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Research Article

Addressing Compassion Fatigue of a Family Caregiver of Adolescents in a Mental Health Setting

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Abstract

Compassion fatigue is a phenomenon found in professional or family caregivers and can result in physical, emotional, and spiritual distress. Family members who care for adolescents with a mental health disorder have similar risk factors of developing compassion fatigue; they are an unrecognized at-risk population. Staff therapists, nurses, educators, and support staff attended a one-hour educational training program on compassion fatigue, included validated screening tools, interventions, and educational materials for family caregivers. A pre/post-Continuing Professional Development Reaction Questionnaire was used to measure the professionals' intention to change practice. The program for family caregivers included group sessions led by a staff therapist, a Family Quality of Life survey, a modified Professional Quality of Life Survey, and interventions of knowledge, coping strategies, peer support programs, self-help, and guided self-help. The Continuing Professional Development Reaction Questionnaire indicates the staff's intention to change their practice, as suggested by the change in intention and beliefs about capabilities response. The results of the Family Quality of Life survey suggest that family caregivers are at risk for compassion fatigue. The families who participated and received information on compassion fatigue gained a new understanding and considered or had implemented one or more of the interventions.

Keywords: Adolescent with a mental health disorder; Compassion fatigue; Family caregivers

Introduction

Compassion Fatigue (CF) is a phenomenon found in professional caregivers or family caregivers, resulting in physical, emotional, and spiritual distress. It is the effect of the relationship between the caregiver and the patient/family member [1,2]. Family caregivers who care for Adolescents with a Mental Health Disorder (AMHD) have many of the same risk factors as caregivers who develop CF. Despite the similarities, CF is unrecognized as a problem for family caregivers of an AMHD.

Over time, the family caregiver may develop a phenomenon referred to as CF, the adverse physical, emotional, and spiritual symptoms associated with caregiving. The concept of CF, referred to as the "cost of caring" [1], has included formal and informal/family caregivers. Early research focused on professional caregivers and the impact of caring for patients who have suffered

trauma and terminal illness or chronic disease or disability. The term CF reported by Carla Joinson in 1992 suggested that CF was a unique form of burnout in nursing that resulted in overwhelming invasive stress [3]. Charles Figley's [1] work in traumatology found that professionals who cared for trauma and violence victims had increased rates of burnout and secondary traumatic stress, which are critical components of CF. This concept has recently expanded to include the family caregiver, primarily those caring for an aging adult with a chronic debilitating disease or disability such as Alzheimer's or terminal illness as at risk for CF.

The cost of caring for family caregivers have many comparisons to a health professional who have reported CF [4,5]. Caregivers list sadness, poor self-care, depleted energy, hopelessness, isolation, and self-sacrifice as an outcome of caregiving. Other symptoms include sleep disturbances, difficulty focusing, substance abuse, and absenteeism, diminished sense of personal worth, low self-esteem, gastrointestinal complaints, chronic fatigue, hypertension, anxiety, and apathy. Lynch &

Lobo [2], utilizing Wilson's concept analysis strategy, found similarities between the current CF attributed the concept to HCP and family caregivers, noting that both have caring and empathetic relationships. The nature of the relationship with the family member adds to the stress of caring for the family caregiver. Unlike the professional caregiver, family caregiver strain can result from the lack of training needed to provide ongoing care. The inability to leave and seek respite from caregiving is also a complicating factor [6]. Parents, siblings, and grandparents of adolescents who have an AMHD and have the primary role of the family caregiver and have significant challenges when caring for an AMHD, which places them at risk for CF.

