for her disease and emotions. I think buying her sanitary pads is good for her because she is afraid of going out, but her feelings may be hurt by my doing so. [P19]

Grievances

Caring for a family member with chronic bladder disease was often emotionally difficult for the participants.

Misunderstandings and even conflicts with the family members were reported by 22 participants. The participants commonly felt frustrated when attempts to care for family members were misunderstood. As one participant stated:

> I know my wife is suffering and under a lot of pressure because of her sickness. Therefore, I sometimes help her to wash her soiled trousers, because I think this act shows my care and support for her. However, she becomes furious. When I reminded her about buying pads or doing bladder muscle exercises, she loses her temper as well. Every time I do something caring related to her bladder condition, she becomes agitated and gets angry. Although I understand a patient's emotions are often negative, her responses are heartbreaking. The pressure on me is great, too, and sometimes I lose my temper with her as well. [P20]

Offering care that was misunderstood or unappreciated often created a great emotional burden on the participants. For some participants, such a prolonged emotional burden caused severe conflict with the sick family members, further worsening their relationship. As one participant shared:

> It was not my intention to hurt my wife's feelings. However, I cannot control my emotions sometimes. When you have been tolerating [your wife's bad temper] for so long, you as the caregiver have to find ways to vent your frustration. However, I can go nowhere else to vent my frustration, because most of my time is devoted to taking care of my wife. When my wife loses her temper, I will become angry with her sometimes, quarrelling with her on several occasions. After all, I also have my emotions, and I need support, too. I feel very frustrated because my wife does not appreciate my care. [P22]

Social withdrawal

Twenty-eight participants withdrew themselves from their social network and activities to care for their family members. These participants commonly believed that staying with their family members was the most appropriate manner through which to express care and support. However, withdrawing from social activities caused the participants to become more isolated, which increased their emotional stress. As one participant stated:

> I am her husband, so I certainly have to bear the responsibility of taking good care of my wife. I can imagine she will feel very helpless if she is alone outside. If I am with her, she will feel much secured because she knows I am there to help her. I can help spot the nearest toilet for her and can get her new trousers if she soils the ones she's wearing. I will be with my wife when I do not need to go to work. I have not met my friends for a long time, and I gave up a lot of my personal life and hobbies. Most of my time is now devoted to taking care of my wife. This is a big pressure for me, and I have taken a long time to adapt to this new lifestyle. [P16]

Withdrawing from social networks and activities often separated the participants from means of receiving support, sometimes resulting in depression. As one participant commented:

> I really feel very down. I have been taking care of my husband's illness for almost 10 years. Ten years is not a short time, especially considering that my husband's temper became very bad after he got sick. He always loses his temper because of his bladder problem. His bad mood is just like an infection that infects me as well. Sometimes I cry without reason. I want to talk to my friends, but I do not have time to meet with them because I must care for my husband. I have no private time; all my time is given to [taking care of] my husband. [P27]

Some participants withdrew from their social activities because of concerns about how others viewed them. As one participant shared:

> If my friends knew that I have to take care of household chores, they may tease me for being a 'slave to my wife'. You know, according to traditional Chinese values, a man should be strong. I cannot tell my friends the truth, because they are just my friends. I do not want to embarrass my wife; bladder problems are really embarrassing. I rarely meet my friends now. Also, my wife needs me; I cannot leave her alone. [P3]

Guilt

Twenty participants developed a sense of guilt for being unable to do much for their sick family members. As one participant stated:

> I feel sorry for my wife because I cannot help her much even though she has been suffering a lot. I am her husband; I am supposed to be the one who protects her. However, I do not even know how to comfort her when she is feeling down with her sickness. I can do nothing except be with her, hold her hand and prepare clean clothes for her. I wish I could do more, but I do not know what I can do to help her feel better. [P17]

Such feelings of guilt caused emotional distress for some participants. The participants often put the blame on themselves when their sick family members experienced any troubles caused by the disease. As one explained:

> Every time I see my wife suffering from the disease, I feel guilty because I cannot find a good doctor and a good remedy to treat her. When she soils her trousers in public, I feel guilty, too, because I brought her out and embarrassed her. I should be more understanding to her condition, but I am not. I feel guilty for failing to understand her physical limitations and worries. I still fail to take good care of my wife. [P25]

Discussion

The literature suggests that relationships exists among the emotions of patients with chronic illnesses, the emotions of care-giving family members and the ability of patients to cope positively with their disease (Untas *et al.* 2012). Thus, support from family caregivers is crucial for improving the emotional health and physical recovery of patients with chronic illnesses and thereby enhancing their ability to cope positively (Christensen *et al.* 1992, Untas *et al.* 2012). Poor emotional health of family caregivers can affect the positive coping ability of patients with chronic illnesses (Untas *et al.* 2012). Therefore, enabling family caregivers to remain emotionally healthy and obtain sufficient support from the community facilitates the recovery of patients with chronic illnesses. However, as demonstrated by the participants, managing OAB and supporting family members with the disease is often difficult and frustrating. Negative emotions, including a sense of powerlessness, helplessness, confusion and guilt, as well as grievances and social withdrawal, were prevalent among the participants.

