Working With the Cards We're Dealt: A Longitudinal Study Exploring the Impact of Intersectional and Systemic Factors on Family Mental Health. Evidence From Understanding Society: UKHLS

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Abstract

Despite it being acknowledged that family is important when thinking about psychological distress, there is limited research in this area, particularly when also thinking about intersectionality. A systematic review highlighted some important factors in relation to psychological distress; however, included literature was relatively weak. Subsequently this research aimed to explore factors influencing psychological distress pre and during the first COVID-19 lockdown, using a systemic theory and intersectionality lens. Data was extracted from the UK Household Longitudinal Study to reach these aims. Participants included families whereby one member had started experiencing psychological distress. Participants were grouped into *offspring of distressed person*, *spouse of distressed person*, and *other family members*. Regression analyses were carried out exploring the relationships between intersectionality variables from timepoint one, relational variables from timepoints three and four and psychological distress from timepoints five and six. Results indicated several factors related to psychological distress, which often differed for different family members. Several factors such as sex and age were found to interact with relational factors, indirectly affecting distress over time. Factors important to psychological distress changed at the start of the pandemic, especially with regards to the relational factors, suggesting that the pandemic was a destabilising event which disrupted the equilibrium of families. The results of this research offer support to intersectionality and systemic theory, particularly in relation to family systems theory, family life cycle, triangulation, and third order systemic thinking. Recommendations are made to mental health services and policy makers in how the evidence can be used to better support families. Further research is recommended to explore intersectionality of families in greater detail and gain more specific perspectives on psychological distress in families.

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List of Abbreviations

BPRS	Brief Psychiatric Rating Scale
BSI	Brief Symptom Inventory
CATPCA	Categorical Principle Components Analysis
CBCL	Child Behaviour Checklist
CDI	Child Depression Inventory
CED-D	Centre for Epidemiologic Studies Depression Scale
DASS	Depression, Anxiety, Stress Scale
ECBI	Eyberg Child Behaviour Inventory
EPDS	Edinburgh Postnatal Depression Scale
GHQ	General Health Questionnaire
HADS	Hospital Anxiety and Depression Scale
HoNOSCA	Health of the Nation Outcome Scale for Children and Adolescents
IOWA CRS OD	Iowa Connors Rating Scale- Oppositional/Defiant Subscale
IPAT CPQ	Institute for Personality and Ability Testing Children's Personality Questionnaire
K10	Kessler Psychological Distress Scale
MASC	Multidimensional Anxiety Scale for Children
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OLS	Ordinary Least Squares
PCA	Principle Component Analysis
PCL	PTSD Checklist
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROMIS	Patient-Reported Outcomes Measurement Information System
PTSD	Post Traumatic Stress Disorder
QATQS	Quality Assessment Tool for Quantitative Studies
SDQ	Strengths and Difficulties Questionnaire
SCL	Hopkins Symptom Checklist
SPSS	Statistical Package for the Social Sciences
SWIM	Synthesis Without Meta-Analysis
UKHLS	UK Household Longitudinal Study
WFC	Work family conflict
YSR	Youth Self Report

List of Statistical Symbols

α	Cronbach's alpha
b	Unstandardised regression coefficient
β	Standardised regression coefficient
CI; [ ]	Confidence Interval
Est	Estimated Coefficient
F	ANOVA F-statistic
M	Mean
N	Total number of cases
ηp^2	Partial eta squared
p	Probability (P-value)
r	Pearson correlation coefficient
r_s	Spearman rank order correlation
R^2	Multiple correlation value squared
SD	Standard Deviation
SE	Standard Error
t	T test statistic
VAF	Variance accounted for
χ^2	Chi-square statistic
λ	Eigenvalue
Z	Standardised score

Chapter 1: Introduction

Chapter Overview

This chapter aims to introduce the research area in which this thesis sits. The chapter has been divided into several sections. Section one explores the context in which this research is being conducted through a reflection of my own context. I use a first-person perspective based on my stance that I am not neutral nor completely objective and inevitably have influence over this research (Bracken & Oughton, 2006; Webb, 1992). The second section introduces the language used throughout this report. This is followed by reports on background literature which highlight the importance of considering family in mental health practice, introduces the reader to systemic theory, considers how we currently work with and support families in the UK through a critical lens and highlights how the current context of the UK may impact psychological distress. Section three includes a systematic literature review exploring what the social, cultural, and religious factors influencing psychological distress in families are. The introduction chapter is concluded with the rationale for this research followed by the aims and research questions.

Context of the Research

Whilst researcher reflexivity is widely accepted and often expected within qualitative research, it is not always typical for quantitative researchers to keep a self-reflexive stance in their writing. However, all research is situated within a context and thus reflection is essential, particularly in aiding critical evaluation (Kingdon, 2005). The process of reflection, which occurs throughout this thesis, not just within the designated sections, considers situatedness and personal investments which may have impacted upon and transformed this research (Gergen & Gergen, 2000; Kingdon, 2005). I have developed an awareness of my

own biases and worked towards reducing these as much as possible. I start this chapter with reflections with the view to navigate the reader to my own lens and hopefully support them to reflect on their own throughout.

Researcher's Context

I am a daughter of two women, an older sister, a granddaughter, a niece, a cousin and a wife. My family are from a working-class background, and although no longer "fit" in this category, are very much influenced by our history. Within my mostly female family, I have been brought up on stories of "strong" women, who do not conform to gender roles and at times, have actively fought against these. We have always been close, geographically and with regards to our relationships, in a way that may be described as "enmeshed" or "too close" by Minuchin (2018).

Throughout my education in Psychology, I have come to learn that my family does not fit with the commonly used theories and therapeutic models, or as I prefer to say, these models do not fit with my family. Throughout my practice as an Assistant Psychologist and a Trainee Clinical Psychologist undertaking additional systemic training, I have come to realise that these models do not fit with many families I meet. As a result, I have developed a stance that families are doing the best they can in societies which are not always set up for them to succeed and therefore am passionate about preventing over pathologising or placing blame on families who seek our help, a passion that I'm sure I share with many.

Whilst being aware of areas in which my family and I may lack power and be discriminated against, it is also important to consider our privileges. I, and most of my family are White British, we have all been educated to at least secondary level, are mostly able-bodied, and all own our own homes. The areas of privilege and discrimination that my family

and I carry with us provides me with insight into differences between families. However, it does not mean that I understand the unique needs of other families without first hearing from them. Therefore, I have attempted to remain open and curious throughout this research. My family influence me in all areas of my life, including my role as a researcher, leading to somewhat of a personal investment in this area of research.

With this research grounding itself in ideas of social justice, it was important to consider the social change ecomap (Iyer, 2017), which can be of benefit at the beginning of a project. In identifying my values, I found myself relating most with the "visionary" role. Within the social change ecomap, "visionaries" are those who "imagine and generate our boldest possibilities, hopes and dreams, and remind us of our direction" (Iyer, 2020). My role as a "visionary" has motivated me throughout this research, thinking up and highlighting ideals on how we can better support families within mental health services. Whilst I do attempt to adopt other roles throughout this research, I acknowledge that specific, valuable positions are likely to be missing.

Language and Definitions

This thesis is influenced by systemic theory which considers how language is used to create meaning in communication. In addition, as a White, British Trainee Clinical Psychologist, a researcher and author of this thesis, I hold power which may be perpetuated through my use of language (Fairclough, 2013). In an attempt to make this research accessible to all who may find it thought provoking and useful, it is important I first highlight and define key terminology that is used throughout this paper.

Family

Defining the term family can be problematic in the idea that there is no definition which would reflect the social reality of family for the whole population (Treuthart, 1991). Whilst I agree with this, I also believe that it is important for the reader to be aware of what is meant by family within this research. For this purpose, I have defined family (based on my own social reality) as a group of individuals who influence each other's behaviour (Pfeiffer & In-Albon, 2022). These individuals may be connected e.g., through birth, adoption/fostering or romantic relationship. I also acknowledge that families may be made up of people who share a household.

Psychological Distress

Psychological distress is referred to within a range of medical and psychology literature, with slightly different definitions. I adopt the definition of Ridner (2003) who describe psychological distress as "the unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person". I attempt to use the term psychological distress, in line with ideas of the Power Threat Meaning Framework (Johnstone & Boyle, 2018), in place of specific diagnostic labels of mental health due to various limitations with the diagnostic system. Whilst diagnostic labels may enable a simpler way for individuals to communicate complex experiences (Baron et al., 2006), they are criticised for their lack of reliability and cultural consideration (Kapadia et al., 2020). Diagnostic labels are accompanied with dominant discourses around the identity, personality and needs of the individual possessing such label. This then guides how others may interact with said individual (Rubington & Weinberg, 2008), which can result in both positive (e.g. caring) or negative (e.g., isolation) experiences. Label driven interactions may then lead to a self-fulfilling prophecy,

strengthening the discourse related with that diagnosis. Despite the criticisms of diagnostic labels, we have constructed a culture in the UK whereby mental health diagnoses have meaning to individuals, services and the law and thus are used within the current literature. Therefore, when referencing prior research, various mental health diagnoses are mentioned.

Mental Health Services

Mental health services will be used when referring to services (NHS, local authority, charitable or private) who offer any form of support to individuals, families or groups experiencing psychological distress. This support could include psychological therapy, help with housing difficulties, guidance on claiming benefits (Mental Health Foundation, n.d.) or pharmacological treatment.

Intersectionality

Originally used to understand discrimination specifically against Black women, intersectionality is a theoretical framework which refers to the interconnectedness of social categories including gender identity, sexuality, disability, religion, class, ethnicity, age and culture (Crenshaw, 1989). The idea of intersectionality teaches us that we each have layered identities which combine and transform creating unique identities but also unique and complex experiences of privilege and oppression. Therefore, addressing each layer in turn, as in models such as the Social GRRRAAACCEEESSS (Burnham, 2018), is unable to meet the needs of an individual.

Background

Discussing Family in Relation to Psychological Distress

When thinking about experiences of psychological distress, we often focus on the individual rather than families and joint experiences. However, research is beginning to explore how psychological distress in one family member can lead to intense and pervasive worry, low mood, hopelessness, and panic in addition to experiences of isolation and loss (Buus et al., 2023). Therefore, this section discusses joint experiences of psychological distress, specifically focusing on the impact of psychological distress of one individual on their children, parents and siblings.

Literature demonstrates that parental psychological distress is associated with psychological distress and general life satisfaction in their children (Amrock & Weitzman, 2014; Cummings & Davies, 1994; Ge et al., 1995; Powdthavee & Vignoles, 2008). Children of parents experiencing psychological distress appear more likely to engage in behaviours which challenge others (Mowbray et al., 2006) and experience hyperactivity (Amrock & Weitzman, 2014). Both of which may be external expressions of psychological distress. More specifically, when compared with children whose parents are not experiencing distress, younger children are more likely to express "abnormal emotional symptoms" and older children are more likely to experience distress in a way that attracts a diagnostic label of "conduct disorder" (Amrock & Weitzman, 2014). Within this research, this appears to be the case whether it is the mother or father of the child who is distressed. However, research exploring youth happiness found that there may be gender differences in relation to the child's gender, with this relationship only being found between the parent-daughter dyad (Webb et al., 2017). This relationship between parental and child psychological distress may be mediated by parentification, defined as the child experiencing an increase in age-

inappropriate responsibilities (Aldridge & Becker, 2003; Mattejat & Remschmidt, 2008). Research also demonstrates that further mediators of this relationship could be parenting behaviours and/or an interference to the parent-child attachment (Cummings & Davies, 1994; Mattejat & Remschmidt, 2008), with attachment playing a large role in one's psychological well-being (Mikulincer & Florian, 2003).

Whilst there is extensive research on the effects of parental psychological distress on children, there is little research exploring how child psychological distress may influence parents. Greally (2023) however conducted both a literature review and narrative research, exploring this topic. It was noticed that there was a trend which found that parents experienced "a psychological tsunami of emotions" when their child was experiencing psychological distress. The literature review concluded that whilst "caring for an intimate stranger" parents often lived with extensive worry and sadness, with suffering being experienced as "a way of life". Greally (2023) found that participants in her own study, who were mostly mothers, experienced fear, especially in relation to their child's self-harming or suicidal behaviour, to the extent where one mother sought therapy for "post-traumatic stress disorder". Parents also reported that their sleep had been affected, that they were worried, were experiencing their child's admission and distress as a loss and that their "emotional pain" was not understood by others. Whilst not related to psychological distress specifically, parents of children with "learning disabilities" and "autism spectrum disorder" also experience increased psychological distress when compared with parents of children without these diagnoses (Arnold & McPherson, 2023; Giallo et al., 2013). Contrasting findings suggest that adolescent happiness is not related to parental distress (Webb et al., 2017) and that adolescent life-satisfaction is only related to paternal distress and not maternal (Powdthavee & Vignoles, 2008). However, the presence or absence of happiness and/or life satisfaction cannot be assumed to signify the presence or absence of psychological distress.

Having a sibling who experiences psychological distress can lead to stress in relation to caring responsibilities, witnessing their sibling becoming unwell, requiring hospital admission and relying on substances (Friedrich et al., 2008). Individuals also report experiencing an ambiguous loss when their sibling is unwell (Abrams, 2009; Kovacs et al., 2019) which may lead to a deep sadness. The distress experienced by siblings is somewhat similar to that experienced by parents (Greally, 2023) which may not be surprising given that siblings of a psychological distressed individual may experience a shift in their family role, often assuming a more parentified position (Kovacs et al., 2019), as children of a distressed parent also might do. Abrams (2009) suggested that the "well sibling" often becomes (or is perceived to become) independent, high-functioning and responsible, potentially reflecting this idea of parentification. In taking on this identity however, there is a risk of their own distress being dismissed by themselves and/or others around them. This may explain why participants from Friedrich et al.'s (2008) research felt that mental health support for their siblings and better relationships with their family was more of a need than mental health support for themselves.

