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Spelling and Grammar Waiver

Contents

Declaration

'I declare that this thesis that I have submitted to Dublin Business School for the award of HDip Psychology is the result of my own investigations, except where otherwise stated, where it is clearly acknowledged by references. Furthermore, this work has not been submitted for any other degree.'

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Signed: Orla Thompson

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To my parents for your unwavering support, encouragement and belief in me. To my dear friends and to Jason, who have kept me sane over the last two years. Thank You

Abstract

The current study aimed to extend the research of caregivers' burden in regards to carers of young adults suffering from mental illness. The main hypotheses explored how the level of burden correlated with the carers' life satisfaction (LS) and psychological wellbeing (PWB). Additionally, which factor of burden was the greatest predictor of PWB. Other demographic variables are analysed in exploratory research section.

Online surveys containing the life satisfaction scale, psychological wellbeing scale and Zarit burden interview were used (n=72).

Analyse found significant negative correlations between burden and LS (H1) and a positive correlation between burden and PWB (H2). It also found that factor 2- social restriction impacted burden levels the most (H3).

This research highlights the need to support caregivers, particularly in terms of rest bite, to improve their own mental health, thus improving the young person's prognosis. Longitudinal studies investigating carer's mental health over time is recommended for further research.

1. Introduction

Medical and psychological researchers share a concern for the wellbeing of informal caregivers (hereafter "caregiver"). Sometime referred to as the "invisible patients" (Manne, 2005), there is a growing research interest in their wellbeing.

Caregiver burden refers to the negative consequences resulting from caring responsibilities on top of managing the physical, mental, social and financial dimensions that it entails (Brannan et al., 2012). This study will investigate the self-reported life satisfaction and psychological wellbeing of people who are caring for young adults that are suffering from a mental illness as correlated to the level of caregivers' burden experienced by the carer. It will start by investigating the existing literature in regard to the mental health of young adults, the importance of family support, the rise of adults living at home with their parents and the impact of caring for a young adult suffering with a mental illness. The methods section follows, detailing the participants, materials, procedure and ethics involved in this research. The study will then outline the findings in the results section. The discussion section will involve an analysis of the results, including any limitations to the study and further research recommendations. Finally, the references and appendices will be found at the end.

1.1. Mental health

Mental ill-health in young people has reached a critical height in the western world. In a global report conducted by the OECD (2019), it is estimated that a third of people will experience a mental health issue in their lifetime. Ireland has one of the highest rates of mental health illness in Europe, ranking joint third out of the 36 countries surveyed (OECD, 2019). Young people more than ever, are suffering from a wide variety of mental health issues (Twenge et al., 2019).

The effects of mental ill-health are far-reaching and, in some cases, devastating with long-lasting effects. Research has found a variety of effects including functional impairment, reduced quality of life for both the person and their family, disability, low work productivity, premature mortality, and increased health care utilization (Cassano & Fava, 2002; Mrazek et al., 2014; Simon, 2003). This is a public health issue. There is a substantial burden on health care resources, families and the wider society. Research has shown that there are not only social pressures but that the economic cost is substantial too (Mrazek et al., 2014). Mental health problems cost the Irish economy over € 8.2 billion annually, and 4% of the total GDP across Europe (OECD, 2019).

1.2. Mental Ill-health in young adults

Young adults (18-25) experience significantly higher rates of depression than the general population (Ibrahim et al., 2013). Several studies have documented increases in a variety of mental health disorders as well as increases in suicide-related outcomes among adolescents and young adults since 2010 (Mojtabai et al., 2016; Plemmons et al., 2018; Twenge et al., 2019).

The transition period between adolescent and adulthood brings about a host of issues and challenges for the individual and their families, even more so for people facing mental health issues (Signorini et al., 2018). It is widely accepted that this is one of the most critical periods in terms of providing robust support and resources for those suffering from mental health issues, however, often the care is suboptimal (Chanen & McCutcheon, 2013; McGorry et al., 2006, 2008; Pottick et al., 2008). Often young people with a need for ongoing mental health care fall 'through the gap' between services once they transition to adulthood. One reason for this is that services tend to be categorised by age and there are poor links and follow-through

for services (Paul et al., 2013; S. Singh, 2005; S. P. Singh & Tuomainen, 2015). This lack of resources can be extremely difficult for families supporting the young person.

The current study will focus on carers of people in adolescence and early adulthood, hereafter termed as "young adults".

1.3. Young adults living with their parents

Within Ireland, given the current housing crisis, many young adults live with their parents. The latest census shows a 4.4% increase from 2011 to 2016 (Linehan, 2017) suggesting an increasing number of young people with mental health issues are now relying on parents providing informal care. These figures are echoed across Europe (Cullen, 2019). Previous research suggests that living with and providing informal care to a mentally ill person is associated with adverse effects on the wellbeing of caregivers (Ehsan et al., 2018; Savage & Bailey, 2004). The caregiver may have to withstand behavioural disturbance and as a result, in many cases, caregivers have to curtail on their social activities including their jobs (Ehsan et al., 2018). This research will explore the psychological effects that caring for a young adult with mental illness might cause.

1.4. Importance of families in recovery

It has been found that the support of parents can be crucial to the overall outcome of the patient suffering from a mental illness (Signorini et al., 2018). However, the parental support required for treatment from a legal or healthcare guidelines perspective ignores the critical role that parents play (Signorini et al., 2018). This is a multifaceted issue as not all young people want their parents' involvement in their mental health issue or treatment and legally they are not required to be as long as they are over the age of 18 (Racine et al., 2014). Commonly, the parent is the primary carer, however, they are not involved in the treatment plan which causes an

increased level of stress for the parent (Racine et al., 2014). The current study hypothises that there will be a high level of caregiver's burden felt by carers, thus having an impact on their life satisfaction and psychological wellbeing. Furthermore, this study investigates psychological differences between sole carers and carers who share responsibilities. This is important as the ability to provide care at this critical stage is impacted by the carers own mental state.

The significance of transgenerational aspects of mental illness must not be overlooked. The presence of mental illness in both the parent and their child is common and therefore adds further complexity to the situation (Signorini et al., 2018). Very few specific interventions have tackled this issue in Europe to date (Reupert et al., 2013; Siegenthaler et al., 2012). Ensuring that the parent can stay as mentally healthy as possible through their child's mental illness will have a positive impact on their recovery. The current study will look at the relation between parents who have a diagnosed mental illness and their levels of carer giver's burden compared to those who don't.

1.5. Impact of informal caregiving

Caring for someone can bring about a host of social, psychological and financial issues on its own. Research has highlighted the numerous negative consequences that informal caregivers can experience while caring for relatives (Jütten et al., 2019). These include the carer's own mental health issues such as stress, depression or anxiety, and most commonly, caregiver burden (Joling et al., 2015; Mahoney et al., 2005; Pinquart & Sörensen, 2003; Schoenmakers et al., 2010; Schofield et al., 1998).

Studies have found that caregivers experience high levels of both objective and subjective burden. The objective burden is classified as the measurable and tangible support provided to

the person such as providing transportation, assisting the person with daily tasks. The subjective burden is considered the intangible responses to providing support such as a reduction in carer's physical and psychological wellbeing and increased worry (Angold et al., 1998).

Caregivers' burden is well researched in some situations, for example, adults caring for parents with Alzheimer disease (see: Joling et al., 2015; Schoenmakers et al., 2010). Additionally, parental carers of children with autism or ADHD show that they suffer similar levels of stress and caregivers' burden as a carer of Alzheimer patients (Cadman et al., 2012).

However, there is limited research into parents caring for young adults with mental health issues (Wingrove & Rickwood, 2019). Therefore, the current study will attempt to add to that body of research.

The research that does exist shows that parents are under significant pressure and are experiencing extreme challenges (Richardson et al., 2013). Parents suffer from high levels of caregiver burden as well as reporting significantly lower life satisfaction (Amirkhanyan & Wolf, 2003; Danhauer et al., 2004; Manor-Binyamini, 2011; Richardson et al., 2013; Shah et al., 2010).

Angold (1998) conducted research with parents of children who have a mental illness and are under the age of 18. It was found that the level of carers burden is related to the severity and frequency of the child's symptoms. If the child was diagnosed with depression or anxiety disorders, these parents typically proved less burdened than children with other disorders. Furthermore, if the parent had a pre-existing mental health problem, they scored higher in terms of perceived carers burden. It is of interest to the current study to compare these findings with results related to when the child reaches the age of 18, and is considered an adult.

1.6. Zarit Burden Interview

Traditionally, there was a distinction made between the constructs of subjective burden and objective burden (Grover et al., 2011). However, the issue with differentiating between subject and objective is that there are many overlapping dimensions, for example, stress (Chakrabarti, 2016). This research uses Zarit Burden interview (ZB) (Zarit et al., 1980) as it relies on the caregiver's perceptions to assess burden without distinguishing between objective and subjective aspects. Furthermore, the Zarit Burden interview has been tested cross-culturally and have been proven to be a robust scale of measurement across different countries and cultures (Chakrabarti, 2016). Cross-cultural applicability is important in this research due to Ireland's changing demographics.

Three factors are named within the ZB scale and are as follows: factor 1 is "social restrictions" (items 2, 3, and 10-15); Factor 2 is "self-criticism" (items 20-21); and Factor 3 is "anger and frustration" (items 1, 4-6, 9, and 16-19) (Oh & Kim, 2018; Smith et al., 2018). Studies have found that the correlation between factors 1 and 3 were much higher ($r=0.79$) (Oh & Kim, 2018). In particular, literature has suggested that the restrictions placed on the carer will have a damaging effect on their carer's ability to partake in social activities, these restrictions could be internal in terms of guilty for leaving the patient, or restrictions in a physical capacity. Both result in the care not being able to take breaks and rest and has negative impacts on their psychological wellbeing (Caqueo-Urízar et al., 2014; Siddiqui & Khalid, 2019). Specifically, this research will investigate which of the three factors has the largest impact on psychological wellbeing, hypothesising that Factor 1 will have the largest impact.