CF has become recognized in family caregivers as more responsibility for care is shifted to home. Approximately 43.5 million caregivers provide unpaid care to an adult or child in the United States [7]. CF is most frequently a result of providing daily care to seriously ill, chronically ill, or a dying family member and a shared pain experience [2]. Typically, the caregiver has a deep sense of empathy for the person and the inability to disengage from caregiving resulting in physical, emotional, and spiritual distress. Symptoms develop throughout caring, and they can experience a variety of physical symptoms such as headaches, chest pain, gastrointestinal complaints, and sleep disturbance. Emotional distress, such as depression, apathy, anger, and irritability, can occur. Many complain of moral distress as there is no end in sight of the suffering [5]. The risk for CF includes the number of hours, coping ability, age, competing demands.

The family caregiver provides regular care or assistance to a friend or family member with a long-term illness or chronic disability [8]. Mental health disorders such as anxiety, depression, eating disorders, and disruptive behavioral disorders are considered chronic illnesses. These conditions are prolonged in nature and do not typically resolve spontaneously [9]. Today, one in five adolescents [10] has a mental health disorder diagnosis.

When examining the family caregivers' experiences for an AMHD, there are similarities to those who experience CF. The research on this population acknowledges the adverse effect of caring for an AMHD but does not explicitly address CF. The cost of caring for an AMHD can have adverse physical, emotional, and spiritual impact. Family caregivers of AMHD report higher levels of stress, emotional turmoil, guilt, and complaints of exhaustion and fatigue resulting from the adolescent's disruptive behaviors and often physical violence. These findings, supported by a systematic mixed study review of family caregivers, found that families experience decreased self-esteem, a negative impact on the family system, stigma, and isolation [11]. Higher levels of strain also resulted from a lack of social supports, feeling that they need to be vigilant and in charge of treatment plans. The chronic nature of mental health disorders contributes to caregiver's stress, and family caregivers reported higher levels of psychological

distress and somatic complaints [12].

Caregivers often face financial burdens associated with lost wages from missed work to attend to the needs of the adolescent [13,14]. Family caregivers report having to take time away from work to interact with the school system, law enforcement, and providers. The majority of caregivers are single mothers who cannot work due to the role [15]. Family caregivers frequently report that they have limited personal resources [16], such as time and money needed for ongoing care necessary for the AMHD. The family caregiver's financial consequences are that they could be responsible for continuing treatment for the adolescent well into adulthood [12].

Needs Assessment

The family's role is an essential piece to the adolescent's care, which includes managing the ongoing treatment plan upon discharge and possibly well into adulthood [12]. Interviews to assess CF's impact in this population included practitioners working with adolescents in an RTC and with providers and staff from three RCTs, one in Sedona, Arizona, and two in Utah. The interviews asked two simple questions: are you aware of CF in the family caregiver, and do you have a program address CF in the family caregiver? Based on the interviews, all had heard of CF's concept, but they do not screen families or provide programs to address CF (A. Rencher, personal communication, June 23, 2018; B. McElligott, personal communication, June 24, 2018; M. Bartlett, personal communication, February 11, 2019; J. Fairbanks, personal communication, March 26, 2019; T. Garden, personal communication, March 29, 2019). The practitioners and the staff at the three RTCs acknowledged that families have significant stress caring for their adolescents. They discuss with families the need to "take care," but they do not have any formal program to screen families for CF or provide interventions.

When presented with CF's concept, the staff at New Haven acknowledged the need to address the families' needs. The project's intent included a method to determine if this population of family caregivers is at risk for CF and implement for both staff and caregivers' interventions that include knowledge of CF and tools to reduce the risk.

Literature Review

A systematic and comprehensive search conducted between September of 2018 and November of 2018 to ask the question is family caregivers who have an AMHD at risk for CF. The following databases Cumulative Index to Nursing and Allied Health Literature (CINHAL) included CINHAL Complete, MEDLINE, and PsycINFO as a combined search tool to search for these five terms: compassion fatigue, family caregiver, family caregiver, and compassion fatigue, family caregiver and adolescent with a mental health disorder, and family caregiver with an adolescent with mental health disorder and compassion fatigue. An initial review

of abstracts yielded 39 studies with 21 retained studies all peer-reviewed and published between 2010 to 2018. The studies were kept based on the quality of the evidence, rigor of the research, and clinical significance (Appendix A).