Based on this background literature it is recognised that psychological distressed is a shared experience within families. Whilst this has been previously identified with regards to "depression", which has been considered a "family disease", this discussion highlights that regardless of diagnosis, we must begin to recognise the impact distress has within families. This brings into question why mental health services (influenced by the National Institute for Health and Care Excellence; NICE) are dominantly based around the client being an individual rather than the family or system, and the "problem" being located within them.

Systemic Theory and Systemic Family Therapy

Systemic theory (which views problems as occurring interpersonally within a context) was developed as a challenge to traditional medical ideas of psychological distress, and psychodynamic orthodoxy (Dallos & Draper, 2015; Dallos & Urry, 1999). Systemic theory and, as a result, the practice of systemic family therapy has developed since it's conception via 1st, 2nd and 3rd order cybernetics. Dallos and Draper (2015) discuss this development as first, second and third phases followed by the twenty-first century ideas, to make the theory more accessible. This section of this thesis will therefore follow the structure of Dallos and Draper, (2015). This section will only include a brief description that orients the reader to one of the lenses in which this research is being conducted, rather than a complete explanation of the theory development.

The first phase (1950s to 1960s), based on systems theory, took a biological/mechanistic perspective with regards to how we can think about problems as interpersonal (Dallos & Draper, 2015). For example, applying ideas of how the body is made up of several components which connect and coordinate in a way that maintains stability or homeostasis (von Bertlanffy, 1968). This phase took the stance that families could be viewed objectively and gave use ideas such as circularity, triangulation, rules, feedback, double-bind and coordination through communication and meta-communication. Many of these ideas were used within family systems theory (Bowen, 1966), which emphasises that change in an individual evokes change in others (Kerr & Bowen, 1988) and introduces ideas such as triangulation and enmeshment. For example, using these ideas, it may be understood that a couple may use their relationship to place their anxiety about themselves onto each other (Kerr & Bowen, 1988), leading to a shared level of anxiety. It may also be expected that if one individual within a couple experiences psychological distress, their partner is likely to

move into an "overfunctioning" role, taking responsibility for the other's emotional state. This was understood to lead the partner to develop psychological distress themselves whilst trying to support their loved one (Brown, 1999). Whilst systems theory tends to discuss this idea in relation to anxiety, Priestley et al. (2017) has also used these ideas to think about depression. For example, reporting that a partner might feel a need to "fix" the depression, shifting from the position of partner to a position of carer, blurring boundaries and rules within the relationship and resulting in reduced confidence and increased stress and worry. If there are children within such a family structure it is understood that the child could become intertwined or "triangulated", taking on emotional responsibility for their parent's distress. From this phase also came the theory of the family life cycle, which acknowledged that problems were often associated with significant periods of change and transition (Dallos & Draper, 2015; Haley, 1973).

With regards to therapy, we saw the rise of structural family therapy (Minuchin, 1974) and strategic family therapy developed by Haley. Structural family therapy took the stance that families were capable of change and prioritised thinking about hierarchies in the family, triangulation, rules and boundaries and ideas of enmeshment. This form of therapy involved the therapist making changes to the organisation structure of the family from a directive position based on ideas of "healthy family functioning" (Dallos & Draper, 2015). This first phase of systemic theory gave us an alternative perspective to thinking about psychological distress, along with key techniques on how to speak with multiple people in the therapy room (e.g., circular questioning and using a team approach). However, the ideas took a normative view of how families "should" be (Dallos & Urry, 1999) based on White, Western, middle-class perspectives of family, meaning that a multitude of families may have been perceived as "failing" by the model.

The second phase (mid 1970s to mid 1980s) took place in the context of the movement from behaviourist approaches to more cognitive approaches in the treatment and understanding of psychological distress. The shift from first-order cybernetics to second-order cybernetics was based on the critiques that therapies stemming from systemic ideas took a mechanistic view on families (Dallos & Urry, 1999). The second order took a more collaborative and reflective stance, whereby therapists began challenging ideas of neutrality and were more reflective of their own values. The therapist began to see themselves as influenced by the family as much as they were an influence to the family. Therapists positioned themselves as a "non-expert", interested in meaning and beliefs which shape experience. The view that the "symptom" or "disorder" served the function of homeostasis in the family was rejected and instead therapists began taking the stance that psychological distress was a result how experiences are interpreted and given meaning by the family (Dallos & Urry, 1999). This second phase placed an emphasis on language, exploring how intention may be attributed by observing systems. Ideas of triangulation were interpreted now as "movement between actions and meanings" (Dallos & Draper, 2015). The Milan approach during this phase brought the idea of having a reflective team within systemic family therapy along with ideas of hypothesising and reframing. Power and culture became central to systemic practice during this second phase.

The third phase (1980 to 2000) of systemic theory grounds itself in social constructionism (Dallos & Draper, 2015) and narrative ideas (White & Epston, 1990). Whilst continuing to reflect on context and power, systemic therapists embracing this phase, actively aim to "meet people in their culture" (Lang & McAdam, 2001). This phase continues to believe that families can be rule-bound and predictable; however further develops on this idea to think about how discourses and culture influence this (Dallos & Urry, 1999). This means that therapists pay close attention to the family's social and cultural origins and the language

and discourses present, focusing specifically on which ones appear dominant or subjugated. The systemic therapist does not impose new ideas onto the family but instead encourages reflection (Dallos & Urry, 1999) and curiosity. The third phase of systemic theory places an emphasis on considering difference within and between families, subsequently placing ideas such as intersectionality at the forefront. Considering intersectionality in addition to society, moves us away from perpetuating feelings of blame within families; however, these ideas, specifically social constructionism can feel like a minefield for clinicians specifically those still training (Dallos & Urry, 1999) or newly qualified systemic therapists. Whilst this third phase is associated with continuing to utilise the reflecting team, externalising the problem and interviewing the internalised other (Dallos & Draper, 2015), it is less concerned with techniques. Instead, it is more concerned with orientations of the therapist such as feminist perspectives, belief of therapy as a conversation and being resource focused (Dallos & Draper, 2015).

Twenty-first century systemic practice considers the history and development of systemic therapy, utilising many of its approaches and techniques across the three phases. However, systemic therapists now are also integrating these ideas with other theoretical models in working with a range of presenting difficulties (Dallos & Draper, 2015).

How Mental Health Services in the UK Work With Families

Mental health services in the UK are required to provide treatments which are considered evidence based and recommended by NICE guidelines. Within the NICE guidelines, families are generally understood as a protective resource for individuals experiencing psychological distress at a level where they meet diagnostic criteria. This makes sense given the idea that for many individuals, families are the primary social unit in which they may seek support; however, it is also argued that in recognising families as a resource,

they are “responsibilised” to reduce the demand on services (McPherson & Oute, 2021). This “responsibilitisation” of families brings a risk of further burdening and increasing psychological distress in the family members (McPherson & Oute, 2021).

With this in mind, it is recommended within the guidelines for various mental health diagnoses (NICE, 2005, 2007, 2009a, 2011, 2012, 2013b, 2013a, 2014a, 2017b, 2018c, 2018a, 2018b, 2022a, 2022b) that families are provided with education and “training” to support their loved one. As well as “responsibilising” the families, these types of interventions place the clinician in the expert position and may therefore perpetuate the idea that there is a way in which families “should” be, which as aforementioned is a common criticism of first-order systemic ideas.

The Care Act (Department of Health, 2014) ensures that professionals acknowledge that family members can experience distress themselves and places a responsibility on professionals and services to offer carer’s assessments. The NICE guidance also acknowledges this at times, specifically in relation to parents of children and young people and recommends that services are equipped to signpost family members to relevant self-help resources, support groups and/or mental health services for individual support (NICE, 2005, 2007, 2011, 2013a, 2014a, 2017b, 2018c, 2018a, 2018b, 2022b). Whilst this may be beneficial to distressed, “responsibilised” family members, it continues to perpetuate the idea that we must focus on an individual rather than a system.

It is understood that family context is important in working with individuals (NICE, 2005, 2012, 2013b, 2019). However, given that NICE guidelines are based around a disease model, whereby the “disease” affects the individual, there remains a preference for individual interventions. Non-individual interventions such as family therapy are not considered “cost-effective” in some cases (NICE, 2017a), which may explain their limited recommendation.

However, it should not be ignored that evidence-based guidelines are heavily influenced by what research is available. With manualised approaches such as Cognitive Behavioural Therapy (CBT) being more easily controlled and assessed, this is where much of the research is focused. In these instances, it is important to keep in mind that whilst guidelines such as NICE are not able to recommend therapies which are not evidence-based, lack of research does not indicate a lack of effectiveness.

Despite this emphasis on individual therapies, professionals are expected to attempt to involve the family within assessment and interventions such as CBT, particularly when working with children and young people (NICE, 2005, 2013b, 2018c), but also with adults diagnosed with "depression" (NICE, 2022a), "eating disorders" (NICE, 2017b) and "personality disorders" (NICE, 2009a, 2009b). There have also been attempts to manualise family interventions, making them more easily researched. This has led to the development of models such as behavioural family therapy, family-based interpersonal therapy, and family therapy for "anorexia nervosa", to name a few. These more structured family interventions are recommended for people who find themselves diagnosed with "bipolar disorder" (NICE, 2014a) "depression" (NICE, 2022a) "eating disorders" (NICE, 2017b), "personality disorders" (NICE, 2009a), adolescents who self-harm (NICE, 2022b) and individuals who find themselves misusing drugs (NICE, 2007). These interventions are often influenced by more first or second order ideas of family therapy, which may more easily fit with the manualised approach. With this however, these clinicians are expected to "directly intervene" with the families in which they work with and suggest ways in which interactions can be more "adaptive" (NICE, 2009a). Ideas which have been criticised with the evolution of systemic theory and therapy. With social constructionist ideas and intersectionality suggesting a uniqueness to individuals and families, it may also be speculated that without proper training in these ideas, they may get lost within more manualised family interventions.

Whilst there is a preference for individualised and/or manualised therapies in the NHS, non-manualised systemic family therapy is offered within many services and is recommended for families where at least one person has been diagnosed with "bipolar disorder" (NICE, 2014a), who have a child with "moderate to severe depression" (NICE, 2019) where a person under 25 is misusing drugs (NICE, 2007) and who have a child or young person who engaging in self-harming behaviour (NICE, 2022b). Systemic family therapy should also be offered in collaboration with CBT to every family where an individual (child or adult) is experiencing "psychosis" or "schizophrenia" (NICE, 2014b). However, these interventions can only be provided in the UK by a Systemic Family Psychotherapist, accredited by the Association for Family Therapy and therefore only services with these professionals can offer these interventions. It should also be noted that whilst Systemic Family Psychotherapists try to focus on the family rather than the individual, they are still influenced by the service context whereby just one individual is the "patient" who is "unwell".

The Current UK Context on Psychological Distress

With this thesis being longitudinal, many societal events would likely have influenced the participants both directly and indirectly. Living in the same country, and in some cases, the same county of the participants I would have also been influenced by these same events, which have likely influenced the conception of this thesis, but also in how I have understood the data.

In March 2020 the UK entered a "lockdown" due to the COVID-19 pandemic. During the pandemic many families experienced loss, whether this is the loss of family members or friends, loss of jobs or loss of time in education or social groups. All of which are factors that we understand as having a negative impact on levels of psychological distress. Whilst we are

yet to understand the full extent of the lasting impact of the pandemic, research that is emerging currently demonstrates that in the first month of the initial lockdown, there was an increase in psychological distress experienced by the UK population (Chandola et al., 2022; Daly et al., 2022; Pierce et al., 2020). Groups who appeared most vulnerable to psychological distress during the first month of the lockdown were people in the 18-24 and 25-34 age groups, women, individuals with young children and individuals who were in employment prior to the pandemic (Pierce et al., 2020). However, psychological distress of the UK population was then found to slowly decrease as the lockdown's continued (between April and June; Daly et al., 2022 and April and July; Chandola et al., 2022) This coincides with findings that the negative impacts of the initial lockdown (e.g., unemployment increasing) began to lessen (Chandola et al., 2022). Whilst researching the middle-upper class United States population, Eales et al. (2021) somewhat supports this with their finding that families were able to begin adapting to the changes placed upon them. This mixed-methods study found that whilst families (parents and children) experienced more unpleasant emotions (worry and sadness) than pleasant emotions (happiness) during the pandemic, most families felt that they were spending more enjoyable time together, and that their relationships had improved. However, there were still many families who felt the opposite, demonstrating that the pandemic was experienced differently by different families.

Following the COVID-19 pandemic, the UK is now experiencing a cost-of living crisis, with many families now struggling to heat their homes and relying on food banks or "children eat free" initiatives to eat (Francis-Devine et al., 2023). It is predicted that the cost-of-living crisis, will lead to cuts in services, an increase in psychosocial stress, lack of resources (including food and shelter) and an increase in poor health behaviours (e.g., smoking and drinking). All these factors are expected to then lead to increased psychological distress in the population, amongst other poor health outcomes (Broadbent et al., 2023).

Research supporting this prediction has shown that individuals are already reporting increased levels of psychological distress which they believe is due to the cost-of-living crisis. Those most vulnerable appear to be individuals who are struggling financially, those in social housing and, similar to who were psychologically vulnerable during the COVID-19 pandemic, individuals who fall within generation X and millennial age categories (Lawson et al., 2023). Unlike with the COVID-19 pandemic however, there have been no signs of any decrease in people's psychological distress as the crisis continues (Lawson et al., 2023).