1.7. Psychological wellbeing of carers

The psychological wellbeing of carers is at risk while caring for a close relative. Many of their issues are fuelled by the lacking resources within the mental health system and by the legal,

social and criminal justice systems which the carer may find themselves interacting between as a result of the person they are caring for Barnes (1996). The institutions and systematic deficiencies are a huge factor in the psychological wellbeing of the carer. Barnes (1996) gives the example that the inability of families to hospitalise or encourage treatment for a relative who is mentally ill has been identified as a source of stress. Moreover, this issue coupled with poor support from systems, processes and organisations results in the likelihood of the carer developing sever levels of stress and impact their psychological wellbeing. This decreases their ability to care for the person as well as manage their other responsibilities. This research echoes Pinquart and Sörensen's (2003) meta analyse where they found that informal caregiving to be an extremely stressful experience that may erode psychological wellbeing and physical health of caregivers.

Ha, et al.'s (2008) research regarding parent carers of children with disabilities suggests that carers have poorer psychological wellbeing when compared to parents of non-disabled children. Interesting, they also found that older parents reported less negative effects in terms of their psychological wellbeing

Given the importance of maintaining and protecting the psychological wellbeing of carers, further research into factors that impact this is needed. This research will aim to identify the relationship between carer givers burden and psychological wellbeing of carers. It will help to add weight to the significance placed on the psychological wellbeing of the carer in terms of designing systems and organisational processes that protect and remove roadblocks.

The majority of research has focused on the negative consequences to the carer in terms of their mental health, however, there has been some suggestion that caregiving can be a positive experience for the carer. This is particularly evident in terms of psychosocial effects related to personal wellbeing and satisfaction with caring for another person (Lin et al., 2009; Tarlow et

al., 2004). In some cases, research has found that greater levels of satisfaction among caregivers were dependent upon the quality of the relationship prior to caring, whether they had a choice to become the carer, the ability to have some free time for oneself, and not working outside the home (López et al., 2005).

1.8. Life satisfaction

Satisfaction with life is the cognitive component of subjective wellbeing. The satisfaction with life scale tends to be relatively stable and is concerned with the participant's overall satisfaction, rather than their current mood. However, despite this stability, research has shown that it can change over time as a result of stressful life events (Brannan & Heflinger, 2006; William Pavot & Diener, 2008).

Research in other caregiver populations consistently demonstrates that caregivers report lower levels of life satisfaction compared to non-caregivers (for example, see (Ha et al., 2008; Möller–Leimkühler, 2005; Pinquart & Sörensen, 2003).

Research has found that caregivers in an informal caring setting who expressed high life satisfaction also score lower on levels of caregiver's burden on the Zarit scale for all the satisfaction dimensions (García-Mochón et al., 2019). However, this research does not specify the relationship or type of caring involved. There is little research regarding this variable in terms of parents caring for their adult or adolescent child who is suffering from mental illness. This could be an important variable in this area and the current research will seek to address this gap in the literature.

1.9. Demographical differences

Research has found multipliable demographic categories impact levels of the burden felt by the caregiver. While investigating carers for elderly relatives generally suffering from

dementia, some authors have reported that men derive greater satisfaction than women from caregiving (Ekwall & Hallberg, 2007; Kuuppelomäki et al., 2004; López et al., 2005). However, others have found that there is no significant difference between genders (Andrén & Elmståhl, 2005; del-Pino-Casado et al., 2018; McKee et al., 2009; Pöysti et al., 2012). In terms of life satisfaction, there has been little research into the potential gender differences for parental carers of their child who is suffering from mental ill-health. To address this gap in the literature, the current study will look at the gender difference within the sample in regards to life satisfaction and level of burden felt.

Furthermore, higher income and educational levels have been found to influence levels of burden. Greater levels of burden have been experienced from higher income and educational backgrounds which are possibly due to opportunity cost in terms of loss of time and earnings (García-Mochón et al., 2019; Oliva-Moreno et al., 2019). Furthermore, it has been found that the psychological wellbeing of the carer is improved if they are in employment and they are not the sole carer (Ha et al., 2008).

Additionally, caregivers reaching retirement age or those in worse health are found to have suffered from higher levels of burden along with other negative outcomes in terms of psychological health and employment (Bauer & Sousa-Poza, 2015). Interestingly, Ha et al.'s (2008) found that in terms of psychological wellbeing, older parents faired better than younger parents when caring for a child with mental illness. The current study will investigate differences between age groups, employment status and income brackets of carers in terms of caregivers burden as part of the exploratory results section.

This research will explore if there is a relationship between the level of psychological wellbeing, life satisfaction and caregiver's burden of parent carers of their young-adults child

who is living at home. This study aims to better understand the psychological pressures of caring for a young adult suffering from mental illness and the impact this has on the caregiver as a whole.

This research will add to current literature in this area and provide insight into the limited research regarding caregivers. The result could potentially assist in decision making regarding funding for support resources and ultimately influence policy, positively impacting the lives of thousands of carers.

1.10.   Rationale for this study

It has been established that the mental health of young people globally is deteriorating at a startling rate. As a result of house prices increasing and salary stagnation over the last decade, more young people are living at home and are therefore relying on the parents for informal care regardless of the fact they are classified as adults. The people who are providing informal care to these young adults are suffering the consequences of the lack of coordination, resources and support from health and government bodies. According to the literature these consequences include as high levels of stress and worry and perceived caregiver's burden as well as lower rates of life satisfaction and impacts to their psychological wellbeing.

The research suggests that parent carers are suffering from both subjective and objective consequences of caring for their ill children. The current study will investigate the degree to which parents rate their level of burden felt on the Zarit Burden (ZB) scale which accounts for both objective and subjective types of burden. The study hypothesises that the level of carer's burden felt by carers will correlate with lower life satisfaction and impaired psychological wellbeing.

Research question: Does the Level of carer's burden predict the self-reported life satisfaction of carers and psychological wellbeing of carers?

Hypotheses 1: There will be a significant negative correlation between Caregivers burden and life satisfaction

Hypotheses 2: There will be a significant negative correlation between Caregivers burden and Psychological wellbeing.

Hypotheses 3: All the factors of Caregivers burden will impact on Psychological wellbeing and factor 1 Social restrictions will have the greatest impact.

2. Method

The methods section will outline how this research was conducted, it will include information regarding; the participants, the research design, the materials used, the procedure, and finally the ethical process subsection.

2.1. Participants

The volunteer participants were obtained using snowball sampling via numerous online channels using google forms. The survey was distributed on social media support groups for parents of children with a variety of mental illnesses, for example, Facebook, Reddit, Twitter and Instagram. Access was granted to these closed group and consent to publish was obtained from the group administrator. Additionally, the form was published directly by some charities such as Body Whys, a charity for parents supporting people with anorexia who published the survey on their social media.

A total of 72 participants completed the survey, 69 females and 3 males, this gender divide was expected given similar research. The ages of the participants range from 29 to 80 with a standard deviation of 8.76.

The inclusion criteria for the survey was that the participant must be a carer of a mentally ill young person. For this research, the carer is defined as someone who has an informal, but active and regular role as a parental figure/supportive relationship to the young person (Bailey & Grenyer, 2015).

Exclusion criteria were if the person was not one of the young person's main carers.

To gain access to the survey, carers were required to endorse the question "Are you the carer (including biological - such as a parent, or non-biological – such as step-parent) for a young person who is suffering from mental health issues?"

Previous research suggests between 70 and 90 participants would be sufficient. In relevant studies N= 66 in Hagell et al.'s (2017) and N=90 in Danhauer et al.'s (2004) research.

2.2. Design

This study is a correlational study below outlines the criterion and predictor variables:

Criterion (CVs) = Self-reported life satisfaction of carers and Psychology wellbeing of carers

Predictors (PV) =   Level of carer's burden

In addition to this, several exploratory analyses were conducted regarding the demographic data collected.

2.3.Materials

The first page of the survey contained a consent form which can be found in appendix A. This was followed by three questionnaires; life satisfaction (Appendix B), psychological wellbeing (Appendix C) and the Zarit Burden Interview (Appendix D). The last page of the survey thanked participants and also contained the researchers' contact details as well as contact details of support services (Appendix E).

2.3.1.   Satisfaction with Life Scale

The Satisfaction with Life Scale contains 5 questions using is a 7-point Likert style response scale Agree (See appendix B) (Pavot et al., 1991). Participants were given five statements and asked to score each of the statements indicating their level of agreement ranging from 1 Strongly Disagree to 7 Strongly Agree. The possible range of scores is 5-35, with a score of 20 representing a neutral point on the scale. Scores between 5-9 indicate the respondent is extremely dissatisfied with life, scores between 31-35 indicate the respondent is extremely satisfied. The Cronbach's alpha for the scale is reported to be .85, indicating that the scale has high internal consistency. Additionally, the scale was also found to have good test-retest correlations, .84, 1-month intervals (Pavot et al., 1991).

2.3.2.   Psychological wellbeing

Psychological Wellbeing (PWB) Scale which measures six aspects of wellbeing and happiness: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff & Singer, 1998) (See Appendix C). Respondents rate how strongly they agree or disagree with 42 statements using a 7-point scale (1 = strongly agree; 7 = strongly disagree). Higher scores represent poorer psychological wellbeing . The Autonomy subscale items are Q15,Q17, Q18. The Environmental Mastery subscale items are Q4, Q8, Q9. The Personal Growth subscale items are Q11, Q12, Q14. The Positive Relations with Others

subscale items are Q6, Q13, Q16. The Purpose in Life subscale items are Q3, Q7, Q10. The Self-Acceptance subscale items are Q1, Q2, and Q5.