Synthesis of Findings

The literature review examined the impact of caregiving on the family with an AMHD and whether family caregivers are at risk for CF. The literature emphasizes the adverse impact on caregivers' physical, emotional, and spiritual well-being, the same conditions as family caregivers who experience CF. Rodriguez describes the physical, emotional, and spiritual effects on the family caregiver [11,12] findings could be addressed as CF. Still, the authors only go as far as detailing them as adverse components of caring. Along with the social-emotional components, Moblebatsi, et al. [15] establish the economic stress of caring for an AMHD.

Parents, siblings, and grandparents of AMHD have the primary role of the family caregiver and have significant challenges when caring for an AMHD, placing them at risk for CF. The families were often under considerable stress as they try to manage the behaviors of an AMHD. Family caregivers reported higher stress levels, emotional turmoil, and guilt associated with disruptive behaviors and physical violence [15,17,18]. Family caregivers frequently report being isolated, have less leisure time, and overall dissatisfaction with family life [11,18]. The problem was identified based on the similarities between family caregivers caring for an aging or terminally ill family member and families caring for AMHD.

Project Frameworks

This project's theoretical framework is The Neuman Systems Model (NSM) developed by Betty Neuman [19]. The NSM is a holistic, multidimensional approach to the client as a system [19]. According to Neuman, the term client can include individual, family, community, and social issues. The client can be the "Practice Setting," and for this project, it will be the RTC. NSM is an open system that interacts with the internal and external environment. NSM describes five interacting variables; physiological, psychological, sociocultural, developmental, and spirituality affected by internal and external stressors [20]. The second role is to facilitate the delivery of primary, secondary, and tertiary prevention, assisting the client in retaining, attaining, or maintaining optimal balance and stability. The third requires an administrator to be dedicated to the holistic model and know that each discipline has its understanding and knowledge. The fourth guideline is that the setting is unique to providing care. The fifth guideline focus is on everyone involved in the delivery of services. For the project, the staff of the RTC was vital in determining how and when to implement the program. An administrator needs to maintain stability for everyone involved [20]. The conceptual

framework for the project is Knowledge to Action (KTA). KTA is a dissemination and implementation framework designed to take knowledge from primary research studies and synthesize it to generate new knowledge tools such as practice guidelines, decision aids, or care pathways [21]. KTA utilizes a collaborative process to adapt knowledge at the local level, which will be staff at an RTC. The KTA framework has been a successful model for implementing new knowledge and skills in various healthcare settings.

Using the KTA framework, the staff at the RTC, an interprofessional team of therapists, nurses, educators, and support staff, would receive new information on CF. The educational programs serve several purposes, initially establishing a relationship with the team and informing them about CF's education. By adapting the KTA, on-site training for the staff allows for identifying barriers, developing interventions to reduce barriers, and identifying anyone who has low compliance with implementing their new program guidelines. The on-site visits also offer the ability to disseminate new knowledge, define an implementation plan, address barriers, and discuss sustainability [22]. NSM adapts the need for education to the client's setting, and this will drive the content by identifying the at-risk family caregiver through the screening tool and identifying which interventions were more likely to be adopted by the family caregiver. The process should be collaborative. NSM believes that anyone can be a learner, and all that is required is an ability to engage in high levels of critical thinking. The overarching goal is to create a process adapted by the team [20].

Methods

Setting

The project introduced the concept of CF to the staff at New Haven, an RTC for adolescent girls with mental health disorders such as depression, anxiety, traumatic stress, substance abuse, eating disorders, and other challenging emotional disorders (www.newhavenrtc.com, 2017). New Haven provides residential care at two campuses North and South, in southern Utah. Each campus has three homes and a school campus. Admission often occurs after the adolescent has spent time in a wilderness program, an inpatient or failed outpatient program. Residential treatment provides psychological care using a variety of therapies in a structured environment.