The cost-of-living crisis is also believed to be influenced by "Brexit" (Broadbent et al., 2023). Brexit, which although voted for in 2016, occurred 4 years later (notably the same year as the COVID-19 lockdowns and the George Floyd Murder in America). Brexit left a number of minority groups vulnerable with regards to uncertainty around their rights. Changes in the rights and legislation concerning minority groups may lead to a reduction in feelings of protection and respect which subsequently impact on people's levels of psychological distress (Heald et al., 2018). Whilst many minority groups were affected by Brexit including women and individuals from the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+) community. The largest groups affected appeared to be individuals who had migrated to the UK and individuals who are Black or Brown. The Brexit referendum campaigns (as recognised by the United Nations) led to an increase in hate crimes towards minority ethnic groups in the UK, and an apparent permission for the media to spread racism and hate that would have previously been considered as unacceptable (Heald et al., 2018). Frost (2020), specifically found that migrants who lived in areas with more "leave" supporters, were more likely to experience discrimination after the referendum. With psychological distress and specific mental health disorders, such as "schizophrenia" in Black communities, being associated with societal factors, it is understood that the discrimination, alienation and fear brought by Brexit has led to increased psychological distress in minority

ethnic populations (Frost, 2020; Heald et al., 2018). It should be noted that discrimination towards those with Chinese heritage was then worsened by the COVID-19 pandemic (Al-Talib et al., 2023; Gray & Hansen, 2021), leaving them particularly vulnerable.

The UK context is not completely summed up by these events and it is important to consider that, the UK is experiencing uncertainty in leadership, with three prime ministers in three years. There has also been a rise in environmental protests and many professions are partaking in strikes seeking better working conditions and higher pay. More positively there has been an increase in acceptance of women in sport with the England Women's football team successes. All of which, will likely impact the levels of psychological distress, for better or worse, of those living in the UK.

Conclusions from the Background Literature

Research demonstrates that psychological distress is often experienced by the family, rather than just one individual alone. With this in mind, it then makes sense that mental health services offer support to the family, if this is what they want. Family interventions are recommended by some NICE guidelines; however, this is limited and often in the form of manualised interventions, which does not typically fit with how systemic theory has evolved. Manualised family interventions which divert from modern systemic ideas, may be criticised for being based on White, Middle-class norms and may therefore fail to consider the unique intersectionality and diversity of families and the individuals within them. This therefore brings into question how family interventions are experienced by families. For example, families who live within multigenerational households, whilst normal within their culture could be at risk of being labelled enmeshed. Inversely, a working-class family, single-parent family, whereby the parent has to work multiple jobs and therefore is not around often, may be at risk of being labelled as a disengaged family. In both instances, the families may be

encouraged to make changes which are incongruent to their beliefs, providing further distress. This is made more complex by intersectionality whereby families may experience a unique combination of privilege and oppression. For example, a Muslim, working-class family might have unique challenges and dynamics compared with a Muslim, middle-class family; whereby their economic difficulties could lead to them being unable to engage in community activities which connect them with their religion. We should also consider how we can better support professionals to update their skills and incorporate concepts of social constructionism and intersectionality into their work, following more recent systemic ideas and reflecting the increasing diversity of family structures in the UK.

Systematic Literature Review

Introduction to Systematic Literature Review

Within this section of the introduction, I present a systematic literature review exploring psychological distress in families. The background literature demonstrates that there are many factors which affect psychological distress including, but not limited to income, discrimination, and employment. Driven by systemic theory and interdependence theory, I take the position that every individual functions within relational systems such as family. Given this, with the need for better psychological support for families, we must first understand factors affecting psychological distress in the context of family rather than individually.

To my knowledge, there are no current literature reviews exploring this topic and thus it was considered that a systematic review would form an essential part of this thesis, enabling me to explore in detail the current literature base and identify knowledge gaps

(Alderman, 2014). This review was also used to inform my variables and provide a context in which my research sits.

I was curious about the absence of a literature review in this specific area and wondered if it reflects uncertainties in using systemic ideas when working with people experiencing psychological distress.

Aim of This Review

This review aims to critically appraise and review the literature exploring the social, cultural and religious influences on psychological distress within families. These influences were chosen due to the background literature highlighting that these may be important areas which impact the psychological distress of families. The research question for this review is therefore: "what are the social, cultural and religious factors that influence psychological distress in families and how do these differ across different family members?" The results of this review were used to inform the research conducted in this thesis. It was hoped that results may also provide a first step in thinking about how we support non-systemically trained clinicians to use and consider diversity, difference and intersectionality when working with families.

Method

To complete this review, five concepts were named and defined: *family*, *psychological distress*, *social influences*, *cultural influences,* and *religious influences*. Both family and psychological distress have been defined earlier on within this report under the subheading 'language and definitions' and therefore will not be repeated here.

Social influences, also known as social determinants, refer to factors which are guided by the interaction between public policies and social norms (Compton & Shim, 2015). Compton and Shim (2015) explain that social influences are underpinned by distribution of opportunity and generally include factors such as education and income.

Cultural influences, refer to ubiquitous, ingrained practices that are deeply felt and form an integral part of people's everyday interactions and relationships (Carbaugh, 1990; Lang & McAdam, 2001). Lang and McAdam (2001) view groups (e.g., families) as each having their own unique culture, as well as wider culture. With each different culture having its own practices and language. They explain that in giving attention to people's culture, we must give attention to all areas of identity and ways in which these guide how they live.

Religious influences refer to any factors which relate to "a system of beliefs, values, rituals, and practices shared in common by a social community as a means of experiencing and connecting with a sacred or divine" (Foy et al., 2011, p. 91). Given that there may be multiple religions within one family system, religious influences could come from one religion or a combination.

Search Strategy. The preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; Page et al., 2020) and Cochrane (Lefebrve et al., 2021) were used to guide both the search strategy and selection of papers.

Five data bases (APA PsychArticles, APA PsychInfo, CINAHL Ultimate, E-Journals and MEDLINE Ultimate) were searched via EBSCOhost. With the latest search being run in October 2023. Search alerts were enabled within EBSCOhost to ensure the inclusion of papers published after this date. A citation search was also carried out via Web of Science. The search terms used were as follows:

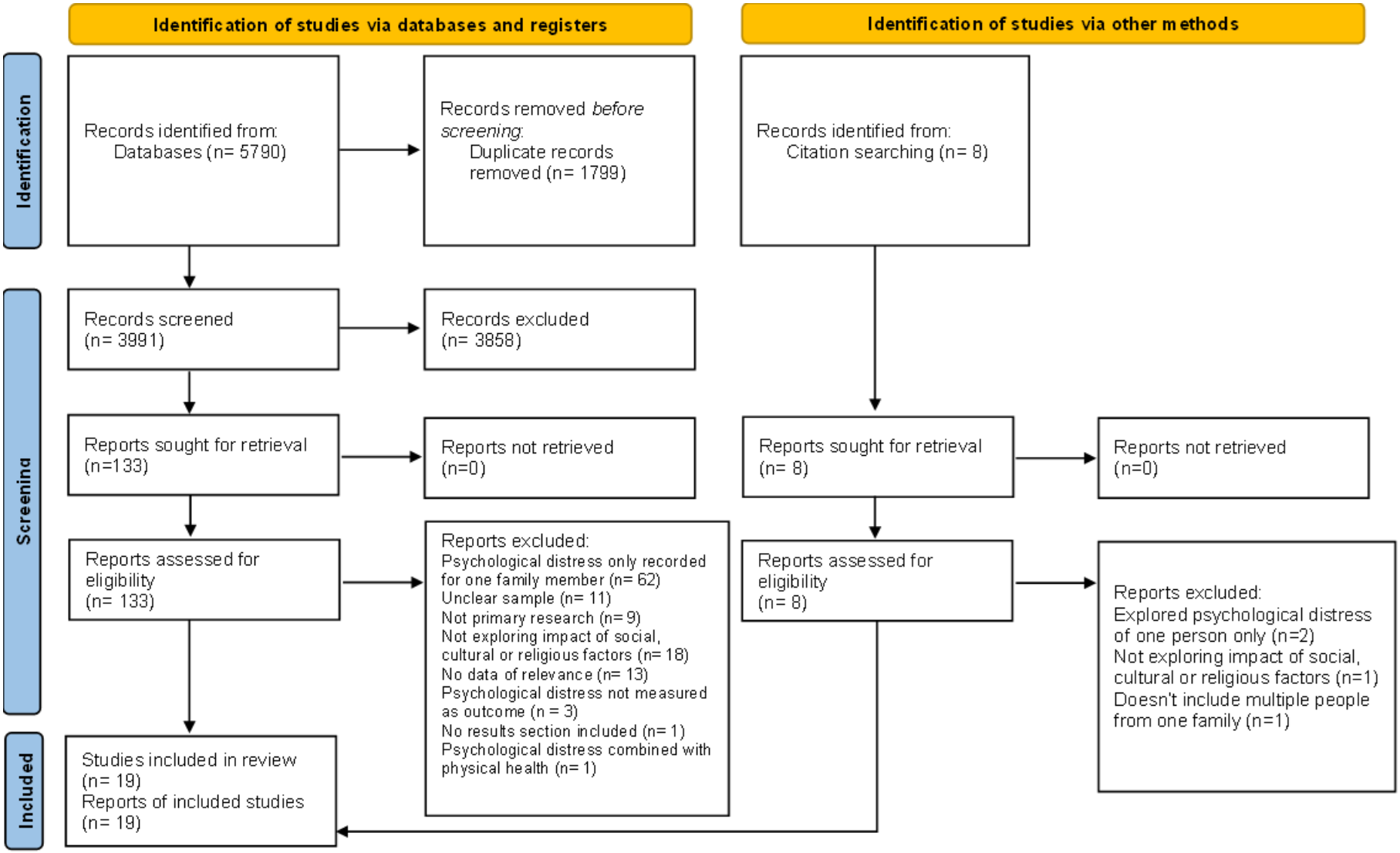
1. ti: famil* OR household* OR generation* OR relative* OR kin*
2. ti: "psychological distress" OR "mental disorder*" OR "mental instability" OR "psychiatric disorder*" OR "stress related disorder*" or "stress-related disorder*" OR psychopatholog* OR "mental ill-health" OR "mental ill health" OR "mental health" OR "mental distress" OR "mental health problem*" OR "mental health condition*" OR "mental health difficult*" OR distress OR "emotional problems"
3. ab: Social OR societal OR income OR socioeconomic OR employment OR discrim* OR financ*
4. ab: Cultur* OR ethnic* OR racial OR heritage
5. ab: Relig* OR faith OR belief* OR divinity OR worship
6. #1 AND #2 AND (#3 OR #5 OR #6)

Inclusion and Exclusion Criteria. The papers resulting from the search were screened against a set of inclusion and exclusion criteria. For studies to be included within the review they had to (a) explore psychological distress in more than one person in the family, (b) explore influences considered as *social*, *cultural* or *religious* that impact psychological distress, (c) be peer reviewed, (d) be primary research, (e) be published in English. Papers were excluded if they were not peer reviewed to ensure that the included studies were of adequate quality. Whilst the exclusion of papers not available in English may introduce bias, it was not possible to include papers in other languages due to not having the time to accurately translate the literature. Papers were also excluded if they focused on how mental health affected people's social, cultural and/or religious contexts and if they looked at COVID-19 as a factor influencing mental health. COVID-19 studies were excluded given that the pandemic influenced many aspects of people's lives, rather than being considered a factor in its own right.

Study Selection and Evaluation. Database searching identified a total of 5790 papers. EBSCOhost removed duplicates; however slight differences in punctuation and spaces between publications meant that some duplicates were missed. Papers were therefore exported into Microsoft Excel and were screened again to remove all duplicates. The titles and abstracts were screened against the criteria, leaving 133 papers. The full text of these remaining papers, along with the eight papers found through citation searching, were read in full, and compared against the inclusion exclusion criteria. After all papers were completely assessed for eligibility, 19 studies were considered to meet criteria and thus were included within this review (See Figure 1).

Figure 1.

PRISMA 2020 Flow Diagram for New Systematic Reviews (Page et al., 2020)



Following PRISMA guidelines, each of the included papers were read for a second time for the purpose of quality appraisal. Most of the papers were quantitative in nature, with only one being a mixed methods study. It was therefore decided that only the quantitative aspect of the mixed methods study would be included in the synthesis. Given that only quantitative data was analysed in this systematic review, the Quality Assessment Tool for Quantitative Studies (QATQS; Ciliska et al., n.d.) was used to critically appraise each of the studies. This is a recommended tool (Deeks et al., 2003) which has acceptable content validity, construct validity and inter-rater reliability (Thomas et al., 2004). This tool is also one that I am familiar with and competent in using, increasing the accuracy of the quality appraisal. The QATQS consists of 21 items which form 8 components: *selection bias, study design*, *confounders*, *blinding*, *data collection methods*, *withdrawals and dropouts*, *intervention integrity* and *analysis appropriate to the questions*. The ratings generated from the first six components are used to calculate a global rating. The global rating is grouped into three categories: *strong* (no weak component ratings), *moderate* (one weak component rating), and *weak* (two or more weak component ratings).

Statistical Methods. Not all the included studies report the necessary statistics (mean and standard deviations) for a meta-analysis to be conducted. Therefore, I completed a narrative synthesis using synthesis without meta-analysis (SWIM; Campbell et al., 2020) guidance. SWIM guidance expands upon guidance such as PRISMA to ensure that the synthesis, methods, and results of the review are reported transparently, protecting this review against the limitations usually associated with narrative synthesis (Campbell et al., 2020). The relevant findings from each paper were extracted and these were grouped by type of influence. This grouping was chosen as it was perceived to be the best fit for answering the research question. Study characteristics in addition to the available statistics have been included within the results.