For coding this scale Q1, Q2, Q3, Q8, Q9, Q11, Q12, Q13, Q17, and Q18 were reverse-scored. Reverse-scored items are worded in the opposite direction of what the scale is measuring. The formula for reverse-scoring an item is: ((Number of scale points) + 1) - (Respondent's answer). Ehsan et al. (2018) found that it has Cronbach alpha reliability of .89 and test-retest reliability of .83.

Table 1 illustrates the Cronbach alpha coefficients of the six sub-scales in previous studies of the scale.

Table 1: *Cronbach alpha coefficients of the six sub-scales of PWB*

	AU	**EM**	**PG**	**PL**	**PR**	**SA**
Ryff and Keyes (1995)	.37	.49	.40	.33	.56	.52
Li (2014)	.60	.75	.74	.73	.71	.75
(Chan et al., 2019)	.77	.87	.82	.88	.77	.80

Key: AU Autonomy, EM Environment mastery, PG Personal growth, PL Purpose in life, PR Positive relations with others, SA Self-acceptance

2.3.3. Zarit Burden Interview

A 22 item questionnaire asking participants to select response options that range from 0 (Never) to 4 (Nearly Always). They refer to problems arising in several domains: health and wellbeing, personal and social life and finances (See Appendix D) (Zarit, Reever, & Bach-Peterson, 1980). The interview is coded by the sum of the scores. Scores between 0 - 21 equalled Little or no

burden, scores between 21 - 40 equalled mild to moderate burden, scores between 41 – 60 equalled moderate to severe burden, scores between 61 - 88 severe burden.

The cronbach alpha coefficient is reported at 0.95 (Zarit et al., 1980), and other research reports its reliability coefficients to range from alpha equals 0.83 (Majerovitz, 1995) to 0.94 (O'Rourke & Wenaus, 1998). Ehsan et al. (2018) found test-retest reliability is .93.

2.4. Procedure

If interested in participating, the participants clicked the link taking them to the google form. They were asked to read the consent form outlining the nature and purpose of the research (Appendix A). It also gave details of the inclusion criteria and that by participating, they were proving consent but they have the right to withdraw at any time by simply closing the form.

If they wanted to participate they would click to the next section where they would find the three surveys with instructions on how to complete each (Appendix B,C,D).

The survey finished with a page thanking them for participating in the research, the researcher's contact details and support resources available (Appendix E).

2.5. Ethics

This research has been approved by the Dublin Business School ethics committee, additionally, it is in line with the PSI code of ethics (PSI, 2011).

The google forms collect anonymous data and comply with local GDPR and lengths were taken to ensure that the questions did not include any identifying features. Participants were aware of their right to withdraw at any time and were instructed to do so by closing the form.

Informed consent was obtained when the participant read the information page and continued to the survey.

3. Results

This chapter presents the research findings. IBM SPSS statistics version 26, 2019, was used to conduct descriptive and inferential analyses and the results are presented below. A battery of descriptive and inferential tests were run to check hypothesis viability and to examine the dataset. The hypotheses are:

Hypotheses 1: There will be a significant negative correlation between Caregivers burden and life satisfaction

Hypotheses 2: There will be a significant negative correlation between Caregivers burden and Psychological wellbeing.

Hypotheses 3: All the factors of Caregivers burden will impact on Psychological wellbeing and factor 1 Social restrictions will have the greatest impact.

3.1. Descriptive statistics

The sample involved 72 participants, 95.8% of whom were female (n=69), 4.2% of whom were male (n=3).

When participants were classified by age (table 2), it was found that 44.4% were between 40 and 49 years of age (n=32), 19.4% were 39 years old or younger (n=14) as well as 19.4% in the 50 to 59 category (n=14). 2.8% were between 60 and 69 (n=2) and lastly, 1.4% were older than 70 years of age (n=1). Age range data was missing for 9 participants. The descriptive statistics are outlined in table 3.

The majority of participants were living in the UK 68.1% (n=49). 18.1% were living in the Republic of Ireland and 4.2% living in Northern Ireland (n=13 and n=3 respectively). Other countries included the USA (5.6, n=4), Australia (2.8%, n=2) and Lebanon (1.4%, n=1).

When asked about their employment status, 30.6% were in full time employment (n=22), 40.3% were not currently in employment (n=29) and 27.8% were working part-time (n=20). One participant did not answer. Furthermore, levels of income are depicted below in table 4. 4 participants did not indicate their total family income

Table 2: *Age range group frequency table*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 30	14	19.4	22.2	22.2
	40 -49	32	44.4	50.8	73.0
	50 - 59	14	19.4	22.2	95.2
	60 - 69	2	2.8	3.2	98.4
	70 and older	1	1.4	1.6	100.0
	Total	63	87.5	100.0	
Missing	-99.00	9	12.5		
Total		72	100.0		

Table 3: *Total family income and Age descriptive Statistics*

	N	Minimum	Maximum	Mean	Std. Deviation
Age	63	29	80	45.65	8.76

Table 4: *Total family income frequency table*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	€30,000 - €49,999	19	26.4	27.9	27.9
	€50,000 - € 69,999	11	15.3	16.2	44.1
	€70,000 - €89,999	4	5.6	5.9	50.0
	€90,000 - €109,999	1	1.4	1.5	51.5
	Over €110,000	2	2.8	2.9	100.0
	Benefits Only	12	16.7	17.6	69.1
	Less than €30,000	19	26.4	27.9	97.1
	Total	68	94.4	100.0	
Missing	-99	4	5.6		
Total		72	100.0		

Prior to statistical analysis, the three scales used were analysed to indicate if the assumptions were met for the parametric analyses (table 5, table 6).

Table 5: *Descriptive statistics for Life satisfaction LS, Psychological Wellbeing PWB, Zarit Burden Scale ZB*

		LS	PWB	ZB
Mean		16.22	71.13	46.93
95% Confidence Interval for Mean	Lower Bound	14.65	68.04	43.44
	Upper Bound	17.79	74.21	50.43
5% Trimmed Mean		16.03	70.94	47.14
Median		15.00	71.00	48.00
Variance		44.68	172.51	221.25
Std. Deviation		6.69	13.13	14.87
Minimum		5.00	39.00	13.00
Maximum		33.00	103.00	73.00
Range		28.00	64.00	60.00
Interquartile Range		10.75	18.00	19.75
Skewness		.425	.152	-.186
Kurtosis		-.681	-.089	-.606

Table 6: *Tests of Normality statistics for Life satisfaction LS, Psychological Wellbeing PWB, Zarit Burden Scale ZB*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
LS	.116	72	.018	.96	72	.023
PW	.065	72	.200[*]	.99	72	.935
ZB	.056	72	.200[*]	.98	72	.288

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

3.1.1. Life satisfaction

When analysing the life satisfaction scale we report the mean value of 16.22 and standard deviation of 6.68 (table 5). The minimum and maximum scores are 5 and 33 respectively. The histogram below (fig. 1) suggests that life satisfaction is not normally distributed. Shapiro-Wilk Test analyses indicated that life satisfaction has a score of .023, therefore, not normally distributed. If the Sig. value of the Shapiro-Wilk Test is greater than .05, the data is normal. If it is below 0.05, as it is with Life satisfaction, the data significantly deviates from a normal distribution

There are 5 items on the life satisfaction scale. Internal reliability analysis of life-satisfaction items yielded a strong Cronbach's α of .88. As this is over .7 it is considered strong.

As it breaks the normality assumption, a spearman's coefficient will be run to address hypotheses 1 - There will be a significant negative correlation between caregivers burden and life satisfaction.
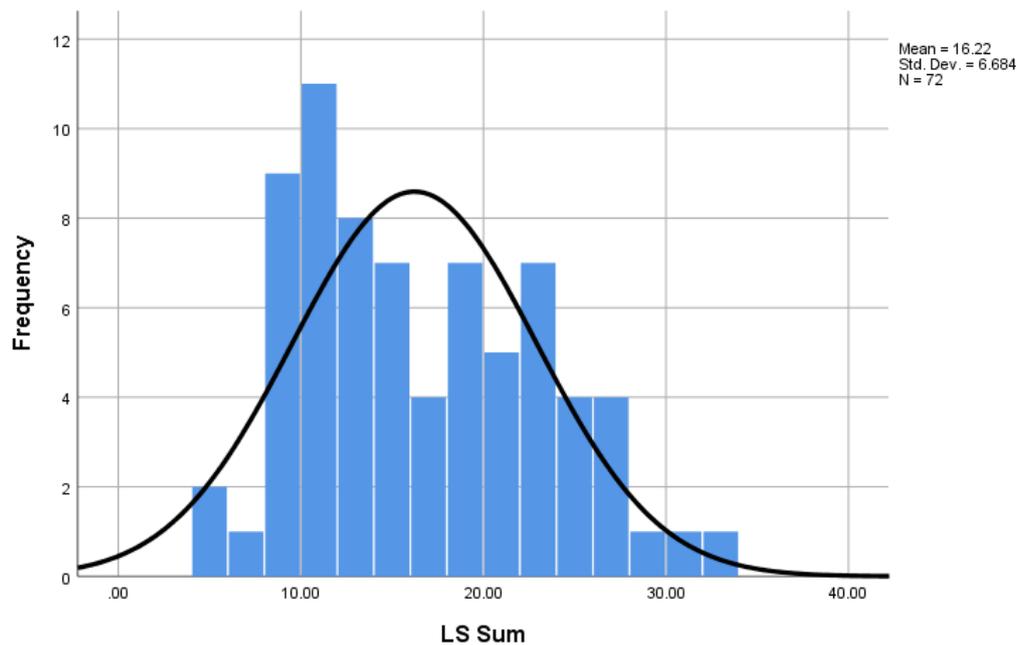
Figure 1 – Histogram for life satisfaction scores

3.1.2. Psychological wellbeing

When analysing the Psychological wellbeing (PWB) scale we report the mean value of 71.12 and standard deviation of 13.13 (table 5). The minimum and maximum scores are 39 and 103 respectively. A higher score in psychological wellbeing scale indicates poorer psychology wellbeing.