Population

New Haven RTC is a multidisciplinary program that includes licensed therapists, recreational therapists, educators, nurses, and support staff. The program provides care for adolescent girls between the ages of 13 to 17. Family caregivers are typically parents but can include siblings, grandparents, and aunts and uncles.

Usual Care

New admissions require one-on-one staff support to evaluate behaviors and safety. An interprofessional team develops a care plan that includes individual and group therapies and an educational program to meet academic needs. The family plays an integral role in the treatment program. Families participate in therapy sessions that address issues that may contribute to a specific mental health disorder. A component of the treatment plan is family weekends, where the families participate in various activities with other families and their children. The weekends may include camping, on-campus events as well as time off-campus with their child. The design of the program is to provide the adolescent and their family opportunities to function with stability. To do this, the treatment team develops a plan that incorporates fewer restrictions for the adolescent and family before discharge.

Intervention

The project included two separate interventions, the first intervention was to educate the staff at New Haven, and the second intervention was implementing a CF program for the family caregivers who attended an on-campus family weekend.

To assess for CF in the family caregiver, the Professional Quality of Life (ProQOL), a tool designed to measure for CF, uses three scales, burnout, Secondary Traumatic Stress (STS), and compassion satisfaction [23]. The survey was designed initially for professionals and used to screen volunteers and family caregivers [24-26]. It was modified to be more inclusive of family caregivers in a study by Lynch & Lobo with Dr. Stamm's assistance, who developed the ProQOL survey [6,23]. Studies showed that when both burnout and STS scores were average/moderate or high that this was an indication of CF [6,23,27].

Research suggests that family caregivers' interventions should include providing programs with multifaceted methods that provide knowledge, coping strategies, and one-on-one support. These have proven to have significant benefits for professionals and caregivers [4,24,27,28]. The interventions are similar to those suggested for family caregivers of AMHD [16,29,30] peer support programs, self-help, guided self-help, workshops, and knowledge as excellent strategies for helping mitigate the stress of caregiving. In a systematic mixed study review by Rodriguez-Meirinhos, et al. [11] found that parents had a significant need for support to manage conflicts as parental roles change, and the adolescent seeks independence and autonomy. Resources are needed to support families through education and supportive care for the caregiver.

Staff at the New Haven RTC North Campus participated in the first one-hour in-person educational program during a weekly staff meeting in June of 2019 and South Campus in October 2019. The educational program for the staff included the history of CF from the professional to the family caregiver. CF's causes include the impact of the relationship between the family member and

the family caregiver, the stresses that are often outside the typical family roles. The symptoms of CF can be physical, emotional, and spiritual. The educational program provided interventions to address physical, emotional, and spiritual distress. Interventions include self-help exercise and diet guided self-help such as mediation and peer support. The validated screening tool is modified from the Professional Quality of Life Survey, entitled the Family Quality of Life Survey (FQLS) (Appendix B).

A staff lead discussion occurred at the end of the educational program to formulate the program for families. The staff agreed that the families could attend a group session, led by a staff therapist. The sessions would include the FQLS and an educational brochure that would include information on CF and interventions. The educational brochure introduced CF's concept, describing what the caregiver may experience as burnout and secondary traumatic stress, and symptoms of physical, emotional, and spiritual distress. The brochure also covered interventions to reduce caregiving's impact, which included the importance of sleep, exercise, nutrition, spiritual care, relaxation, meditation information on peer support, and sharing with other family caregivers.

Data Collection

Using the Continuing Professional Development (CPD) Reaction Questionnaire, a pretest-posttest assess the staff's commitment to a practice change (Appendix C). The CPD questionnaire measures a practitioner's response to receiving new knowledge and a subsequent change in practice [31,32]. According to Légare et al. [33], a practitioner whose response increased after participating in a CPD for the constructs of intention and a belief about capabilities are more likely to incorporate the practice change. Based on the result, self-reported behavior can be a proxy of behavior change.