All available statistics have been included within this review, including P-values, confidence intervals (CI), means and standard deviations.

Results

Study Characteristics and Quality Assessment. A total of 19 studies were included in this systematic review exploring the social, cultural, and religious influences on psychological distress in families. The combined sample consisted of 48,483 individuals from 17,232 families. Most studies explored factors affecting psychological distress of familial dyads (N=16), with two studies looking within triads and one within the full family. Table 1 presents the characteristics and quality ratings of each study. To collect data on dyads only, many studies excluded children from multi-child households. Only one study (Vostanis et al., 1998) included multiple children from one family. Whilst 13 of the 19 studies included males, the number of males in the samples were noticeably lower than those of females. It was noticed that one study (Götze et al., 2017) considered an alpha of .2, a significant result. Including these findings in this literature review would be misleading and thus they will not be commented on here. Within the results of the literature review I will only consider findings significant if the alpha value is equal to or below .05.

Most of the included studies (N= 17) were rated weak in quality, whilst one study was rated as moderate and another as strong. Weak ratings were largely due to limited detail within the reports or participant recruitment being reported elsewhere. All but four studies had moderate-strong ratings for selection bias and all studies had strong ratings for the data collection method (see Appendix A for the individual component scores).

Table 1.

Study Characteristics of Included Studies

Author	Country	Sample	Relevant factors	Measures	Quality
Samuelsson (1994)	Sweden	Parent-Child dyads (N=78)	Social networks	Rutter Children's Behaviour scale & SCL-90	Weak
Friedemann & Webb (1995)	America	Marital dyad (N=39)	Economic stress	IPAT CPQ	Weak
Vostanis et al. (1998)	UK	Families with children (N=79)	Homelessness	CBCL/ 4-18, /2-3 & GHQ-28	Weak
Sonuga-Barke & Mistry (2000)	UK	Child-mother-grandmother dyads (N=86)	Acculturation and religion	HADS & Rutter B2 Children's behaviour Scale	Weak
Weisman et al. (2005)	America	Patients-relative dyads (N=47)	Religiosity/ spirituality & ethnicity	BPRS & DASS	Weak
Karim et al. (2006)	UK	Mother-child dyads (N= 35)	Homelessness	HADS, ECBI & HoNOSCA	Weak
Ayon et al. (2010)	America	Parent-child dyads (N=150)	Discrimination, education, familismo & income	YSR, CES-D	Weak
Novello et al. (2011)	Australia	Partner dyads (N=129)	Isolation	K10	Weak
Essau et al. (2013)	UK & Japan	Parent-child dyads (N=689)	Culture	SDQ & DASS	Weak
Gotze et al. (2017)	Germany	Patient-partner dyads (N=81)	Employment & social support	HADS	Moderate

Author	Country	Sample	Relevant factors	Measures	Quality
Acri et al. (2017)	America	Child-primary caregiver dyads (N= 484)	Poverty	IOWA CRS OD & CESD-SF	Weak
Huffman et al. (2017)	America	Marital dyads (N= 78)	Work family conflict	GHQ-12	Weak
Secinti et al. (2019)	America	Patient-family caregiver dyads (N= 50)	Loneliness and social constraints	Global mental health subscale from PROMIS	Weak
King et al. (2020)	Australia	Mother-father-child triads (N=13,846)	Employment arrangements	K6 & SDQ	Strong
Curci et al. (2021)	America	Mother-child dyads (N= 322)	Culture specific stress, neighbourhood Latinx concentration & family income	EPDS, CES-D & CBCL/1.5-5.	Weak
Borelli et al. (2021)	America	Mother-child dyads (N= 330)	Sociodemographic risk	MASC, CBCL/6-18, CDI, YSR & BSI-18	Weak
Arreola et al. (2022)	America	Mother-child dyads (N= 160)	Sociodemographic risk & fear of deportation	BSI-18 & YSR	Weak
Wen & Goh (2022)	Singapore	Mother-child dyad (N= 448)	Economic status	DASS-21 & CBCL 6-18	Weak
Khalil et al. (2023)	America	Marital dyads (N= 101)	Adversity related to being a refugee	PCL-5, SCL-25	Weak

Note: Rutter Children's Behaviour Scale (Rutter, 1967), Hopkins Symptom Checklist (SCL-90; (Derogatis et al., 1973), -25 (Derogatis et al., 1974), Institute for Personality and Ability Testing Children's Personality Questionnaire (IPAT CPQ; Porter et al., 1968), Child Behaviour Checklist (CBCL/4-18; Achenbach, 1991, /2-3; Achenbach, 1992, / 1.5-5; Achenbach, 2001, /6-18; Achenbach & Rescorla, 2001), General Health Questionnaire (GHQ; Goldberg, 1978), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), Brief Psychiatric Rating Scale (BPRS; (Overall & Gorham, 1962), Depression, Anxiety, Stress Scale (DASS; (Lovibond & Lovibond, 1995), Eyberg Child Behaviour Inventory (ECBI; Eyberg & Ross, 1978), Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA; Gowers et al., 1999), Youth Self-Report (YSR; Achenbach, 1991; Achenbach & Rescorla, 2001), Centre for Epidemiologic Studies Depression Scale/ Short Form (CES-D/ SF Radloff, 1977), Kessler Psychological Distress Scale (K10; Kessler et al., 2003, K6; Kessler et al., 2002), Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), Iwoa Connors Rating Scale-Oppositional/Defiant Subscale (IOWA CRS OD; Waschbusch & Willoughby, 2008), Patient-Reported Outcomes Measurement Information System (PROMIS; Hays et al., 2009), Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987), Multidimensional Anxiety Scale for Children (MASC; MARCH et al., 1997), Child Depression Inventory (CDI; Kovacs, 1992), Brief Symptom Inventory (BSI-18; (Derogatis, 2001), PTSD Checklist (PCL-5; (Weathers et al., 2014).

Narrative Synthesis. The results of the included papers have been organised thematically according to the type of factor influencing psychological distress in families. Relevant factors were taken from each of the papers to be grouped into themes. These themes were: *navigating exile*, *economic status*, *social connection*, *employment*, *homelessness*, *religion*, *culture and ethnicity* and *education*. It was noticed that several studies reported on where multiple factors are associated with each other and therefore a final theme was created titled *where factors influencing psychological distress intersect.*

As could be expected from the background literature, many studies found significant associations between the psychological distress of family members (Acri et al., 2017; Curci et al., 2021; Essau et al., 2013; Khalil et al., 2023; Novello et al., 2011). However, this was not found for Japanese families (Essau et al., 2013).

Navigating Exile. *Navigating exile* refers to findings relating to participants' experiences of feeling exiled or unwanted within their communities for various reasons. Three studies contained factors which were deemed relevant within this theme, including adversity related to being a refugee (Khalil et al., 2023), discrimination (Ayón et al., 2010) and fear of deportation (Arreola et al., 2022).

Within Khalil et al. (2023), more than half of both the husbands and wives' perceptions of adversity was reported at the maximum level, perceptions of which were positively associated ($r = .44$, $p < .001$). Husbands' perceived adversity was positively related to their own psychological distress (PTSD symptomology: $r = .3$; $p < .02$; depression/anxiety: $r = .26$; $p = .04$) but also the psychological distress of their wives (depression/anxiety; $r = .23$; $p = .08$). Interestingly, the wives' perceived adversity was not significantly related to their own nor their husband's distress.

Fear of deportation was significantly associated with youth and maternal depression (b = 13.79, SE= 4.99, 95% CI [3.93, 23.65], p < .01; b = 3.65, SE = 1.06, 95% CI [1.56, 5.74], p < .01 respectively); however, was not significantly associated with youth or maternal anxiety nor self-reported youth aggression (Arreola et al., 2022). Whilst fear of deportation similarly affected both parent and child, perceived discrimination was only found to be significantly associated with the psychological distress of children (measured as an increase in internalising behaviours) which appeared to increase with increased discrimination (Ayón et al., 2010). It is wondered if the psychological distress of mothers and fathers within the parent sample were explored separately whether, like in Arreola et al. (2022), *navigating exile* would be associated with the mothers' psychological distress. It is also wondered whether, as within Khalil et al. (2023), father's perceptions of discrimination would affect psychological distress of the parents, more so than the mothers' perceptions.

In summary, husbands' perceptions of *navigating exile* may be more important in relation to the psychological distress experienced by couples than wives' perceptions. Whilst fear of deportation appears to be similarly associated with both mothers' and their children's psychological distress, there is something specific about perceived discrimination, in that it is only associated with the psychological distress of children and not parents.

Financial Situation. This theme was created to summarise studies which included factors associated with finances within the family. In total, five studies were included within this theme exploring factors labelled economic stress (Friedemann & Webb, 1995), economic status (Wen & Goh, 2023), income (Ayón et al., 2010), poverty (Acri et al., 2017) and family income (Curci et al., 2021).

In parents, household income was found to be significantly associated with "depression" symptomology, with symptomology decreasing as income increases (β = -.24)

(Ayón et al., 2010). More specifically, primary caregivers in low-income families, were 40% more likely to have scores which suggested "clinically significant levels of depressive symptoms", evidenced by a decrease in the likeliness of having "depression" as they moved from making $9,999 or less to $10,000 or more annually (b = -.6, SE= .22, 95%CI [.35, .85]) (Acri et al., 2017). However, within couples experiencing economic stress, focal economic stress, controlling for present economic stress, was related to "depression" of wives (b_1 = .18, p <.05) but not of husbands (Friedemann & Webb, 1995), suggesting that within Ayón et al. (2010) and Acri et al. (2017), the scores of mothers may be overshadowing the scores of fathers who made up 6% and 2% of the samples, respectively. It should be noted that within Acri et al. (2017) a further 14% of the sample was made up of joint mothers and fathers as the primary caregiver.

Whilst mothers in high stable economic hardship did not have significantly higher levels of "depression" than mothers in low stable economic hardship (b = 4.71, p = .06), mothers in decreasing hardship did (b = 1.9, p= .002). This suggests that stability in finances may be just as important, if not more than the quantitative amount someone may have (Wen & Goh, 2023). In relation to "anxiety" however, mothers within families of high stable economic hardship and mothers with moderate decreasing economic hardship experienced greater levels of anxiety compared with mothers in families with low stable economic hardship (b = 4.88, p = .03; b = 2.56, p <.001, respectively). This suggests that "anxiety" in mothers may be more related to higher levels of income (Wen & Goh, 2023).

Similarly to their primary caregivers, children within low income families experienced greater psychological distress than those in higher income families in relation to "oppositional defiant behaviours" (M = 18.67, SD = 8.08; M = 21.61, SD = 6.01; t(422)= 3.94, p < .001) (Acri et al., 2017) and "depression" (those from high stable economic

hardship families did not have higher levels of "depression", $b = .53$, $p = .31$) (Wen & Goh, 2023). Like their mothers, children within families of moderate decreasing economic hardship, had higher levels of "depression" ($b = .43$, $p = .03$) than those in low stable income families (Wen & Goh, 2023). However, unlike their mothers, children in families with high stable economic hardship did not experience greater levels of anxiety ($b = .91$, $p = .21$) than those with low stable economic hardship. Children in moderate decreasing hardship however did ($b = 1.19$, $p < .001$).

Despite these findings, Curci et al. (2021) found no correlations between family income and maternal "postnatal depression", "child behaviour problems", "infant negative temperament" nor maternal "depressive symptoms". However, the sample in this study were also experiencing culture specific stress which may influence how affected their psychological distress levels are by their financial situation.

In summary, having low income and unstable (decreasing) income appears to (in most cases) be associated with psychological distress of mothers and their children. However, it is unclear whether finance affects the adult males in the family in the same way.

Social Connection. *Social connection* refers to the interactions and relationships individuals have with those around them. Factors within this theme include social networks (Samuelsson, 1994), isolation (Novello et al., 2011), social support (Götze et al., 2017), social constraints (Secinti et al., 2019) and loneliness (Secinti et al., 2019). With regards to social constraints, this was used to refer to participants' perceived barriers to disclosing their thoughts and feelings regarding their cancer diagnosis to the other person in the dyad. Two of the papers had the context whereby one of the dyad members had a diagnosis of cancer (Götze et al., 2017; Secinti et al., 2019).

Within couples (who were also parents in both Novello et al. (2011) and Götze et al. (2017)) there was found to be an interaction between distress levels and remoteness (χ^2 = 4.58, p = .03), with father distress becoming more associated with the distress of mothers as remoteness increases (Novello et al., 2011). Loneliness (which may be associated with remoteness) and one's own social network was also found to be associated with global mental health for both dyad members (loneliness: "patient": b = -.59, p < .001; caregiver: b = -.49, p = .001 social network: r = -.52, p < .001) (Samuelsson, 1994; Secinti et al., 2019). Götze et al. (2017) found that when couples received greater social support the distress of the "patient's" partner was found to decrease (β = -.45, p < .0001). Secinti et al. (2019) however, found significant relationships between emotional support and global mental health for both dyad members (r = 0.43, p = .002; r = 0.36, p = .01). This effect however was not direct for patients, whereby loneliness acted as a mediator (b = .32, 95% CI [.11, .52]).

Within Götze et al. (2017), partner effects were not found to be significant, meaning that the social support of one dyad member was not found to affect the psychological distress of the other (β = -.03, p > .2; β = -.02, p > .2). This was also found when 'loneliness' was the predictor (Secinti et al., 2019). However, Secinti et al. (2019) found that lower social constraints from the "patient" was associated with better "global mental health" in the caregiver (r = -.33, p < .018), implying that if the "patient" is better able to access support, the family caregiver will experience less psychological distress. "Patient" social constraints, however, were not associated with their own psychological distress.