Figure 2 suggests that the PWB scale is normally distributed, skewness is .152 suggesting normal distribution. Shapiro-Wilk Test of Normality shows a significance of .94, being higher that the .05 suggested that the data is normally distributed.

There are 19 items on the psychological wellbeing scale (PWB N=19). The Cronbach's alpha score is .75, again as this is over .7, it is considered satisfactory.

As the assumptions are met, PWB is appropriate to use in the Pearson's analyse for addressing Hypotheses 2: There will be a significant negative correlation between Caregivers burden and Psychological wellbeing. As well as using a multiple regression when addressing Hypotheses 3: All the factors of Caregivers burden will impact on Psychological wellbeing and ZB factor 1-Social restrictions will have the greatest impact.
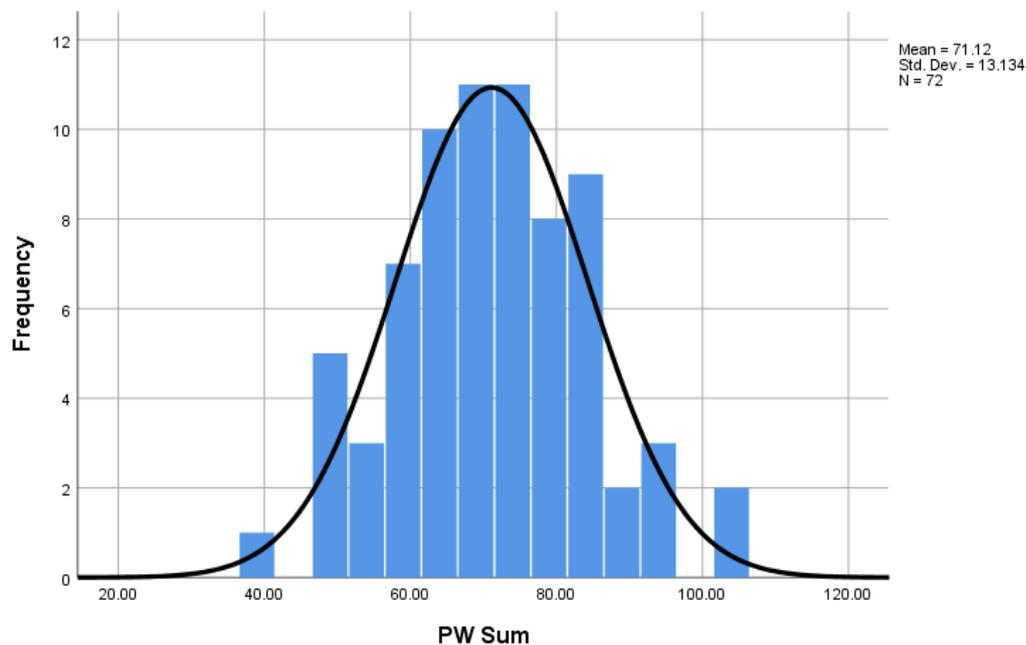

Figure 2: Graph showing the distribution of Psychological wellbeing (PW)

3.1.3. Zarit burden scale

When analysing the Zarit burden scale we report mean value of 46.93 and standard deviation of 14.87 (table 5). The minimum and maximum scores are 13 and 73 respectively.

The histogram (Figure 3) and skewness figure of -.19 suggests that the Zarit burden scale is normally distributed. Shapiro-Wilk Test of Normality shows a significance of .29, being higher that the .05 suggested that the data is normally distributed. There are 22 items on the Zarit burden scale (n=22). The Cronbach's alpha score is .88. As this is over .7 it is considered satisfactory.

Given that the assumptions are met, Pearson's parametric analyse is the appropriate test to run when addressing the first two hypotheses: H1: There will be a significant negative correlation between Caregivers burden and life satisfaction, H2: There will be a significant negative correlation between Caregivers burden and Psychological wellbeing
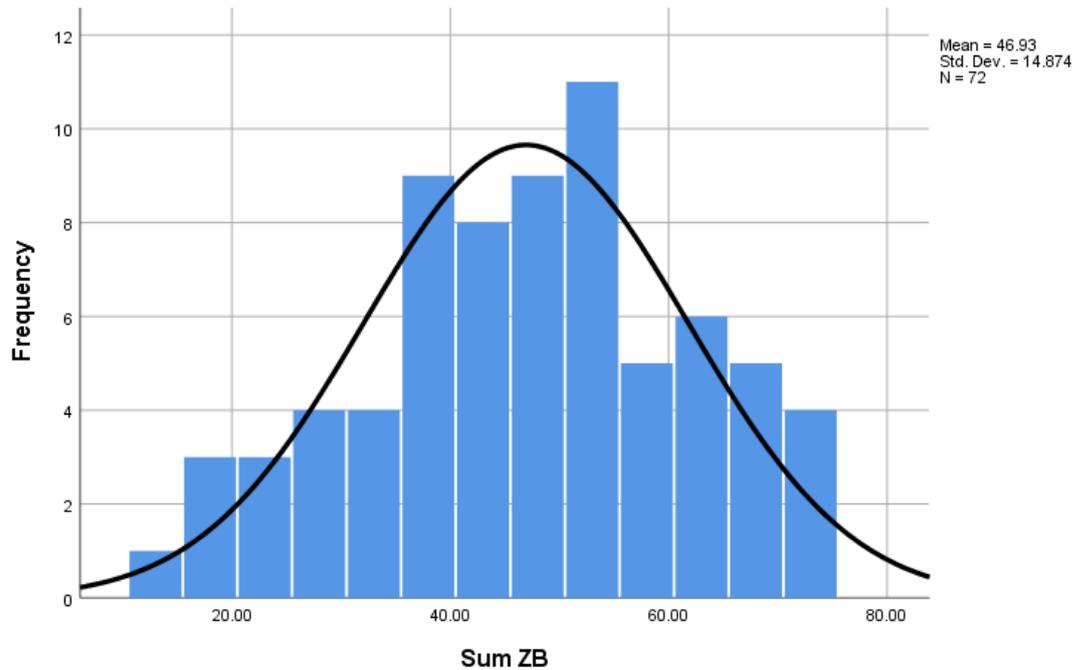

Figure 3: Graph showing the distribution of caregiver's burden levels (ZB)

3.1.4. Factor 1 in the Zarit burden scale

When analysing the Factor 1 "Social Restrictions" Zarit burden scale, the mean value is 19.35 and the standard deviation of 6.94. The minimum and maximum scores are 2 and 31 respectively. There are 8 items on the Factor 1 - "social restrictions" (items 2, 3, and 10-15), n=8 (table 7). Figure 4 shows that the Zarit burden factor 1 is normally distributed, skewness is .29 suggesting normal distribution. Shapiro-Wilk Test of Normality shows a significance of .15, being higher than the .05 suggested that the data is normally distributed. The cronbach's alpha score is .87. As this is over .7 it is considered satisfactory.

Table 7 : *Descriptive Statistics for Factor 1, 2 and 3 of the ZB scale*

		ZB.F1	ZB.F2	ZB.F3
N	Valid	72	72	72
	Missing	0	0	0
Mean		19.35	4.00	14.90
Std. Error of Mean		.817	.25	.82
Median		20.00	4.00	14.00
Mode		16.00[a]	4.00	10.00
Std. Deviation		6.94	2.11	6.97
Variance		48.09	4.45	48.57
Skewness		-.32	-.04	.40
Std. Error of Skewness		.28	.28	.28
Kurtosis		-.46	-.38	-.29
Std. Error of Kurtosis		.56	.56	.56
Range		29.00	8.00	30.00
Minimum		2.00	.00	2.00
Maximum		31.00	8.00	32.00

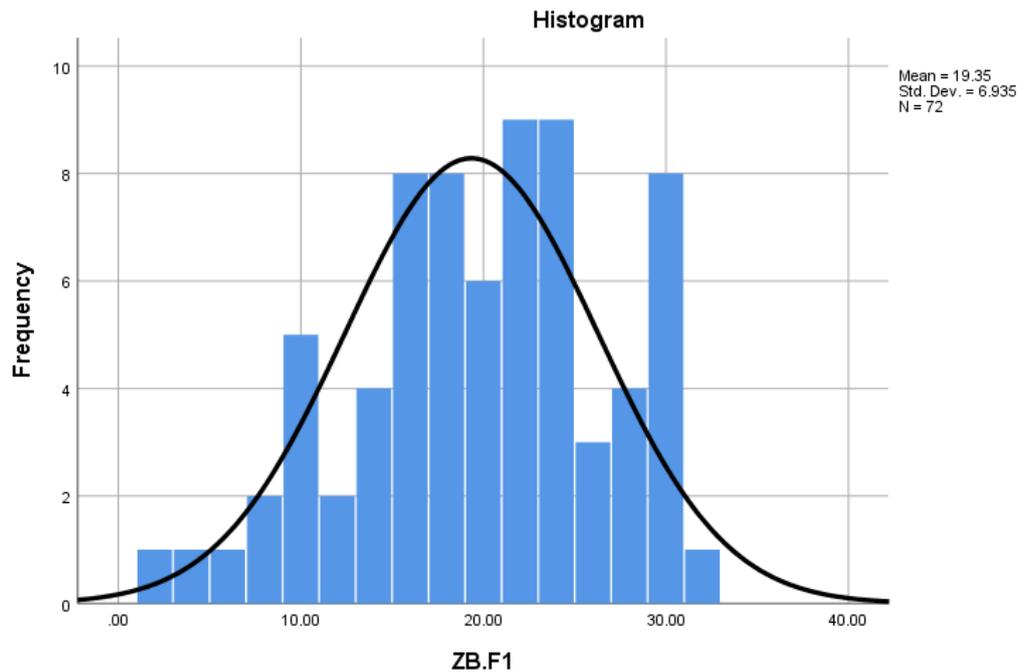a. Multiple modes exist. The smallest value is shown