The questionnaire was distributed in a paper format and collected by the author before and upon completing the education intervention on June 26 & 27, 2019, at the North Campus and October 23, 2019, at the South Campus. Once the questionnaires were collected, the de-identified data were uploaded into Qualtrics to organize the data by the constructs of intention, social influence, beliefs about capabilities, moral norms, and beliefs about consequences. North Campus implemented the project during a family weekend in July and October of 2019. Families participate in a variety of programs lead by staff therapists. The initial plan was to include families who were on campus for their first visit with their daughter. These families received the FQLS; the therapist-led a discussion on CF with the brochure. The lead therapist at North Campus also distributed the pamphlet and FQLS to all families on campus. During group setting, second- and third-time visiting parents were given CF information but in a less formal manner.

The FQL survey is a thirty item Likert scale used to measure compassion satisfaction, burnout, and secondary traumatic stress.

Moderate to high scores for burnout and secondary traumatic stress indicate CF [6,23]. New Haven provided families with a Follow-Up Survey approximately ten days after attending the family weekend. The follow-up survey determines how families received information, their understanding of the impact, and what they have done since acquiring the CF information. The Family Quality of Life Survey was distributed and collected by the lead therapists during the family weekend. The Follow-Up Survey was emailed to families by New Haven about ten days following the family weekend in an electronic survey.

Data Analysis

Data for staff participants were analyzed using descriptive statistics, similar to the method developed by Légaré et al. [32]. The data analysis included mean, median, and Wilcoxon signed-rank tests. This non-parametric testing allows for a hypothesis that is not about population parameters and is best suited for comparing two paired groups. The test will calculate the difference between each set of paired data and is best suited to analyze the differences between pre and post-interventions [34]. The data from Qualtrics was exported into excel to organize the responses based on the question constructs of intention (questions 1 & 7), social influence (questions 2, 6, 9), beliefs about capabilities (questions 3, 5, 11), moral norms (questions 4,10), and beliefs about consequences(questions 8 & 12). Calculations used the formula as defined by Légaré et al. [32] (Appendix D). Once sorted, it was analyzed using the JMP Pro statistical software (Table 1).

		North Campus			
		Pre		Post	
Construct	N	Item Mean	N	Item Mean	
Intention	10	4.5	10	5.75	
Social Influence	10	2.5	10	3.83	
Beliefs about Capabilities	10	3.2	10	5.37	
Moral Norms	10	5.55	10	6.25	
Beliefs about Consequences	10	5.75	10	6.35	
South Campus					
		Pre		Post	
Construct	N	Item Mean	N	Item Mean	
Intention	20	3.9	20	5.95	
Social Influence	20	3.2	20	3.25	
Beliefs about Capabilities	20	3.26	20	5.6	
Moral Norms	20	5.075	20	6.075	
Beliefs about Consequences	20	5.25	20	6.53	

Note. Predictive validity was estimated by comparing the pre-post scores of the CPD reaction questionnaire using a p-value < .05 as statistically significant. Wilcoxon signed rank test P value was <0.001

Table 1: CPD Reaction Questionnaire.

The lead therapist compiled the Family Quality of Life survey results, using the modified constructs developed for the ProQol tool [6,23,26]. The results were hand scored by the family member or staff, allowing the team to discuss the family member (Appendix E). The New Haven staff tabulated the Follow-Up Survey questions; an electronic survey sent to families who attended the family weekend (Table 2).