Despite individual social support not influencing the psychological distress of their partners, parents' social networks were found to be significantly related to their children's "behavioural disturbances" on the Rutter Scale and Rutter Asocial scale but not the Rutter Neurotic scale (r = -.3, p < .01; r = -.4, p < .01; r = -.11, p > .05, respectively) (Samuelsson,

1994). The better the parents' support network, the less distressed the children appeared (as measured via their behaviour). It is important to note however, that a better network does not mean a larger network. A larger number of contacts on parents' network map was associated with an increase in distress in their children. This appeared more relevant for daughters than sons. Whilst parent social networks were found to impact their children's psychological distress the reverse was not found.

In summary social connection was found to be associated with psychological distress in couples. Despite psychological distress being associated within couple members, especially when remoteness increases, only one's own social connection is related to their psychological distress. The exception to this however is, that fewer social constraints are only associated with partners' distress. Parental social connection is associated with their child's psychological distress.

Employment. This theme was chosen to synthesise three studies that included work family conflict (WFC; Huffman et al. 2017), employment (Götze et al., 2017) and employment arrangements (King et al., 2020). Huffman et al. (2017) was conducted in the context whereby one member of the dyad is an employee of the military.

When both members of a couple ("patient" and partner) are unemployed, psychological distress of the partner is increased ($\beta = .42$, $p < .05$). Partner effects were not found, meaning that one's own employment status did not affect the psychological distress of their partner ($p > .2$). When breaking this down further, looking at the specific employment configurations within families, it was found that there was no association between employment configuration and maternal mental health. However, when households were in a male-breadwinner arrangement fathers had higher psychological distress than when they were in a 1.5 earner arrangement (estimated mean difference = .21, 95% CI [.05, .36]). No other

associations were found between any other employment arrangements and psychological distress (King et al., 2020).

When one member of the dyad was employed in the military, one's own reported WFC had a large direct effect on their psychological distress ($\beta = .51$, $p < .01$) and an indirect effect ($\beta = .07$) on their partner's distress. Spouse perceptions of their military partner's WFC also had an indirect effect on their own distress ($\beta = .08$). The military employed partner's WFC and spouses' perceptions of their WFC did not indirectly affect the military partner's psychological distress (Huffman et al., 2017).

In children, there was no evidence to suggest that household employment configuration is associated with psychological distress (King et al., 2020).

In summary, employment is associated with psychological distress in adults within the family. One's own employment appears to be associated with one's own psychological distress, shared employment configuration is related to decreased psychological distress in fathers and WFC in one individual increases the psychological distress of their partner.

Homelessness. Only two studies explored psychological distress in homeless families (Karim et al., 2006; Vostanis et al., 1998). Despite Vostanis et al. (1998) collecting data on fathers, these were excluded from analysis due to small numbers. Both participants in both studies had lived in hostels and had either been rehoused or remained.

When measured via the General Health Questionnaire (GHQ), the rate of psychological distress in homeless mothers was 52%, decreasing to 26% after one year (and being rehoused) ($p = .002$). Whilst there appeared to be a decrease in rate of general psychological distress, this was still higher than comparison mothers and rates seen in the general population (Vostanis et al., 1998). However, when psychological distress was

measured via the Hospital Anxiety and Depression Scale, there was no significant change seen in individual scores of psychological distress (Z = -.56, p = .58), nor the rate of psychological distress (determined via a score of 11 or greater; Z = .001, p = 1) (Karim et al., 2006). When breaking this down further into separate anxiety and depression scores, still no change was found (Z =.49, p = .62; Z = -.45, p = .66) and when compared with those families still living in the hostel, no significant differences were found.

Children within homeless families were found to have improved communication scores; however, this was not a significant improvement (p = .07) and their communication remained significantly more delayed than that of the comparison group and where they would be expected to be for their age. There were also no significant changes in children's psychological distress as measured by the Child Behaviour Checklist (p = .53; Vostanis et al., 1998), Eyberg Child Behaviour Inventory (ECBI) number of behaviours (Z = -1.28, p = .20), ECBI intensity score (Z = -.11, p = .91) nor most of the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) subscales (Karim et al., 2006). The one HoNOSCA subscale that was found to improve was "disruptive behaviour" (Z = -1.93, p = .05). However, when compared with children still living in hostels, there appeared to be improvement in 'emotional symptoms' (Z = -1.99, p = .05), 'self-care' (Z = -2, p = .05) and 'problems in family life' (Z = -2.11, p =.04) (Karim et al., 2006).

In summary, homeless families experience greater psychological distress than their non-homeless counterparts and the general population. Whilst individual psychological distress was not generally found to improve at follow up, after families had been rehoused, the psychological distress of rehoused children was found to be better than children remaining in the hostels.

Religion. *Religion*, as defined in the methods section of this review, was considered as a factor contributing to psychological distress in two of the included studies, labelled religion (Sonuga-Barke & Mistry, 2000) and religiosity/spirituality (Weisman et al., 2005). Whilst Weisman et al (2005) found that religion was not found to be associated with general emotional distress nor psychiatric symptoms of "schizophrenia" ($r = .12$, $p > .05$), Sonuga-Barke and Mistry (2000) found mixed results. In relation to anxiety in mothers and children's scores on the Rutter scale, religion was not found to be significantly associated with psychological distress. However, in relation to depression, religion was found to have a significant impact on psychological distress (F (1,164) = 9.25, $p < .005$). More specifically, women of Muslim faith reported higher levels of depression than women of Hindu faith (Sonuga-Barke & Mistry, 2000).

In summary, religion may only be associated with psychological distress in relation to specific religions.

Culture and Ethnicity. *Culture and ethnicity* encapsulates two different concepts, with one's ethnicity not determining one's cultural values or traditions and vice versa. Despite this, the concepts are often confused, combined, or used interchangeably within literature, including some of the studies within this review. As this is the case, the concepts have been combined here. This factor was reported in five of the included papers under the labels of acculturation (Sonuga-Barke & Mistry, 2000), ethnicity (Weisman et al., 2005), familismo (Ayón et al., 2010), culture (Essau et al., 2013), and culture specific stress (Curci et al., 2021).

Culture and ethnicity were not found to be significantly associated with psychological distress within two of the studies ($p > .05$, Weisman et al., 2005; $r_s < .22$, Sonuga-Barke & Mistry, 2000). However, when exploring specific cultural practices such as familismo,

culture was found to be significantly associated with "depression" in mothers (β = -.23) and children's internalising behaviour (β = -.41), with increased familismo, relating to decreasing psychological distress in both mothers and their children (Ayón et al., 2010).

The results of Curci et al. (2021) and Essau et al. (2013) support Ayón et al.'s (2010) findings in that they also found culture and ethnicity to be associated with psychological distress. More specifically, psychological distress of mothers from the United States was higher than those born in Mexico (*Est*= -6.638, *SE Est* = 2.232, p = .003; Curci et al., 2021) and psychological distress in English families was higher than Japanese families (F (1,644) = 5.29, $p < .05$, $\eta p^2 = .01$; Essau). This was found to be the case with "depression" (F (1, 670) = 54.54, $p < .001$, $\eta p^2 = .08$), "anxiety" (F (1, 672) = 87.83, $p < .001$, $\eta p^2 = .12$) and "stress (F (1, 663) = 120.52, $p < .001$, $\eta p^2 = .15$) (Essau et al., 2013). In relation to culture specifically, symptoms of "post-partum depression" were found to be predicted by cultural-specific stress experienced by mothers (*Est* = 3.67, *SE EST* = .887, $p < .001$) (Curci et al., 2021).

Culture and ethnicity were also found to influence the psychological distress of children within the families ($p < .001$), with adolescents in England having greater difficulties in relation to "conduct problems", "hyperactivity-inattention" and "peer problems" than adolescents within Japanese families (Essau et al., 2013).

In summary, findings on whether culture and ethnicity influence psychological distress appears to be mixed. However, this may be due to unclear definitions of these two concepts within the current literature whereby the two separate concepts have been combined.

Education. Only one of the included studies explored education as an individual factor potentially impacting psychological distress within families. Within this study it was

found that lower levels of psychological distress, specifically "depression" were associated with higher levels of education (β = -.21; Ayón et al., 2010). Other studies did consider education (Arreola et al., 2022; Borelli et al., 2021); however, this was grouped within a broader factor of sociodemographic risk and thus these are discussed within the theme *where factors influencing psychological distress intersect* below.

Where Factors Influencing Psychological Distress Intersect. As discussed in the definition of intersectionality, considering each area of privilege and oppression separately is unable to explain the complex experiences of individuals. This theme was created to include the ten studies that reported on the relationship between multiple factors associated with psychological distress of families (Arreola et al., 2022; Ayón et al., 2010; Borelli et al., 2021; Curci et al., 2021; Essau et al., 2013; Friedemann & Webb, 1995; Huffman et al., 2017; Sonuga-Barke & Mistry, 2000; Weisman et al., 2005; Wen & Goh, 2023).

Sociodemographic risk, which included food insecurity, low educational attainment, high number of children, low family income, single marital status, and young maternal age (Arreola et al., 2022; Borelli et al., 2021), was mostly found to not be associated with psychological distress. Borelli et al. (2021) found that there was no association with mother nor with child "anxiety" (mother: β = -.03, *b* = -.12, *SE* = .25, 95% CI [-.61, .36], *p* = .6 child: β = -.09, *b* = -1.03, *SE* = .68, 95% CI [-2.37, .30], *p* = .13). Neither was it associated with maternal or child "depression" (mother: β = -.08, *b* = .37, *SE* = .25, 95% CI [-.86, .11], *p* = .13; child: β = .01, *b* = .14, *SE* = .85, 95% CI [-1.53, 1.81], *p* = .87) nor child "externalising symptoms" (β = .01, *b* = .2, *SE* = 1.8, 95% CI [-3.33, 3.72], *p* = .91). Instead, important factors relating to psychological distress were found to be more relational between the mother and child (Borelli et al., 2021). Arreola et al. (2022) however found that sociodemographic risk was associated with higher levels of youth-reported "depression" (*b* = 6.1, *SE* = 2.28, *p*

<.001) and "aggression" (b = 6.73, SE = 3.1, 95% CI [.60, 12.85], p < .05), but not child "anxiety", nor mother's "depression" or "anxiety". They found that fear of deportation moderated the association between sociodemographic risk and youth-reported "depression" (b = -20.99, SE = 7.75, 95% CI [-36.31, -5.97], p < .05) and "depression" of mothers (b = -5.2, SE = 1.64, 95% CI [-8.44, -1.96], p < .01). Specifically, when a family's sociodemographic risk was low, deportation fear was associated with increased child psychological distress (p <.05) and when deportation fear was high, sociodemographic risk was inversely associated with maternal psychological distress (p < .01) (Arreola et al., 2022).

The association between economic hardship and psychological distress was found to be moderated by "family hardiness" in relation to mother's "depression" (F = 10.48, p < .001) and "anxiety" (F = 32.47, p < .001) and their child's "anxiety" (F = 6.09, p <.001). This was not found to be the case however when child's "depression" was the dependent variable (F = .88, p =.48) (Wen & Goh, 2023). Interestingly, when this was examined cross-sectionally rather than longitudinally, this moderating effect was not found (p's > .05). In addition, when adding "marital relationship" into a prediction model with economic stress, the model was significantly improved (R^2 change = .14) (Friedemann & Webb, 1995).

In relation to employment, it was found that WFC (which was a significant factor affecting psychological distress), was related to perceptions of fairness and division of household chores (military employed partner: β = -.28, p <.01; spouse: β = -.29, p <.01; Huffman et al., 2017).

Weisman et al. (2005) found no initial interactions between ethnicity and family cohesion; however, when adopting Pedhazur's (1997) criteria to minimise type II errors, the R^2 change (.08) was significant (p =.09). More specifically, a cohesive family was associated with less psychological distress in families "coping with schizophrenia" in African American

families (r = .76, p <.05) and Hispanic American families (r = -.51, p <.05) but not Anglo-American families (r = 0.03, p >.05). Essau et al. (2013) found that English female children scored higher than Japanese female children in relation to hyperactivity-inattention and that Japanese male children scored higher than English male children in relation to peer problems. Female children generally experienced greater psychological distress than male children in England; however, this was reversed in Japanese children. With regards to parents, "depression" was significantly higher in males than in females in England, but no significant differences were found between Japanese parents.

In relation to the association between ethnicity and culture, Sonuga-Barke and Mistry (2000) found that within their sample, Hindu families in the UK were more acculturated than Muslim families in relation to how they observe UK customs, their employment practice, and their social activities. Supporting that these two concepts are different and should ideally be treated as such. It was also found that Hindu and Muslim extended families in the UK were more likely to engage in culturally based activities than those within nuclear families (Sonuga-Barke & Mistry, 2000).

The influence of culture on psychological distress was not found to be moderated by discrimination (Ayón et al., 2010). However, access to one's culture (measured by neighbourhood Latinx concentration) was found to indirectly affect psychological distress via several moderators (Curci et al., 2021). Prenatal neighbourhood Latinx concentration was associated with maternal role expectations (p = .03), which related to "postpartum depression" (p = .003), which related to child psychological distress (p = .05) and maternal "depression" (p <.001).

Another interesting finding was that within Hindu and Muslim nuclear families in the UK, grandmothers were found to experience greater "anxiety", whereas in extended families,

it was mothers that experienced greater "anxiety" and "depression" (Anxiety: F (1, 164) = 9.17, p <.005; depression: F (1, 164) = 13.1, p <.001; Sonuga-Barke & Mistry, 2000).

In summary, the literature demonstrates the presence of intersectionality, and that moderators and mediators are often present in the impact of social, cultural, and religious factors on psychological distress.

Discussion

This review aimed to explore social, cultural, and religious factors which influence psychological distress within families and explore how these may differ across different family members.