Figure 5: histogram showing factor 1 of ZB scale

3.1.5. Factor 2 in the Zarit burden scale

When analysing the Factor 2 "Self-criticism" Zarit Burden scale the mean value is 4 and standard deviation of 2.12 (table 7). The minimum and maximum scores are 0 and 8 respectively. Figure 6 shows that the Zarit burden factor 2 and its skewness reported as .29 suggests normal distribution. However, Shapiro-Wilk Test of Normality shows a significance of .003 which is not higher that .05 and therefore does not suggest that it is normally distributed. The Cronbach's alpha score is .83. As this is over .7 it is considered satisfactory.
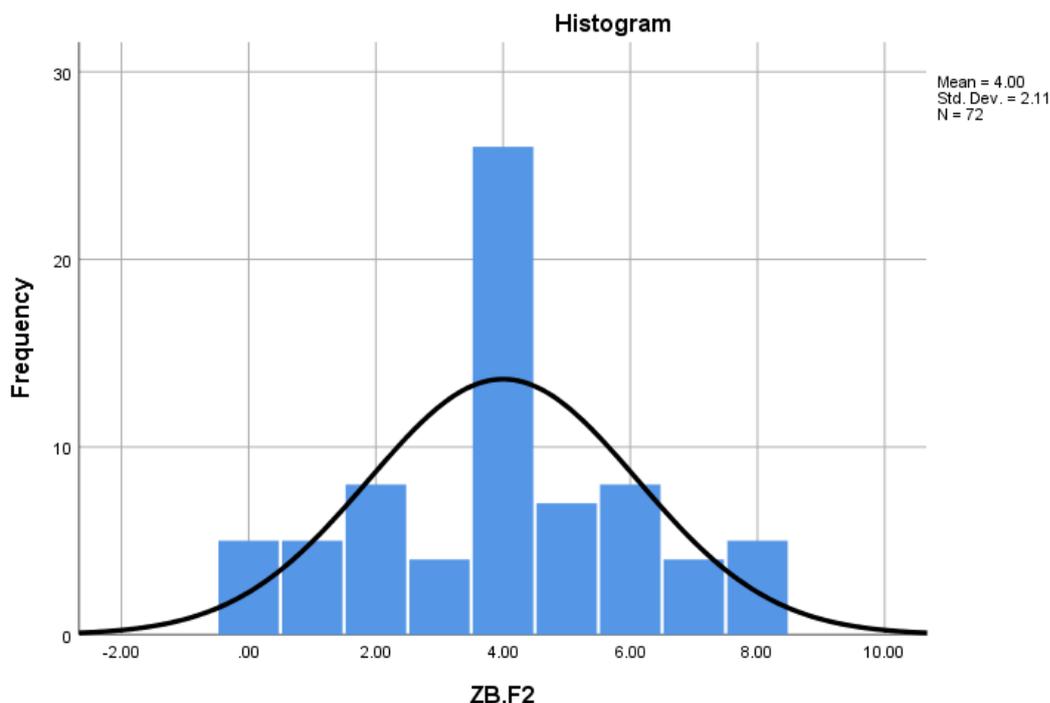
Figure 6: histogram showing factor 2 of ZB scale

3.1.6. Factor 3 in the Zarit Burden scale

When analysing the Factor 3 "Anger and frustration" Zarit Burden scale there are 9 items (items 1, 4-6, 9, and 16-19) n=9. The mean value is 14.9 and a standard deviation of 6.97. The minimum and maximum scores are 2 and 32 respectively. Figure 7 suggests that the Zarit burden factor 3 is normally distributed, skewness reported as .40 suggesting normal distribution. Shapiro-Wilk Test of Normality shows a significance of .12 (table, being higher that the .05 suggested that the data is normally distributed.. The Cronbach's alpha score is .81. As this is over .7 it is considered satisfactory.

As the assumptions are met, multiple regression is used to address Hypotheses 3: All the factors of Caregivers burden will impact on Psychological wellbeing and factor 1 Social restrictions will have the greatest impact.
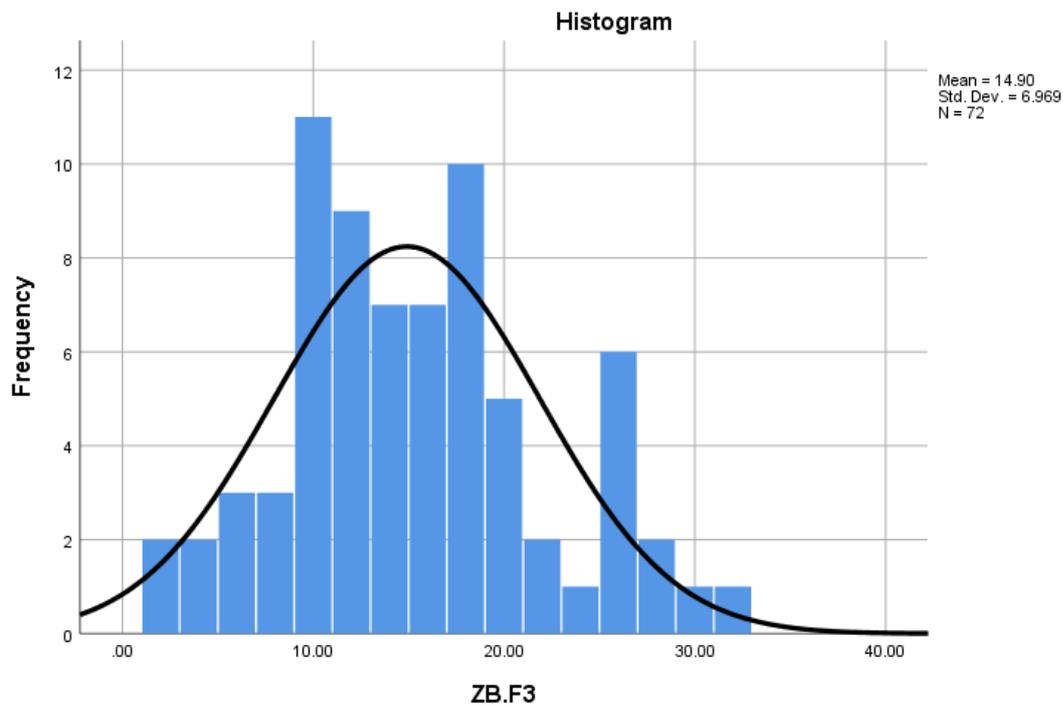
Figure 7: histogram showing factor 3 of ZB scale

Table 8: *Tests of Normality for factor 1, 2, 3 of ZB scale*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
ZB.F1	.07	72	.200[*]	.98	72	.155
ZB.F2	.19	72	.000	.94	72	.003
ZB.F3	.08	72	.200[*]	.97	72	.121

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

3.2.Inferential Statistics

A correlational design investigated the relationship between the criterion variables of self-reported life satisfaction of carers and psychological wellbeing of carers and the predictor variable of Level of carer's burden. Other descriptor variables were also investigated as exploratory research.

The bivariate Pearson Correlation produces a sample correlation coefficient, *r*, which measures the strength and direction of linear relationships between pairs of continuous variables. By extension, the Pearson's Correlation evaluates whether there is statistical evidence for a linear relationship among the same pairs of variables in the population, represented by a population correlation coefficient, ρ ("rho"). The Pearson Correlation is a parametric measure.

Spearman's is the non-parametric test which is ran when the assumptions are not met for the Pearson correlation, as with the case of life satisfaction in this research.

Multiple regression is an extension of simple linear regression. It is used to predict the value of a variable based on the value of two or more other variables. The equation is $y = b_1x_1 + b_2x_2 + a$. This is used when analysing the three factors which make up the Zairt burden scale and their effect on psychological wellbeing.

A one-way ANOVA uses the F-ratio to test the overall fit of a linear model. It implies a linear model in which a continuous variable is predicted from one categorical variable, of two or more categories. If the F-test suggests that there are significant group differences (i.e. you can predict the outcome significantly from category membership) it further analysis is conducted with a post hoc test. A one – way ANOVA is used as part of the exploratory investigations.

3.2.1. Hypotheses 1: There will be a significant negative correlation between Caregivers burden and life satisfaction.

Not all variables were normally distributed, as assessed by Shapiro-Wilk's test (p < .05) (table 6). As the assumptions for Pearson's were not met, the non-parametric Spearman's test was run. It found that there was a negative moderate but significant relationship between Zarit Burden and life satisfaction (r(72) = -.44, p < .001). Therefore the null hypothesis can be rejected.

3.2.2. Hypotheses 2: There will be a significant positive correlation between Caregivers burden and Psychological wellbeing.