Did you receive information on CF?	Yes	No	Maybe				
	16	12	2				
How did you receive the information?	Group	Brochure	Both				
	8	4	5				

Do you have a new understanding of compassion fatigue and how it may impact you?	Yes	No	Maybe				
	12	1	6				
Have you shared the information on compassion fatigue with family and/or friends?	Yes	No					
	7	9					
Have you considered or have you implemented the following interventions?	Spoken to someone you trust	Eating a healthy diet	Made sleep a priority	Started an exercise program	Reconnected with church, nature, renewed relationship	Learned to relax or Meditate	Participated in a Support Group
	13	11	10	9	8	9	2

Table 2: Family Follow Up Survey.

Results

New Haven RTC staff participated in implementing a new program for family caregivers for CF. The data from the staff participants' CPD reaction questionnaires and the family caregiver FQOLS and Follow-Up surveys served to evaluate the project's impact.

The result of the CPD reaction questionnaires is an indicator of the staff's intention to change their practice. While there was an increase in responses for all questions, items measuring intention and beliefs about capabilities were significant. The construct items of intention, a median increase of 4.75 to 5.5, for South Campus a median increase of 4 to 6 for North Campus and beliefs about capabilities the median increase of 3.17 to 3.67 for South Campus and median increase 3 to 5.6 ($P < 0.001$) were a positive indicator for all participants at New Haven North and South Campus intention to change practice behavior (Table 1).

The Family Quality of Life Survey ($n=21$) suggests that the family caregiver's role is CF's risk. Caregivers scored in the moderate range (score of 23-41) for both burnout and secondary traumatic stress (Table 3). The Follow-Up Survey for families ($n=30$) suggests that not all families received information on CF. More than half received information (attended a group or received the brochure) and indicated a new understanding of CF's impact (Table 3). There is evidence that families who participated and obtained information on CF had either considered or had implemented one or more interventions. The interventions, including speaking to someone they trust, eating a healthy diet, made sleep a priority, and learned to relax and meditate. The families who participated in the program have indications for CF and had gained new knowledge and interventions for CF after participating in the program.

	High	Moderate	Low
Compassion Satisfaction (CS) ^a	6	14	1
Burnout ^b		18	3
Secondary Traumatic Stress (STS) ^c	2	17	2

Note: The FQL Survey was adapted from the Professional Quality of Life Survey.

^aCS scores of 22 or less are considered low and scores of 42 or more are high (Alpha scale reliability of 0.88) [23].

^bBurnout scores between 23 and 41 are considered moderate and score of 22 or less are considered low (Alpha scale reliability of 0.75) [23].

^cSTS scores of 42 or more are considered high, scores between 23 and 41 are considered moderate and score of 42 or more are considered high(Alpha scale reliability of 0.81) [23].

Table 3: Family Quality of Life Survey.

Predictive validity was estimated by comparing the intention (median intention construct score) after the CPD activities with the intention score and using a p-value $< .05$ as statistically significant. Overall, there was an increase in both campuses' scores for all constructs after the educational program ($P < 0.001$). There are noticeable increases for the construct of intention (median increase of 4.75 to 5.5 for South Campus and a median increase of 4 to 6 for North Campus) and beliefs about capabilities (the median increase of 3.17 to 3.67 for South Campus and median increase 3 to 5.6) (Table 1).

The Family Quality of Life Survey results included twenty-one respondents, with eighteen reporting a moderate level of burnout and seventeen with moderate levels of secondary traumatic stress scales, which are indicators of CF (Table 3). A total of 38 family participants replied to the Follow Up Family Surveys. Sixteen family participants reported receiving information on CF, two were unsure, and 12 responded no. Those who received information reported they attended a group, received a brochure, or both. Twelve family participants reported that they had a new understanding of CF and its impact. For the response to having received the information, 60.5% reported considering implementing or had implemented one or more of the interventions. Interventions of sharing information with someone they trusted (50%) reported making sleep a priority, eating a healthy diet, and learned to relax and meditate (37%) (Table 2).