Results found that fear of deportation, perceived discrimination, income/economic status and the stability of this, social connection (including remoteness, loneliness, and social constraints), employment, housing status, religion, culture, ethnicity, and education all appear to be important factors impacting psychological distress within families. The findings synthesised here have come from various countries, and thus may not all be applicable to families living in the UK.

Whilst psychological distress within family members was often related, different factors appeared to impact members differently. For example, husbands' perceptions of navigating exile appear to be more impactful than the perception of wives. In addition, children's psychological distress is impacted by discrimination, whereas their parents' is not. Whilst income impacts the psychological distress of mothers and children, fathers may not be impacted in the same way. Personal experiences of social constraints appear associated with partner's psychological distress rather than one's own. Parental social connection impacts children's levels of psychological distress; however, children's social connections do not

impact their parents' psychological distress. Employment is only associated with psychological distress in adults. Employment configuration within households only appears to impact the psychological distress of fathers. Lastly, only the psychological distress of children appears to improve after homeless families have been rehoused.

The results of this review highlight the importance of exploring how different factors interact to influence psychological distress within families to account for intersectionality. Importantly, whilst this review did not set out to explore family and relational factors, the results demonstrated their importance in thinking about pathways in which social, cultural, and religious factors may impact psychological distress in families.

Strengths and Limitations. Using SWiM (Campbell et al., 2020) guidance to synthesise the research within this review in collaboration with PRISMA (Page et al., 2020) and Cochrane guidance enabled me to review the relevant literature in this field, extensively and transparently. This review included papers which had (on average) large sample sizes and were from seven different countries. Whilst most studies were conducted in America, participants from these studies often had different ethnicities to Anglo-American. Whilst most studies were rated weak in overall quality, they all were rated strong in relation to data collection methods and the majority were rated moderate to strong in relation to selection bias. This suggests some validity and reliability in the results.

What should be considered is that due to the cross-sectional nature of some of the studies, general conclusions on causal influence were not able to be made. In addition, the samples of these studies should be taken into consideration when thinking about the generalisability of these findings. Whilst some studies did include adult males in their sample, these were often in very small quantities and in a few cases were subsequently excluded from the analysis. In addition, when psychological distress was explored within

couples, these were only heterosexual couples and thus the uniqueness of being within a same sex/ non-heteronormative couple, was not considered. In families with multiple children, usually only one child was included in the sample. With family systems theory (Bowen, 1966; Burnham, 2018) highlighting the importance of sibling positioning in psychological distress within families, it is likely that different findings may have been found if multiple children per family were included within the sample.

As mentioned within the results section, culture and ethnicity within the included studies was not often properly defined and as a result the two concepts were merged or considered interchangeable. This is problematic in that it can lead to assumptions being generated regarding individuals from specific ethnic groups, specifically within clinical settings whereby a clinician may assume a client follows a particular cultural or religious practice, simply due to their ethnicity or ethnic heritage. With regards to the search terms used, broad terminology was used such as "social factors" to encapsulate factors such as education and income. Given that this review was exploratory, it was deemed necessary to keep search terms broad to include a comprehensive number of studies. This also ensured that the review accounted for multiple definitions of the term "social factors" rather than limiting the search to my own definition. This may have impacted the results in that some important factors were not considered in detail with, for example, education only being considered in one paper. However, within the initial screening of papers, it was noted that education was a considered factor within multiple studies; however, these did not meet the inclusion criteria in that they were not family studies. Therefore, it is likely that by including terms separately there would be little to no change in the results of this review.

Implications and Recommendations for Future research. The results in this review highlight important factors which influence psychological distress in families and begin to

explore how these may intersect. Whilst this begins to highlight the importance of systemic therapy influenced by social constructionist ideas, more, higher quality, research is required in this field. Future research should try to consider families within their entirety, rather than focusing on dyads or triads and as a result should try to include males in their sample. In addition, research should also begin to explore in greater detail how factors intersect rather than exploring just one or two factors which increase the likeliness of practitioners guided by this research simply layering areas of privilege and oppression rather than considering how they may uniquely intersect within families and individuals.

Conclusion. Several social cultural and religious factors appear to impact the psychological distress of families in unique ways. These factors appear to interact with each other and other relational factors in protecting families or increasing their vulnerability to psychological distress. More research is required in this area to further explore intersectionality and psychological distress within families to begin to consider how we can better support families within mental health services.

Gaps in the Literature

Whilst the literature review did not initially set out to explore intersectionality, the results highlight the importance in considering this when exploring psychological distress within families. Third wave systemic family therapy expects that therapists explore external family influences in addition to areas of difference with the recognition of difference being seen as the "key to understanding" (Bateson, 1972). Whilst therapists may choose to do this using different models (e.g., Social GRRRAAACCEEESSS; Burnham (2018), my preferred theoretical framework, and the model I have been taught to use most in systemic practice is intersectionality (Crenshaw, 1989), which remains less discussed than Social GRRRAAACCEEESSS (Burnham, 2018) in clinical practice. Given that this is grounded in

social constructionism, it can be difficult to grasp in relation to how to apply it clinically with clients, in services which are driven by an evidence base which sits more within ideas of empiricism.

Research currently appears driven by Social GRRRAAACCEEESSS (Burnham, 2018) in that it often considers areas of privilege and oppression independently of each other. Where attempts have been made to explore interactions between factors, only a few are considered within one study, failing to account for the uniqueness of individuals. Considering that countless studies have demonstrated that psychological experiences can be a shared experience within families and is not purely individual, there is limited evidence exploring factors relating to psychological distress in families. Where this has been attempted, research has only focused on a subsample of families and is mostly weak in quality. It is therefore important that future research in this area is required before we can go on to explore ways in which we can better support families in mental health services.

There have been extensive amounts of research on the effect of COVID-19 on psychological distress (e.g., Chandola et al., 2022; Daly et al., 2022; Pierce et al., 2020), and likely disrupted the intersectionality of families; for example, through loss of employment. However, the pandemic has not been explored from the systemic perspective, as a destabilising event which may have disrupted the equilibrium and intersectionality of families. The third phase of systemic theory highlights the importance of considering society and therefore, it is important that we begin to explore how we can systemically understand cultural and societal events such as the COVID-19 pandemic.

Aims and Research Questions

Multi actor panel approaches make it possible to examine psychological distress and intersectionality in families over time and explore the differentiating effects of individual roles within the family (Ponnet & Wouters, 2014). Therefore, by using this approach, this study aims to provide better insight into the different ways in which families respond to adverse situations, considering their social, cultural, religious, and relational contexts. It is hoped that by identifying factors related to distress and highlighting how these may interact through mediation, this thesis will contribute to discussions about the use of family interventions in mental health services within the UK. It is also hoped that this research will provide better support to clinicians working with families. To reach these aims three research questions were generated:

1. What factors appear to influence psychological distress of families when one member is already experiencing distress?
2. Are there specific factors that help or hinder families?
3. Do factors effecting distress remain the same during the COVID-19 pandemic?

Chapter 2: Method

Chapter Overview

This research aims to explore the complex nature of families in the context of intersectionality when psychological distress is present, taking the stance that the family is doing the best they can. This chapter presents the methodology of this research. First, ontology and epistemology is discussed followed by a reflection in relation to my own philosophical positioning. The research process and procedure for both the UK Household

Longitundinal Study (UKHLS) and this current study are then presented followed by ethical considerations and plans for dissemination. The chapter is concluded by my reflections relevant to the methodology.

Philosophical Positioning

Ontology concerns itself with the nature of being, existence and reality. The positions within ontology therefore address questions regarding what exists, how entities relate to each other and the general nature of reality (Guarino et al., 2009). Epistemology on the other hand concerns itself with the development of valid and high quality knowledge (Goertz & Mahoney, 2012; Park et al., 2020). Various epistemological positions make up assumptions and theories regarding how the world operates and how we can accurately come to understand it (Park et al., 2020). Therefore, the position a researcher adopts, forms the foundation of the research, which then guides its methodology (Bryman, 1984).

I have come to relate to different epistemological positions within this research and take the stance that my epistemological positioning is not static. A general understanding of the different epistemological positions can help with the evaluation of the quality of the conclusions drawn from a piece of research (Park et al., 2020). Therefore, I will report on the three mains positions; positivism, critical realism, and social constructionism before then reflecting on my own philosophical positioning which has guided this research. It should be noted that whilst not discussed in detail here, when exploring my own philosophical positioning I also explored empiricism, rationalism, constructivism, pragmatism, scepticism, feminist epistemology, and historical materialism.

Positivism

Positivism, inspired by philosophers such as Descartes and Locke (Park et al., 2020), started a shift from "truth via decree" towards the discovery of an objective, evidence-based truth. Positivism redefined the laws of nature to make causal inferences regarding the world that can support with prediction and control of phenomena (Gergen, 2001; Sciarra, 1999). Positivism is aligned with the hypothetico-deductive model to verify and build upon theory. This circular model explains that hypotheses, derived from theory, are used to operationalise variables which are then used to conduct research, from which the findings can be used to guide theory.

Researchers who position themselves with positivism generally take the stance that research should be replicable and that large samples should be used to generalise findings that form a single truth. The research must be developed from a completely objective stance and should not be influenced by the views and values of the research or participants who are completely separated from each other (Park et al., 2020). However, many are sceptical about whether this is truly achievable. The positivist position has come under criticism, mainly regarding reducing individuals to "mechanistic systems" (Eells & Sober, 1983), minimising the complexity of human interaction and society by attempting to understand it with limited isolated variables (Schrag, 1992).

Critical realism

Critical realism is often perceived as a middle ground between positivism and social constructionism. The positioning was developed by Bhaskar and multiple social theorists with the attempt to find out what must be true, for science and the discovery of knowledge to be possible (Steinmetz, 1998).

Whilst positivism focuses more on observable "surface level" findings, critical realism goes beyond, with researchers adopting this position, thinking about underlying mechanisms including discourse, language, and social power (Alvesson & Skoldberg, 2009; Gorski, 2013). Critical realism is grounded in the understanding that reality arises from both the natural and social world. Critical realists take the stance that social structures have agency which drive human behaviour and that scientific knowledge is comprised of descriptions of both the social and natural structures of the world (Gorski, 2013).

Although critical realism is social in nature and thus shares similarities with social constructionism, researchers adopting this position believe that there is a reality. In other words, whilst critical realists understand that the production of knowledge is fallible, they generally take the stance that experimentation can uncover 'truths' or 'laws' which are independent from the influence of the experiment itself (Steinmetz, 1998). These laws are descriptions of the patterns of mechanisms or powers in the world that exist, regardless of language (Gorski, 2013; Steinmetz, 1998).

Critical realists have come under scrutiny for pushing the limits of social science by both attempting to produce knowledge and acknowledging the social construction of the world (Hammersley, 2009). Therefore, researchers adopting this position must be aware of research limits to reduce bias and scientism.

Social constructionism

Social constructionism, which has its origins in sociology, was developed to understand the nature of reality (Andrews, 2012). Proponents of social constructionism criticise positivist research, stating that positivists ask the wrong questions and that their research is conducted from a position of power which neglects the voice of the "ordinary

person" (Burr & Dick, 2017). Social constructionists are described as taking an anti-realist stance (Hammersley, 1992) whereby knowledge and reality is understood as being constructed between individuals within society (Schwandt, 2003; Shotter & Lannamann, 2002; Young & Collin, 2004).

The key features of social constructionism are (a) language, (b) cultural and historical specificity, (c) discourse and disciplinary power, (d) power relations and (e) relativism (Burr & Dick, 2017). Social constructionists take the perspective that the way in which we understand the world will not reflect actual reality and thus is more concerned with how knowledge is constructed and understood through language, discourse, and cultural norms.

Social constructionism typically lends itself to qualitative research and researchers taking this position must accept that there are multiple perspectives of reality. Therefore, they should seek not to find a definitive truth. As a result of this however, research driven by this positioning is not considered generalisable to the wider population of individuals who are not directly being observed and thus the research has been considered "forever unfinished" (Shotter & Lannamann, 2002). The lack of generalisability makes it difficult for research to guide theory and influence social change to benefit the very people it is attempting to understand.

My Philosophical Positioning

When initially tasked to identify my own philosophical positioning, I did so in a very academic way, reading up on various positions and meticulously and systematically calculating where my beliefs fitted most. Following this I decided that I took a critical realist stance. I was aware that this thesis would only provide a snapshot into the reality of families and that research carried out on a different sample with different demographics would likely

find different results. Underneath these potentially different findings, I believed that there could be an underlying reality or truth. However, on reflection I wonder if I chose this stance because I was not sure, and it felt like a middle ground between positivism and social constructionism. I brought this to my thesis supervisors and told them how I did not feel as if I fit with just one position, that as I read, and learnt, wrote, and analysed, my position kept changing and I became more and more confused regarding this section of my methodology. What I was looking for here is permission to be reflective and transparent about this, to my surprise (because I originally believed quantitative research was not reflective), this was encouraged.

To understand my ever-changing philosophical positioning for this research I reflected on my professional contexts including my position as a Trainee Clinical Psychologist, my position as someone completing the intermediate systemic training, and my position as a researcher. I also reflected on my personal contexts, thinking about my role as a friend, my family, and my personal values. It was this that drove me to challenge my previously held beliefs about how research should and should not be written up and begin my introduction with a reflection of my own context. I noticed that in my practice I often adopt a social constructionist stance, specifically influenced by my passion and interest in third order systemic theory and intersectionality. But how do I adopt a social constructionist position whilst doing quantitative research on secondary data? This seemed to break every "rule" I knew about social constructionism and quantitative research. Even now when I speak with colleagues about my research and my social constructionist stance I get looks of confusion or comments trying to "correct me" in how this cannot be done. However, I disagree.