A Pearson's correlation coefficient found that there was a positive moderate but significant relationship between Zarit Burden (M = 46.93, SD = 14.87) and psychological wellbeing (M = 71.13, SD = 13.13) (r(70) = .41, p < .001). Poorer psychological wellbeing indicated by a higher scored in PW positively correlates with higher levels of burden experienced. Therefore the null hypothesis is rejected. This relationship can account for 16.50% of the variation of scores (figure 8).
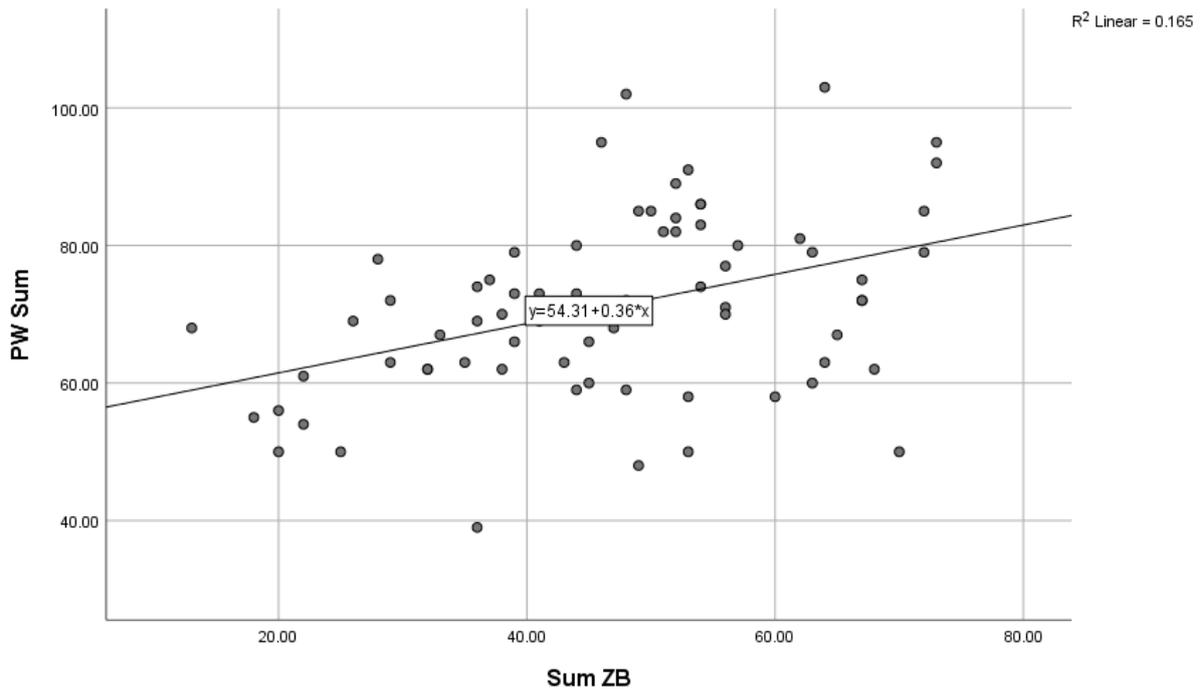
Figure 8: Scatter graph depicting PW and ZB scores correlation

3.2.3. Hypotheses 3: All the factors of Caregivers burden will impact on Psychological wellbeing and Zarit Burden Factor 1 Social restrictions (ZB) will have the greatest impact.

A multiple regression was run to investigate the three factors of the ZB scale and their impact on psychological wellbeing. There was linearity as assessed by partial regression plots and a plot of studentised residuals against the predicted values. Residuals were independent, as assessed by a Durbin-Watson statistic of 2.6. There was homoscedasticity, as assessed by visual inspection of a plot of studentised residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There was no studentised deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met. The multiple regression model statistically significantly predicted $F(3, 68) = 6.53$, $p < .001$. R^2 for

the overall model was 22.4% with an adjusted R^2 of 19%, a large size effect according to Cohen (1988).

R^2 is based on the sample and is considered a positively-biased estimate of the proportion of the variance of the dependent variable accounted for by the regression model, Adjusted R^2 corrects for this positive bias in order to provide a value that would be expected in the population. Therefore the results of the regression indicate that the predictors explained 19% of the variance. Partial plots showing the three factors of the ZB scale and psychological wellbeing are below (figure 9, 10, 11).

The three factors are summarised below:

ZB factor 1 (beta = .37, p = .011, CI (95%) = .17, 1.22)

ZB Factor 2 (beta = .28, p=.01, CI (95%) = .43 , 3.09)

ZB Factor 3 (beta = .26, p = .836, CI (95%) = -.47,.58)

As ZB Factor 1 has the greatest beta value therefore ZB Factor 1 was the strongest predictor (table 9).
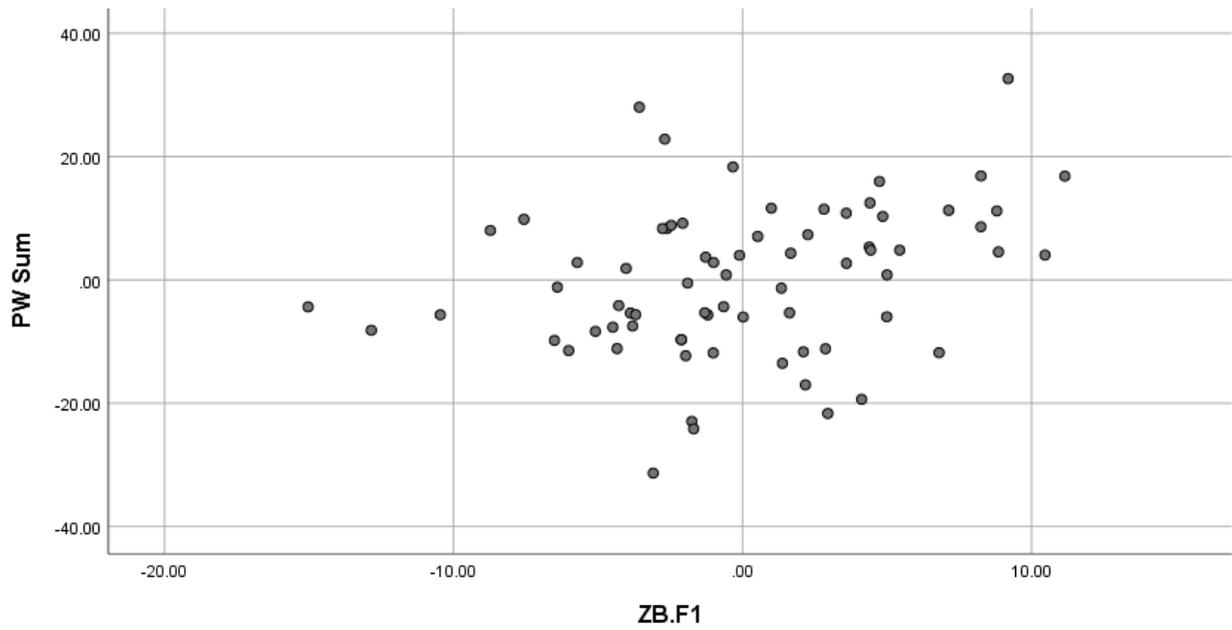
Figure 9- Partial regression plot for Psychological wellbeing and factor 1
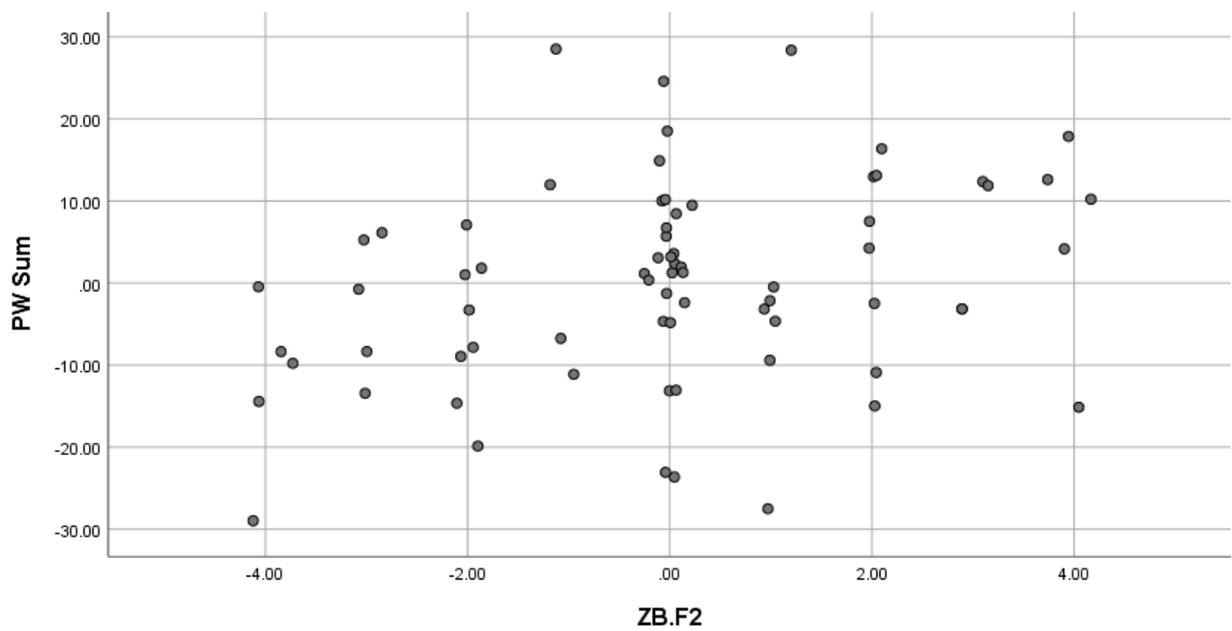
Figure 10- Partial regression plot for Psychological wellbeing and factor 2