The participants commonly lacked knowledge of OAB, the physical and psychological needs of patients with the disease, and the possible methods of caring for them, which reduced their confidence and sense of control in serving as a caregiver. Because OAB receives little attention in Hong Kong, the participants encountered difficulty in obtaining information about this chronic bladder condition and were confused about effective treatment options and how to care for family members. The participants thus performed ‘treatment shopping’, selecting various remedies and approaches for alleviation the symptoms of their family members. However, this trial-and-error approach could not only endanger the health of patients but also created a great emotional stress for the participants during the remedy-search process. The literature shows that more information, resources and care-giving knowledge for family caregivers can improve the quality of life of both patients and caregivers (Gibson 2014) and reduce the care-giving burden on the family caregivers (Yeh & Chang 2014). Therefore, OAB care programmes should provide support and care-giving empowerment services for family caregivers. Having more knowledge about the disease and care-giving techniques can empower family caregivers as they assist in the recovery of their family members.

Unfortunately, as reflected in the participant responses, support for family caregivers of OAB patients is absent in Hong Kong. No social or health-care support service was available for the family caregivers at the time of this study. Because of the low social visibility and lack of awareness of OAB among the public, the participants often experienced substantial difficulties in seeking help and care-giving advice. The literature indicates that appropriate social and rehabilitation support substantially reduces the care burden on and the anxiety and depression levels of caregivers and facilitates acquiring the knowledge and skills required for care-giving (Karahan *et al.* 2014). Therefore, a comprehensive social and health-care support service for family caregivers would reduce the emotional burden on families (Chien *et al.* 2007). The paradigm of chronic care should be shifted from a patient-centred approach to a combined patient–caregiver approach to empower the patients and their family caregivers (Olawale *et al.* 2014) and thereby enhance the care-giving experiences of the family caregivers.

A strong relationship between patients and family caregivers can alleviate the care-giving burden on family caregivers (Yeh & Chang 2014). However, as indicated by the participant responses, a remarkable lack of communication existed between the participants and their family members with OAB, causing the participants to experience additional difficulties in the care-giving process. Such a lack of communication has numerous causes. For example, OAB is frequently considered an embarrassing disease, causing patients to feel reluctant to communicate openly about the disease with family caregivers. In addition, because of the lack of knowledge about and the low social visibility of OAB, the participants encountered difficulty in initiating discussion with family members. In addition, the negative emotions of the OAB patients and participants were critical. Discussing the disease sometimes agitated the family members and, in extreme cases, resulted in quarrels and conflicts. Conflict created emotional burdens for caregivers and less treatment compliance and more anxiety and depression among patients (Untas *et al.* 2012). Patient mood was also noted as a main contributor to the stress and emotional burden on caregivers (Santos-García & de la Fuente-Fernández 2014). Not knowing how to respond to the emotions of family members with OAB affected the emotions of family caregivers; any discussion about the disease and care-giving with family members became increasingly difficult, and miscommunications occurred easily. Therefore, future support services should encourage and enhance communication between patients with OAB and their family caregivers.

Consistent with previous studies indicating that family caregivers often experience a large burden from care and an intense struggle in balancing work and care-giving (Chen 2014), the participants in this study experienced the triple burden of employment, home duties and care-giving that led to physical and emotional burnout. Although the patients with OAB were not strongly dependent on the participants during daily living, the participants spent substantial amounts of time caring for the family members, socially withdrawing and disconnecting. Thus, physical and emotional burnout caused by the triple burden of work, home duties and care-giving can endanger the general well-being of participants.

Traditional Chinese cultural values on gender roles exerted a tremendous effect on the participants, particularly the men, that related to the cultural expectations for the male–female division of labour in a family. According to traditional Chinese cultural values, women should be the homemakers, whereas men are expected to manage non-domestic duties. The sampled men, however, were forced to perform domestic roles because of the chronic bladder condition of their spouses. This situation clashed with the traditional Chinese gender role expectations, making the participants experience emotional difficulties and motivating them to withdraw from their social network to avoid rejection.

Furthermore, chronic illness in one partner can result in increased responsibilities for the other partner, leading to burnout (Ekberg *et al.* 1986). This increase in responsibility explains the burdened care-giving experiences of the male participants. In traditional Chinese culture, husbands are expected to be strong and responsible for protecting and caring for their spouses. Therefore, the male participants exerted great effort to care for their spouses, possibly causing physical and emotional burnout. Moreover, the negative emotions of the patients and the limited amount of disease improvement caused the male participants to feel that they were insufficiently providing care, which caused a sense of guilt. Further devotion to care-giving could lead to social network breakdown, causing the male participants to experience further difficulty in seeking assistance. As a result, future support services aimed at relieving the emotional burden on family caregivers and building social support networks should be provided, particularly for male caregivers in ethnic Chinese communities.

Limitations

The findings of this study were based on a sample of 35 family caregivers of patients with OAB. Therefore, further research involving a larger sample of OAB patient family caregivers from different therapeutic settings may enable a more comprehensive understanding of such caregivers. Furthermore, this study was conducted by a single researcher, thus rendering cross-checking coding with other researchers impossible. To overcome such coding limitations, recoding was performed 1 month after the initial coding.

Conclusion

This study investigated the experiences of caregivers in caring for family members with OAB. Unpleasant experiences were prevalent among the participants, causing great physical and emotional burdens on the caregivers. These negative experiences were often caused by confusion regarding caretaking duties. The negative emotions of the participants and their family members also caused a lack communication and mutual understanding about the disease. Furthermore, because of traditional Chinese cultural values and gender expectations, the male participants experienced the triple burden of employment, domestic duties and care-giving, making them more vulnerable in experiencing physical and emotional burnout. More holistic education, social and healthcare support services should therefore be provided for the family caregivers of OAB patients, empowering such caregivers to attend to family members and care for their own emotional well-being.

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