I have also realised that I am influenced heavily by feminist epistemology, being female, being within a mostly female family. This encourages me to think about power and

privilege a lot and consider it within this research. I am aware of my power as a white researcher in this context and I do not intend to ignore this within this thesis.

However, I want this research to contribute towards the evidence base of family therapy in mental health services. Therefore, I spent lots of time thinking about large sample sizes, replicability, blinding, everything that a positivist might do. Does this mean I take a positivist position? At times I probably do. This does not take away from my beliefs and values which align themselves with social constructionism or critical realism but instead, strengthened this idea that philosophical positioning is not static, at least not in my experience.

Research Process

Design

A quantitative methodology was adopted to investigate the aims of this study. This research is a longitudinal, panel study using secondary data from Understanding Society: the UKHLS.

Justification of Design

The use of longitudinal data allows this research to follow change over time (Caruana et al., 2015) and thus it is better able to capture the complexity of dynamic family relationships (Hsiao, 2006). I take the stance that behaviour is driven by the social, political, and cultural contexts a family finds themselves in. Therefore, it could be expected that the ways in which families respond to psychological distress would be a dynamic process, influenced by multiple factors. By adopting a longitudinal design, the findings of this

research may better reflect a reality of families who are moving through family life-cycle transitions.

Whilst I do not believe a researcher can be completely objective, by using secondary data from the UKHLS, I remain separate from the participants. Whilst aware that their responses will be used for research, participants are blind to my specific aims and research questions. Whilst I believe I cannot avoid bringing my context when interpreting results and making conclusions, this was discussed within supervision to minimise bias where possible.

It should also be noted that UKHLS provides a unique household focus within a large, culturally diverse sample which allows for the study of smaller subgroups whilst keeping statistical precision (Lynn & Knies, 2016).

A risk of using longitudinal study data is that dropout rates tend to be high (Caruana et al., 2015); however, the UKHLS is considered "one of the most stable longitudinal studies in the world" with high retention rates (Understanding Society the UK Household Longitudinal Study, n.d.-c).

If rated against the Quality Assessment Tool for Quantitative Studies (QATQS; Ciliska et al., n.d.), a moderate rating would be achieved for both the design and blinding subscales.

Participants

The sample of participants have been obtained from UKHLS. The UKHLS sample consists of the *general population sample*, the *ethnic minority boost sample* and the *immigrant and ethnic minority boost sample*. The *general population sample* is a clustered and stratified sample of around 25,500 households living in the UK in 2009/2010

(Understanding Society, 2023). The sample size was purposefully made large enough to enable research to focus on smaller-sub populations (Lynn, 2009). The *ethnic minority boost sample* included an additional 4,000 (approximately) households from areas in which there were high proportions of individuals from ethnic minority backgrounds in 2009/2010 (Understanding Society, 2023). Specific households targeted were ones which contained people from Indian, Pakistani, Bangladeshi, Caribbean, African, Chinese or other Asian backgrounds. White minority groups and non-white minority groups with diverse origins were excluded from this boost sample (Berthoud et al., 2009). The *immigrant and ethnic minority boost sample*, which was added during wave six (2014-2015) of UKHLS included approximately 2,900 households, selected from areas with a high proportion of individuals from ethnic minority groups (Understanding Society, 2023). This boost sample was made up of households whereby at least one member was born outside of the UK or was from an ethnic minority group.

The UKHLS core sample include all household members recruited from wave one (2009-2010) or from the boost samples, along with their offspring. Individuals who join core sample households form a temporary sample and remain as participants of UKHLS for as long as they remain living with at least one core sample member (Institute for Social and Economic Research, 2021).

Participants for This Study. This research consisted of a sub-population drawn from UKHLS who met a set of inclusion criteria: (a) have one adult whose scores of psychological distress, moved from a non-clinical range to a clinical range between waves, and (b) have at least two family members within the household. The demographics of the sample will be discussed in the results section of this thesis. Participants included ‘children’ (participants

ages under 16 years), ‘young adults’ (participants aged 16-21) and ‘adults’ (participants ages over 21).

If rated against the QATQS (Ciliska et al., n.d.), a moderate rating would be achieved for the selection bias subscale. A strong rating would not be achieved due to not having data on the percentage of individuals who agreed to participate from the original invited sample.

Procedure

UKHLS Data Collection Procedure. Details regarding the UKHLS procedure were taken from Understanding Society (2023). Participants within UKHLS were interviewed on a yearly basis if they were living in the UK, could be located, contacted and provided their consent to be interviewed. A “knowledgeable adult” was asked to complete a household renumeration grid to identify each household member and collect basic information. The eldest owner or paying tenant of the home answered a further household questionnaire to collect information regarding the whole household. Each household member was then interviewed separately regarding family life, social network, education, work, aspirations, attitudes, behaviours, health, and wellbeing. A core set of questions were asked at every wave and additional questions were asked less frequently (Appendix B). A trained interviewer asked all questions except for those that formed the self-completion questionnaires. These were completed on paper for the first two waves and then via the computer from wave three (2011-2012) onwards. Questionnaires differed depending on the age of the participants. Adult questionnaires were completed by participants aged 16 and over, the youth questionnaire was completed by participants aged 10-15, and the young adult questionnaire was completed by participants aged 16-21. For children below the age of 10, parents or carers answered segments of the youth questionnaire on their behalf.

Initially, all interviews took place face to face; however, after wave three (2011-2012), a small number of individuals completed their interviews via telephone. Adults who did not engage with the interviews at wave six (2014-2015) were offered online interviews at wave seven (2015-2016). During wave eight (2016-2017), adults who took part in wave seven were also invited to complete their interviews online. During each wave from here on, a proportion of individuals were invited to move from face to face to online interviews, up until a maximum of 80% of the sample were completing the interview online. Adults who did not complete their online interviews were assigned an interviewer who then offered them face-to-face meetings to complete the questionnaires. At the end of each fieldwork period, participants who had not yet completed their interviews were offered to complete these via telephone.

In March 2020, face-to-face interviews were suspended in accordance with COVID-19 government guidance in the UK. Participants were sent a letter informing them of this and providing them with details to complete the interview online. Participants who did not engage with this were offered a telephone interview. Face-to-face interviews resumed once restrictions were relaxed.

To encourage participation and thank participants for their time, incentives were provided. An unconditional ten-pounds gift voucher was enclosed in the invitation to participate in the research. In addition to this, adults completing the online interviews were offered an additional ten-pounds voucher if they completed this within five weeks. When participants turned 16, they were entered into a prize draw for an iPad. Lastly, if participants did not complete an interview during one wave, they were offered a twenty-pound incentive to re-engage with the study.

Participants were withdrawn from the study if they withdrew consent to participate, emigrated, died, or were deemed to lack the capacity to provide consent. From wave four (2012-2013), participants were also withdrawn from the study if they were not contactable or did not complete their interviews for two consecutive waves.

Procedure for This Study. This research made use of a special licence dataset (SN 6931), which was requested via the UK Data Service. Once permitted access, the data was downloaded as an SPSS file. Only variables considered appropriate for this research were extracted from the main data set. This included variables measuring psychological distress, relating to areas of intersectionality and ones which were considered family or relational factors relating to systemic theory. These variables were picked out from the questionnaires and grouped into broad categories. Groupings were then sent to the supervisors of this thesis to comment on and identify any variables which may have been missed. Once supervisors and I were happy that we had an exhaustive list of variables, these were grouped into smaller themes. A Family Systemic Therapist and lecturer at the university, who was separate to this research also explored the variables and grouped them into themes, these were discussed with me and an agreement on the final themes was reached.

Based on the variables selected, only three data files were used. These were the adult, youth and household files. Research questions one and two included data from waves one (2009-2010) to nine (2017-2018). For research question three, COVID-19 data was added. Wave ten was not included as it took place both before and during the COVID-19 pandemic and before the UK government mandated lockdowns (2018-2019).

Measures

UKHLS Survey Development. UKHLS surveys and questionnaires consist of the household renumeration grid, household questionnaire, adult questionnaire, the young adult questionnaire and youth questionnaire. The content of these were developed by the Scientific Leadership Team consisting of survey methodologists and subject experts (Understanding Society the UKHLS, n.d.-a). New questions are tested by the Survey Development Team on the Innovation Panel (1,500 households who mimic the main survey sample) (Understanding Society the UKHLS, n.d.-a).

Measures for This Study. Most questions used within this study were extracted from the surveys and questions belonging to UKHLS (discussed above), except for psychological distress which was measured via the General Health Questionnaire (GHQ)-12 and Strengths and Difficulties Questionnaire (SDQ).

If rated against the QATQS (Ciliska et al., n.d.), a strong rating would be achieved for the data collection method subscale.

GHQ-12. The GHQ-12 (Goldberg & Hillier, 1979) was used to measure psychological distress in adults and young adults. The questionnaire includes 12-items (Appendix C) related to psychiatric "disorders" which are rated by participants on a four-point Likert scale. Total scores range from zero to 36, with higher scores indicating psychological distress. The GHQ-12 is a brief screening tool, developed from the original 60-item measure, commonly used to measure psychological distress within non-clinical samples (Goldberg et al., 1997; Hystad & Johnsen, 2020). Whilst it is commonly used to measure the "clinical" presence/absence of symptoms related to "mental health disorders" (Böhnke & Croudace, 2016), the GHQ-12 is not a diagnostic tool and within this study will not be

considered as such. The brevity of the GHQ-12 has been found to improve participation rates and reduce participation fatigue suggesting that its use produces better quality data than longer measures (Hystad & Johnsen, 2020).

The wording of the positive and negative items in the GHQ-12 has been found to lead to a response bias. As a result, it has been proposed that the GHQ-12 would be more valid if it were to be treated as a bi-factor measure rather than one that assumes a single factor of psychological distress (Hankins, 2008; Ye, 2009). Hystad and Johnsen (2020) however, found that whilst it may be more reliable to consider the GHQ-12 as consisting of multiple dimensions of psychological distress, associated with item wording, there is evidence reflecting a single general factor. This general factor was found to have strong associations with other measures such as the Bergen Insomnia Scale and the Hopkins Symptom Checklist-25. The consequences of ignoring the multidimensionality of the GHQ-12 are considered small (Hystad & Johnsen, 2020).

The GHQ-12 was used within this study to measure the psychological distress of individuals from various ethnic backgrounds. The GHQ-12 has been used with individuals from multiple backgrounds; including, but not limited to, Nigeria (Iheanacho et al., 2015), India (Endsley et al., 2017), Korea (Ju et al., 2017) and Northern Ireland (Tseliou et al., 2018) and has been translated into several languages. The GHQ-12 is considered a reliable and stable measure across diverse samples (Picardi et al., 2001).

To identify families for the research sample, a cut off score was used; however, this was not used when exploring psychological distress as the dependent variable. Research suggests that when using the Likert scoring method, a cut off score of 11/12 yields the best specificity (77.4%) and sensitivity (78.9%) in identifying people who would meet criteria for a clinical diagnosis of a mental health difficulty (Goldberg et al., 1997) and therefore

increases the likeliness that the research sample will be similar to the individuals and families who are accessing mental health services in the UK. The GHQ-12 was completed by participants during every wave.

SDQ. The SDQ (Goodman, 1997) was used to measure the psychological distress of children. This behavioural screening questionnaire consists of 25 items (Appendix D) assessing behaviours, emotions and relationships of children aged four to 17 years old. The measure is separated into five subscales: (1) conduct problems, (2) emotional symptoms, (3) hyperactivity, (4) peer problems and (5) prosocial behaviour. The total difficulties score on the SDQ ranges from zero to 40 (Pote et al., 2020).

The SDQ is widely used as a screening tool which produces "clinically meaningful" psychopathology profiles of children (Rothenberger & Woerner, 2004). However, it does not cover all mental health "disorders" and is not considered comprehensive enough to be used as a diagnostic tool (Muris et al., 2003). The hyperactivity scale within the SDQ has been recognised as the most useful in distinguishing between clinical and non-clinical symptomology (Lai et al., 2010); however, this scale is more reliably measured via parent-reports than self-report (Becker et al., 2004). Like the GHQ-12, the briefness and simplicity of the SDQ acts as an advantage to the measure (Rothenberger & Woerner, 2004). The self-report and parent-report measures have been found to be both reliable and valid across many countries; including Germany (Becker et al., 2004), England (Goodman, 1997), Netherlands (Muris et al., 2003), Finland (Koskelainen et al., 2000), Italy (Di Riso et al., 2010), Australia (Hawes & Dadds, 2004) and Hong Kong (Lai et al., 2010). Di Riso et al. (2010) suggests that the validity of the SDQ extends to children as young as eight, despite the measure being intended to screen for psychological distress in children eleven and over.

Despite the support this measure has received in the literature, the reliability of the self-report SDQ is reduced when looking at specific difficulties (Becker et al., 2004) whereby the combination of parent and teacher reports are of better use. It should also be noted that the normative scores in the Eastern regions of the world are much higher than those in the Western regions (Lai et al., 2010) and thus caution should be taken in interpreting scores across cultures.

Only the SDQ total difficulties score was used within this study as a dependent variable. Scores of 17 and over on the total difficulties component are considered "abnormal" (Bryant et al., 2020). However, cut off scores were not used in the main analysis in line with the aims of the research. The SDQ was completed during odd waves only.

Variable Development.

In total 89 variables from UKHLS were identified as being relevant to this research. As aforementioned, these were grouped into themes, which are mentioned in turn below. This was done to reduce the complexity of the data for analysis but also to increase the power of the analysis and mitigate problems such as multicollinearity. Where appropriate nonlinear Principal Components Analysis (PCA) was conducted for the purpose of dimension reduction (Linting et al., 2007; Linting & van der Kooij, 2012). This was used over traditional PCA due to its ability to incorporate nominal and ordinal variables (Linting et al., 2007). Nonlinear PCA was conducted via the CATPCA method in SPSS using the guidance set out by Linting and van der Kooij (2012).