Table: 9 – Coefficients data for the three factors of ZB

Model	Unstandardized Coefficients B	Std. Error	Standardized Coefficients Beta	t	Sig.	95.0% Confidence Interval for B Lower Bound	Upper Bound	Correlations Zero-order	Partial	Part	Collinearity Statistics Tolerance	VIF
1 (Constant)	49.87	5.00		9.96	.000	39.87	59.86					
ZB.F1	.69	.27	.37	2.62	.011	.17	1.22	.38	.30	.28	.59	1.71
ZB.F2	1.76	.67	.28	2.64	.010	.43	3.09	.27	.31	.28	.99	1.00
ZB.F3	.06	.26	.03	.208	.836	-.47	.58	.27	.02	.02	.59	1.71

a. Dependent Variable: PW Sum

Figure 11- Partial regression plot for Psychological wellbeing and factor 3

3.2.4. Exploratory Analyses

After investigating the main hypotheses above, this research also investigated other factors which from previous literature suggest will impacts the level of burden felt by carers. A one-way anal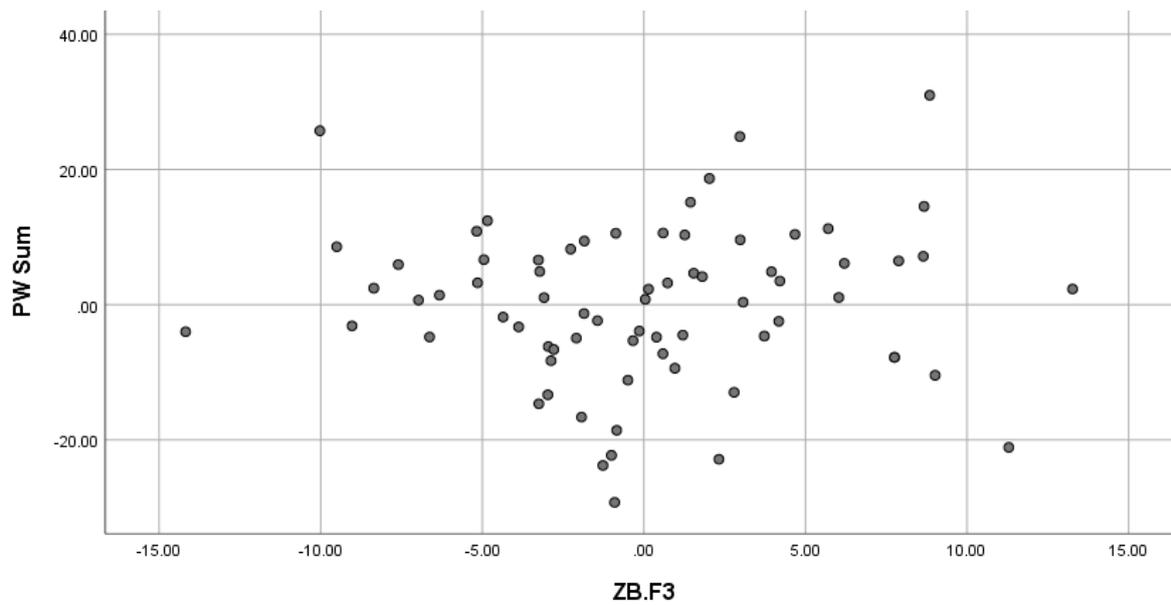ysis of variance (ANOVA) was used to investigate; Employment status, age bracket of carers, whether the carer also suffers from a mental illness, if they live with the person, the length of time they have been a carer and lastly, whether they are the sole carer. Spearman's rho correlation was ran to investigate the relationship between the length of caring for the person and life satisfaction

3.2.4.1. Employment status and level of burden

A one-way ANOVA was conducted to determine if the level of burden experience (ZB) was different for groups with different employment status. Participants were classified into three groups: not currently working (n=29), working part-time (n=20) and working full time (n=22) (table 9). There were no outliers, as assessed by boxplot; data was normally distributed for each group, as assessed by Shapiro-Wilk test (p > .05); and variances were homogeneous, as assessed by Levene's test of homogeneity of variances (p = .872). Data are presented as mean and standard deviation are presented in table 10. However, a one way ANOVA found that differences between these groups were not statistically significant, $F (2,68) = 1.024$, p = .365. A p-value of .365 is greater than .05 and therefore not significant and the null hypotheses cannot be rejected.

Table 10: *Working status and ZB Descriptives*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Not working	29	49.93	14.80	2.75	44.30	55.56	20.00	73.00
Part time	20	45.30	16.18	3.62	37.72	52.87	18.00	73.00
Full time	22	44.36	14.03	2.99	38.14	50.59	13.00	70.00
Total	71	46.90	14.98	1.78	43.36	50.45	13.00	73.00

3.2.4.2. Age category and level of burden

A one-way ANOVA was conducted to determine if the level of burden was different for different age brackets of carer. The number of participants in each bracket are outlined in table 2. There were no outliers, as assessed by boxplot; data was normally distributed for each group, as assessed by Shapiro-Wilk test ($p > .05$); and variances were homogeneous, as assessed by Levene's test of homogeneity of variances ($p = .19$) . The analyse reports that the difference between these groups was not statistically significant, $F_{(3,59)} = .748$, $p = .528$.

3.2.4.3. Does the carer suffer from a mental illness and level of burden

A one-way ANOVA was conducted to determine if the level of burden was different for carers if they suffered from a mental illness or not. Number of participants with a mental illness is 31

(n=31) and 41 did not (n=41) (table 11). There were no outliers, as assessed by boxplot; data was normally distributed for each group, as assessed by Shapiro-Wilk test (p > .05); and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances (p = .44). The analyse reports that the difference between these groups was not statistically significant, F (1, 70) = 1.58, p = .213.

Table 11: Descriptive statistics for showing if carers also have a mental illness

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	Upper Bound	Minimum	Maximum
Yes	31	49.45	16.09	2.89	43.55	55.35	13.00	73.00
No	41	45.02	13.78	2.15	40.68	49.37	18.00	72.00
Total	72	46.93	14.87	1.75	43.44	50.43	13.00	73.00

3.2.4.4.Do they live with the person they care for and level of burden

A one-way ANOVA was conducted to determine if the level of burden was different for carer if they lived with the person or not. Number of participants with a mental illness is 66 (n=66) and 6 did not (n=6) (table 12). There were no outliers, as assessed by boxplot; data was normally distributed for each group, as assessed by Shapiro-Wilk test (p > .05); and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances, p=.80.

The analyse reports that the difference between these groups was not statistically significant, F (1, 70) = .224, p = .638.

Table 12 – *Descriptive statistics for carers if they do or do not live with the person they care for*

Sum ZB

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	Upper Bound	Minimum	Maximum
Yes	66	47.18	15.06	1.85	43.48	50.88	13.00	73.00
No	6	44.17	13.56	5.53	29.94	58.39	29.00	63.00
Total	72	46.93	14.87	1.75	43.44	50.43	13.00	73.00

3.2.4.5. Length of time caring and life satisfaction

A Spearman's rho correlation was run to investigate the relationship between the length of time caring for the person (in years) and life satisfaction. Length of time caring is not normally distributed and therefore does not meet the assumptions of Pearson's test so the non-parametric test was run instead.

A Spearman's rho correlation found that there was no significant association between length of caring and life satisfaction (rs(71) = .000, p = .998). Therefore the null hypotheses cannot be rejected.

3.   Discussion

The purpose of this study was to provide a quantitative investigation of the psychological wellbeing and life satisfaction of carers who are caring for someone who is suffering from a mental illness. This research posed the question; Does the Level of carer's burden predict the self-reported life satisfaction of carers and psychological wellbeing of carers? The current study aimed to extend the research on the topic of caregivers' burden. The main hypotheses explored how the level of caregivers' burden correlated with the carers self-reported life satisfaction as well as their psychological wellbeing. Additionally, it explored which factor of caregivers' burden impacted psychological wellbeing the most. Lastly, some additional findings were noted concerning the carer's employment status ie not working or full/part time hours, the mental health status of the carer, age of the carer. This chapter will discuss the study findings, the findings in terms of previous research, the study's strengths and limitations, and the application and implication of findings for future research.

In regards to the first hypothesis: There will be a significant negative correlation between caregivers burden and life satisfaction; this research found that there is a negative relationship between the level of burden felt by carers and their self-accessed level of life satisfaction. The greater the level of burden experienced by the carer can predict a lower self-reported life satisfaction score. This complements previous results discussed earlier (Amirkhanyan & Wolf, 2003; Danhauer et al., 2004; García-Mochón et al., 2019; Manor-Binyamini, 2011; Richardson et al., 2013; Shah et al., 2010). As mentioned life satisfaction is usually stable over life, but can be reduced by major stressful life events, such as caring for an ill child. A limitation of this study is that it does not compare life satisfaction from before the person they are caring for becoming ill. Furthermore, it also does not use a control group where the researcher can

compare the life satisfaction of carers to the life satisfaction of parents of children that do not suffer from a mental illness. A recommendation for further research would be to use previous data or a control group to allow for individual differences.

Previous research suggested that caring for their mentally ill child would decrease the carer's life satisfaction over time. However, when examining the number of years that the carer has cared for the person and their life satisfaction. A spearman's rho found that there was no significant relationship between these variables. This contradicts previous research which suggested that people who have been caring for the person for a longer period would have a lower life satisfaction (Brannan & Heflinger, 2006; William Pavot & Diener, 2008). However a limitation to this study is that this question was misunderstood by participants, some participants responded with the age of their child as they have cared for them since birth, however, the question interested in how many years they have cared for them since they became ill.

In regards to Hypothesis 2; There will be a significant negative correlation between Caregivers burden and Psychological wellbeing. A moderate positive correlation has been found between the level of burden experienced and the carer's psychological wellbeing. The relationship between these two variables can account for 16.81% of the variation of scores. To a moderate degree, the level of carer's burden can predict the psychological wellbeing of the carer therefore the null hypothesis is rejected and Hypothesis 2 is accepted. A higher score psychological welling scale is interpreted as poorer psychological wellbeing.

Research suggests that the wellbeing of carers is one of the most important factors when looking at the recovery of the patient. Given this importance of maintaining and protecting the psychological wellbeing of carers, it is interesting to note the current study found that the psychological wellbeing was worse when participants had a higher burden. Pinquart and Sörensen (2003) and Ha et al.'s (2008) both reported that caregiving burden was significantly associated with psychological wellbeing, thus mirroring this study's findings

Previous research suggests that this will harm the quality of care that they can provide and may indeed hamper the recovery of the person suffering from a mental illness (Signorini et al, 2018). Signorini et. al, (2018) found that the outcome of the patient correlates significantly with the level and quality of family support they receive. If the carer has poor psychological wellbeing as a result of a high level of burden experienced, the quality of care that they will be able to provide will decrease. This highlights the importance of identifying carers with poor psychological wellbeing so that additional support can be provided which will benefit both the carer and the person with the mental illness. This study recommends health care support resources not overlook the mental health and psychological wellbeing of the family support network of the patient as this is imperative to the patient's prognosis long-term.