The result of the CPD reaction questionnaires is an indicator of the staff's intention to change their practice. While there was an increase in all questions' responses, items measuring for intention and beliefs about capabilities were significant. The construct items of intention, a median increase of 4.75 to 5.5, for South Campus a median increase of 4 to 6 for North Campus and beliefs about capabilities the median increase of 3.17 to 3.67 for South Campus and median increase 3 to 5.6 ($P < 0.001$) were a positive indicator for all participants at New Haven North and South Campus intention to change practice behavior.

The Family Quality of Life Survey suggests that a family caregiver's role is a risk for CF. Eighteen of the caregivers scored in the moderate range (score of 23-41) for both burnout and secondary traumatic stress, indicators of CF. The Follow-Up Survey for families (n=30) suggests that not all families

received information on CF. More than half (n=17) received information(attended a group or received the brochure) and indicated that they had a new understanding of the impact of CF (n=12). There is evidence that families who participated and received CF information had either considered or had implemented one or more interventions. The interventions including having spoken to someone they trust (n=13), eating a healthy diet (n=11), and made sleep a priority (n=10). The families who participated in the program have indications for CF and had gained new knowledge and interventions for CF after participating in the program.

A post-conference was held with the lead therapist from North Campus after the July 2019 implementation. The lead therapist determined that first-time visiting families seemed overwhelmed and not ready to attend the CF program. Families visiting for a second or third visit were more receptive to learning about CF based on families' informal feedback. In January 2020, the program was formally introduced at both campuses with a designated therapist to implement the program. The cost of implementation included the cost of staff training and the program's implementation for families provided by a lead therapist. For staff training, New Haven estimated the cost for thirty staff during a weekly team meeting for a one-hour session at \$3650.00. The cost for the family session is estimated at \$54 per hour.

Discussion

The project aimed was to address CF's incidence for the family caregiver. The project provided the staff at New Haven North and South Campus with education on CF, screening tools, and interventions to develop and implement a new program for family caregivers. There were three components for evaluating the project, CPD reaction questionnaire from staff participants, the Family Quality of Life Survey to measure CF in the family caregiver, and the Follow-Up survey to measure the family response to CF's information. First, it is essential to understand the staff's willingness to implement a new program - the CPD reaction questionnaire given to the team as a pre/post measurement of an intention to change. The CPD reaction questionnaires' results, comparing the median for both intention and beliefs in capabilities after participating, showed an increase in both constructs ($P < 0.001$). The findings are suggestive of the intent to change.

Secondly, it was essential to evaluate families using the results from the Family Quality of Life Survey. Ten family caregivers responded with eight responses having scored in the moderate range (scores between 23 and 41) for burnout and secondary traumatic stress, the two scales suggestive of CF. Finally, the Follow-Up Survey was essential to determine what information was gained by the families. The survey results (n=30) suggest that not all families received information (n=12) or were sure that they received information (n=2). Families who received information (n=16), only eight reported gaining a new understanding of CF. All who received information indicated they had either considered or implemented one of the interventions. The most saying that they spoke to someone they trust (n=13), eating a healthy diet (n=11), and made sleep a priority (n=10).

Limitations

The current project has limitations. First, the sample size of families was relatively small and may not be generalizable. Secondly, the project was implemented in a different state from the project developer and not on-site for the entire project; this may have led to some deviation from the planned intervention, such as ensuring that all families received the FQLS or participated in a group session. The FQLS, an adapted form of the ProQoL Survey, contains language that does not quite fit with the role of the family caregiver, which may result in some misinterpretation by the person(s) taking the survey.

Conclusion

CF arises from a caring relationship for someone with a chronic illness. It can result in physical, emotional, and spiritual distress, and the family caregivers with an AMHD are at risk for CF. Providing family caregivers with AMHD information and CF interventions can be an effective way to improve the caregiver's well-being. While this project addresses those caring for an adolescent, it could be potentially useful for caregivers caring for someone with a mental health disorder of any age. There is more opportunity to study the phenomenon of CF and the family caregiver and overtime and determine which interventions are more effective.

Author Note

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