The multiple regression carried out as part of this research found that all of the factors of the Zarit caregiver's burden scale impacted the carer's psychological wellbeing; addressing hypotheses 3: All the factors of caregivers burden will impact on psychological wellbeing and factor 1 "Social restrictions" will have the greatest impact. ZB Factor 1 has the greatest beta value (beta = .37), it was found to be the strongest predictor, therefore accepting hypothesis 3. As suggested by previous literature, the social restriction placed on carers' either implied or explicit, has the greatest toll on their psychological wellbeing (Caqueo-Urízar et al., 2014; Siddiqui & Khalid, 2019). This highlights the need for carers to take rest bite from their carer

responsibilities. In terms of impact, these finds add weight to rest bite programmes offered by healthcare services and charity organisations by further embedding the importance and impact that this rest bite has for the carer.

The current literature in the area of caregiver's burden found that many factors could impact the level of burden a carer experienced while providing informal care to someone with mental health problems. Firstly, employment status was suggested to be affecting the level of burden experienced, however, this sample reposts a nonsignificant finding (López et al., 2005; Ha et al., 2008). Secondly, Bauer and Sousa-Poza (2015) found that a higher level of burden was experienced by older people who were reaching retirement age while caring for their child suffering from a mental illness. However, Ha et al (2008) found that younger parents had higher levels of burden than older parents. Our data present a non-significant result in terms of age bracket.

The multi-generational issues of mental health were highlighted by both Signorini et al., (2018) and Angold (1998). They found that higher levels of burden were experienced by carers who also suffered from a mental illness. However, the sample reported here did not find a significant association between the carer that did suffer from a mental illness and those that did not. Similarly, there was no association found between carers who lived with the person they cared for and those who did not as suggested by Ehsan et al. (2018) and Savage & Bailey (2004), however the vast majority of participants in the research did live with the person they cared for (n=66) and only 6 did not. This is a limitation to this finding. A recommendation for further investigation is that a larger population side for carers who do not live with the person they care for.

Lastly, the results presented here find a non-significant association between carer who is the sole carer and carers who have the support of someone else. The research suggests that carers would experience lower levels of burden if they care for the person with the help of someone else (Ha et al., 2008), however, this sample did not find this association.

It is important to note the limitations of this study. In terms of demographics, the research cannot compare gender difference or differences between relationships as the sample size was not large enough.

Due to the limited sample size, caution needs to heed when applying to a wider population. The research is restricted as it does not compare life satisfaction and level of burden experienced from before the person they are caring for becoming ill or after the person is in recovery. As mentioned, a recommendation for further research is a longitudinal study which investigates how life satisfaction of carer's as well as the level of burden experienced changes from when their child is first diagnosed with a mental illness, during the treatment and after recovery. This would help account for other individual differences seen in the research.

Additionally, when reporting that the first factor "social restriction" of ZB impacts psychological wellbeing the most, it is identified that the second factor may have normality issues and therefore results should be interpreted with caution.

In addition, as with all self-reported surveys, the questions are open to interpretation, as discussed with the limitation in regards to the number of years the carer has been caring. This may have been interpreted differently between participants impacting its validity.

Further research in this area is very important to provide the carers of young people with a mental health issue with appropriate support. Not all results in this research were significant. To summarise, the main finding of this research was that carer giver's burden has a significant

association with life satisfaction and psychological wellbeing. And the social restriction factor of caregiver's burden is the biggest predictor of psychological wellbeing. Demographics such as age, employment status, whether they were the sole carer, living together were all found to be not significant in this sample.

Recommendations for further study is to increase the sample size to improve the reliability of results. As mentioned, it would be beneficial to conduct a longitudinal study to investigate the psychological changes which occur throughout the caring timeframe.

Carer's of young people with mental illness suffer from lower life satisfaction, impaired psychological wellbeing and high levels of caregiver burden. This research aimed to investigate the degree to which carer's of young adults experienced caregiver's burden and its correlation to both psychological wellbeing and life satisfaction.

This research did indeed support other literature in this area by finding correlations between caregiver burden and life satisfaction and psychological wellbeing. It also found that of the three factors, it was the first factor of caregiver's burned which impacted psychological wellbeing the most, thus supporting previous research.

The finding presented by the research highlights the need to counsel family caregivers when they accompany their family members to their health care appointment. By investing resources that support the primary caregiver's mental health, the outcome of the young person suffering from a mental health illness is much more positive.

Providing support to caregivers without stigmatising their emotional and psychological needs would help prevent a deterioration of their own mental health and improve the overall family's quality of life.

4.   References

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6. Appendices

6.1 Appendix A: Consent form

My name is Orla Thompson and I am conducting research in DBS's Department of Psychology that explores the pressures and psychological wellbeing of carers while caring for someone who suffers from a mental illness. This research is being conducted as part of my studies and will be submitted for examination.

You are invited to take part in this research by completing the following anonymous google survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services is included in the final page.

Participation is completely voluntary so you are not obliged to take part. You can withdraw from the survey by simply closing the window.

Participation is anonymous and confidential. Thus responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been collected.

The questionnaires will be securely stored with password protection and will be stored for one year after the submission of the report.

It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

Should you require any further information about the research, please contact

Orla Thompson ███████@mydbs.ie. My supervisor, Stephen Fitzgerald, can be contacted at

Alternatively please visit aware.ie for specific help or resources.

Thank you for taking the time to complete this survey.

6.2 Appendix B: Life satisfaction scale

Below are five statements that you may agree or disagree with.

Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate

number on the line preceding that item. Please be open and honest in your responding.

• 7 - Strongly agree

• 6 - Agree

• 5 - Slightly agree

• 4 - Neither agree nor disagree

• 3 - Slightly disagree

• 2 - Disagree

• 1 - Strongly disagree

_____ In most ways my life is close to my ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

Scoring interpretation

♣ 31 - 35 Extremely satisfied

♣ 26 - 30 Satisfied

♣ 21 - 25 Slightly satisfied

♣ 20 Neutral

♣ 15 - 19 Slightly dissatisfied

♣ 10 - 14 Dissatisfied

♣ 5 - 9 Extremely dissatisfied

6.3 Appendix C: Psychological wellbeing scale

Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate

number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Neither Agree or Disagree

5 = Slightly Agree

6 = Agree

7 = Strongly Agree

1. "I like most parts of my personality."

2. "When I look at the story of my life, I am pleased with how things have turned out so far."

3. "Some people wander aimlessly through life, but I am not one of them."

4. "The demands of everyday life often get me down."

5. "In many ways I feel disappointed about my achievements in life."

6. "Maintaining close relationships has been difficult and frustrating for me."

7. "I live life one day at a time and don't really think about the future."

8. "In general, I feel I am in charge of the situation in which I live."

9. "I am good at managing the responsibilities of daily life."

10. "I sometimes feel as if I've done all there is to do in life."

11. "For me, life has been a continuous process of learning, changing, and growth."

12. "I think it is important to have new experiences that challenge how I think about myself and the world."

13. "People would describe me as a giving person, willing to share my time with others."

14. "I gave up trying to make big improvements or changes in my life a long time ago"

15. "I tend to be influenced by people with strong opinions"

16. "I have not experienced many warm and trusting relationships with others."

17. "I have confidence in my own opinions, even if they are different from the way most

other people think."

18. "I judge myself by what I think is important, not by the values of what others think is important."

Scoring:

The Autonomy subscale items are Q15,Q17, Q18. The Environmental Mastery subscale items are Q4, Q8, Q9. The Personal Growth subscale items are Q11, Q12, Q14. The Positive Relations with Others subscale items are Q6, Q13, Q16. The Purpose in Life subscale items are Q3, Q7, Q10. The Self-Acceptance subscale items are Q1, Q2, and Q5.

Coding:

Q1, Q2, Q3, Q8, Q9, Q11, Q12, Q13, Q17, and Q18 should be reverse-scored. Reverse-scored items are worded in the opposite direction of what the scale is measuring. The formula for reverse-scoring an item is:

((Number of scale points) + 1) - (Respondent's answer)

(Ryff & Singer, 1998)

6.4 Appendix D: Zarit Burden Interview

Please indicate how often you feel the below statements apply to you:

0 Never

1 Rarely

2 Sometimes

3 Quiet Frequently

4 Nearly Always

1. Do you feel that your relative ask for more help than he/she needs?

2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?

3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?

4. Do you feel embarrassed over your relative's behaviour?

5. Do you feel angry when you are around your relative?

6. Do you feel that your relative currently affects your relationship with other family members?

7. Are you afraid about what the future holds for your relative?

8. Do you feel that your relative is dependent upon you?

9. Do you feel strained when you are around your relative?

10. Do you feel that your health has suffered because of your involvement with your relative?

11. Do you feel that you don't have as much privacy as you would like, because of your relative?

12. Do you feel that your social life has suffered because you are caring for your relative?

13. Do you feel uncomfortable having your friends over because of your relative?

14. Do you feel that your relative seems to expect you to take care of him or her, as if you were the only one he or she could depend on?

15. Do you feel that you don't have enough money to care for your relative, in addition to the rest of your expenses?

16. Do you feel that you will be unable to take care of your relative much longer?

17. Do you wish that you could just leave the care of your relative to someone else?

18. Do you feel uncertain about what to do about your relative?

19. Do you feel that you should be doing more for your relative?

20. Do you feel that you could do a better job in caring for your relative?

21. Overall, how burdened do you feel in caring for your relative?

Interpretation of Score:

Cat 1: 0 - 21 Little or no burden

Cat 2: 21 - 40 mild to moderate burden

Cat 3: 41 - 60 moderate to severe burden

Cat 4: 61 - 88 severe burden

6.5 Appendix E: Closing letter

Thank you for taking part in this research

Should you require any further information about the research, please contact

Orla Thompson ██████@mydbs.ie. My supervisor, Stephen Fitzgerald, can be contacted at

If you have been affected by taking part in this research and want some resources. Please reach

out to:

Freephone 24/7 Samaritans on 116 123

Aware.ie

Thank you for taking part in this research