Intersectionality Factors. Whilst discussed together here, intersectionality variables (Table 2) were not grouped into one theme. Nonlinear PCA was not therefore required for these variables. The only variables which were grouped were two separate religion variables

for children, one that was used to explore the religion of children living in Great Britain, and the other, for children living in Northern Ireland. These were grouped to have one single child religion variable.

Table 2.
Intersectionality Variables

Variable	Population for which there is data available	Waves data is available for
Sex	Children, young adults, and adults	All
Sexual orientation	Young adults and adults	3, 5, 7, 9
Disability	Young adults and adults	All
Religion	Children, young adults, and adults	All (for adults and young adults), 1, 3, 5, 7 (for children).
Social class (measured via present job)	Young adults and adults	All
Ethnicity	Children, young adults, and adults	All (for adults and young adults), 1, 3, 5, 7, 9 (for children)
Age	Children, young adults, and adults	All
Employment	Young adults and adults	All
Relationship status	Young adults and adults	All
Highest qualification	Young adults and adults	All
Household Income	All households	All

Age wanting to leave home. This theme originally consists of two variables, one for children and one for young adults. Data for these variables were collected from wave three for young adults and odd waves for children. The two variables were not combined as they were measured in different populations therefore nonlinear PCA was not required for these variables.

How often the Family Spend Time Together or Apart. This theme consisted of nine variables (Table 3). Variables were grouped by *asked to children*, *asked to young adults only* and *asked to young adults and adults*. Given only the *asked to young adults and adults* group contained more than two variables, this was the only group for which a nonlinear PCA was conducted. CATPCA revealed two dimensions with *screlparwt*, *scparoutint* and

screlparei loading highest onto dimension one (α = .78, λ = 2.66, VAF = .53) and *socialkid* and *dinner* loading highest onto dimension two (α = .39, λ = 1.45, VAF = .29). VAF values were considered excellent and fair respectively (Comrey & Lee, 1973).

Table 3.
How Often the Family Spend Time Together or Apart Variables.

Variable (label)	Population for which there is data available	Waves data is available for
In past seven days how, many times have you eaten an evening meal together with family? (ypeatlivu & eatlivu)	Children and young adults	All (for children), from wave 3 (for young adults)
In past month, how many times have you stayed out past 9.00pm without parents knowing? (yplate & late)	Children and young adults	All (for children), from wave 3 (for young adults)
How often respondent and partner work together on a project? (screlparwt)	Young adults and adults	1, 3, 5, 7, 9
Do you and your partner engage in outside interests together? (scparoutint)	Young adults and adults	1, 3, 5, 7, 9
Frequency of leisure with child (socialkid)	Young adults and adults	1, 3, 5, 7, 9
Frequency of eating dinner with kids (dinner)	Young adults and adults	1, 3, 5, 7, 9
How often respondent and partner have a stimulating exchange of ideas? (screlparei)	Young adults and adults	1, 3, 5, 7, 9

Parents being Present and Supportive of Children. This variable theme includes 14 different variables from the UKHLS (Table 4). Nonlinear PCA was conducted for these variables. Variables were grouped into *asked to children*, *asked to young adults only* and *asked to adults and young adults*. Variables *ypupset* and *upset* were changed to didactic variables which were only concerned with whether the child and young adult would go to their family member for support or not. CATPCA revealed that all child variables loaded

highest onto one single dimension (α = .65, λ = 2.19, VAF = .36 [good; Comrey & Lee, 1973]). However, when separated into *parents being emotionally supportive* (*ypfamsup, ypupset, yptlkm, yptlkf*) and *being supportive of schooling* (*ypparsch, yppareve*), the variance explained increased (α = .61, λ = 1.83, VAF = .46; α = .33 λ = 1.20, VAF = .60, respectively). VAF values were considered very good and excellent (Comrey & Lee, 1973).

Three dimensions were found to the *young adults only* variables. Dimension one consisted of the variables *famsup* and *upset* (α = .82 λ = 3.19, VAF = .53) with explained variance considered as excellent (Comrey & Lee, 1973). Variables *tlkm* and *tlkf* explained the majority of variance in dimension two (α = .57 λ = 1.92, VAF = .32), which was considered good (Comrey & Lee, 1973). The variables *parsch* and *pareve* explained the majority of variance in dimension three (α = .54 λ = 1.82, VAF = .30), which was considered good (Comrey & Lee, 1973). As only *hlphmwk* and *talkmatter* were asked to the *adult and young adult* group, a CATPCA was not initially planned. However, given that *being emotionally supportive* and *supportive of schooling* appeared to be different dimensions for children and young adults, a CATPCA was run to examine whether this was also the case for adults. Two separate dimensions were confirmed (*emotional supportive of children*: α = .64 λ = 1.47, VAF = .74; *supportive of child's schooling*: α = .09 λ = 1.05, VAF = .53), with the variance explained by both dimensions being excellent (Comrey & Lee, 1973).

Table 4.

Parents Being Present and Supportive of Children Variables.

Variable	Population for which there is data available	Waves data is available for
Do you feel supported by your family? (ypfamsup & famsup)	Children and young adults	1, 3, 5, 7, 9 (for children), from wave 3 (for young adults)
Suppose you felt upset or worried, who would you turn to first within your family? (ypupset & upset)	Children and young adults	1, 3, 5, 7, 9 (for children), from wave 3 (for young adults)
How often do you talk to your mother about things that matter? (yptlkm & tlkm)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you talk to your father about things that matter? (yptlkf & tlkf)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9, 11 (for young adults)
Parents are interested in how I do at school. (ypparsch & parsch)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9, 11 (for young adults)
My parents come to school parent evenings (yppareve & pareve)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
Parent helps their children with homework (hlphmwk)	Young adults and adults	1, 3, 5, 7
How often talk about important matters with children (talkmatter)	Young adults and adults	1, 3, 5, 7, 9

Intimacy and Affection Within the Family. This variable theme was chosen to group three UKHLS variables (Table 5). Nonlinear PCA revealed that *screlparks* loaded highly onto dimension one ($\alpha = .88$ $\lambda = 2.41$, VAF = .80), explaining the majority of variance, whilst *praisekid* and *cuddlekid* explained the majority of variance of dimension two ($\alpha = .77$ $\lambda = 2.1$, VAF = .69). VAF scores were considered excellent (Comrey & Lee, 1973).

Table 5.

Intimacy and Affection Within the Family Variables.

Variable	Population for which there is data available	Waves data is available for
Relation with partner: kiss partner (screlparks)	Young adults and adults	1, 3, 5, 7, 9, 11
How often praise child (praisekid)	Young adults and adults	1, 3, 5, 7, 9, 11
How often hug or cuddle child (cuddlekid)	Young adults and adults	1, 3, 5, 7, 9, 11

Discipline of Children Within the Family. This theme groups two variables: *how often spank or slap child* and *how often should at kid*. Data was collected for both variables from young adults and adults from waves one, three, five, seven, and nine. Nonlinear PCA was not deemed necessary for this theme given that there were only two variables.

Arguing and Fighting Within the Family. Within this variable theme, 23 variables from UKHLS were included (Table 6). Nonlinear PCA was conducted for these variables. Three separate analyses were run (for *children*, *young adult only*, and *young adult and adult* variables). With regards to the child variable group, variables loaded onto two dimensions with the first summarising *arguing and fighting amongst siblings* ($\alpha = .86$ $\lambda = 4.43$, VAF = .44 [very good; Comrey & Lee, 1973]) and the second summarising *arguing with parents* ($\alpha = .63$ $\lambda = 2.33$, VAF = .23 [fair; Comrey & Lee, 1973]).

This was the same with the *young adult only* variables (*arguing with siblings*: $\alpha = .88$ $\lambda = 4.75$, VAF = .48 [very good; Comrey & Lee, 1973]; *arguing with parents*: $\alpha = .78$ $\lambda = 3.32$, VAF = .81 [excellent, Comrey & Lee, 1973]). With regards to the *young adult and adult* variables, two dimensions were found. Variables *screlparcd* and *screlparar* loaded highly onto the first ($\alpha = .66$ $\lambda = 1.79$, VAF = .60) and *quarrel* loaded highly onto the second ($\alpha = .27$ $\lambda = 1.21$, VAF = .40). VAF scores were considered excellent and very good, respectively (Comrey & Lee, 1973).

Table 6.

Arguing and Fighting Within the Family Variables.

Variable (label)	Population for which there is data available	Waves data is available for
How often do your brothers or sisters hit, kick or push you? (ypsibhit & sibhit)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do your brothers or sisters take your belongings? (ypsibsteal & sibsteal)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do your brothers or sisters call you nasty names? (ypsibverab & sibverab)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do your brothers or sisters make fun of you? (ypsibtease & sibtease)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you hit, kick or push siblings? (yphitsib & hitsib)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you take siblings belongings? (ypstealsib & stealsib)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you call siblings nasty names? (ypverabsib & verabsib)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you make fun of siblings? (ypteasesib & teasesib)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you quarrel with your mother? (ypargm & argm)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often do you quarrel with your father? (ypargf & argf)	Children and young adults	1, 3, 5, 7, 9 (for children), 3, 5, 7, 9 (for young adults)
How often respondent and partner calmy discuss something (screlparcd)	Young adults and adults	1, 3, 5, 7, 9
How often do you and your partner quarrel? (screlparar)	Young adults and adults	1, 3, 5, 7, 9
How often quarrel with children (quarrel)	Young adults and adults	1, 3, 5, 7, 9

Happiness in Family Relationships. This theme consisted of four variables (Table 7). Nonlinear PCA was conducted for the *young adult and adult* variables. CATPCA revealed that one single dimension explained the data best ($\alpha = .67$ $\lambda = 1.81$, VAF = .60). The VAF score was considered excellent (Comrey & Lee, 1973).

Table 7.
Happiness in Family Relationships Variables

Variable	Population for which there is data available	Waves data is available for
How do you feel about your family? (yphfm)	Children	All
How often do you discuss, or have you considered divorce, separation or terminating your relationship? (screlpards)	Young adults and adults	1, 3, 5, 7, 9
How often do you and your partner get on each other's nerves? (screlparir)	Young adults and adults	1, 3, 5, 7, 9
Which best described the degree of happiness, all things considered of your relationship? (screlhappy)	Young adults and adults	1, 3, 5, 7, 9

Individual Carer Status. This theme only consisted of two UKHLS variables: *cares for handicapped/other in household* and *non-residents cared for*. Data for these variables were gathered from young adults and adults, within all waves. Nonlinear PCA was not deemed necessary for this variable.

Home Environment. This theme included five UKHLS variables (Table 8). Nonlinear PCA was conducted for these variables. For this to be completed, the first three variables in Table 8 needed recoding to ensure that responses did not include a value of zero. CATPCA found two dimensions with the variance of the first dimension being mostly explained by *pdeph1*, *pdepi1*, *pdepf1* and *cdephave2* ($\alpha = .94$, $\lambda = 3.97$, VAF = .79) and the

variance of dimension two being explained by *cdelply* (α = .89, λ = 3.48, VAF = .69). VAF scores were considered excellent (Comrey & Lee, 1973).

Table 8.
Home Environment Variables

Variable (label)	Population for which there is data available	Waves data is available for
Damp free home (pdeph1)	All households	4, 6, 8
Home kept warm (pdepi1)	All household	4, 6, 8
Home good state of repair (pdepf1)	All households	4, 6, 8
Children have enough bedrooms (cdephave2)	All households	1, 2, 4, 6, 8
Space outdoors to play (cdelply)	All households	1, 2, 4, 6, 8

Wider Support Networks. This theme included eleven UKHLS variables (Table 9). *Number of close friends* is a continuous variable and given that prior literature (Samuelsson, 1994) states that this factor itself influences psychological distress, this was kept separate to the other variables. All other variables were grouped by *asked to children*, *asked to young adults only* and *asked to young adults and adults*. Given that only the latter group contained more than one variable, nonlinear PCA was only conducted for this group. The variable *orgat11* was relabelled prior to the CATPCA to ensure that responses did not include values of zero.

CATPCA revealed three dimensions. Variance of dimension one was explained by the variables *scopngbha, scopngbhb* and *scopngbhc* (α = .95, λ = 5.30, VAF = .75 [excellent, Comrey & Lee, 1973]). Variance of dimension two was explained by the variables *scfletdown*, *scfrely* and *scfundstnd* (α = .89, λ = 4.27, VAF = .61 [excellent; Comrey & Lee, 1973]). The variance of the third dimension was explained by the variable *orgat11* (α = .70, λ = 2.52, VAF = .36 [good, Comrey & Lee, 1973]).

Table 9.
Wider Support Networks Variables

Variable (label)	Population for which there is data available	Waves data is available for
I have one good friend or more (ypsdqk)	Children	1, 3, 5, 7 (for children)
Number of close friends (ypnpal & closenum)	Children, young adults, and adults	All (for children),4, 5, 7, 8, 10 (for young adults) 3, 6, 9 (for adults)
Friends let me down (scfletdwn)	Young adults and adults	2, 5
Can rely on friends (screfly)	Young adults and adults	2, 5
Friends understand the way I feel (scfundstnd)	Young adults and adults	2, 5
Active in any of listed organisations (orgat11)	Young adults and adults	3, 6, 9
Belong to neighbourhood (scopngbha)	Young adults and adults	1, 3, 6, 9
Local friends mean a lot (scopngbhb)	Young adults and adults	1, 3, 6, 9
Advice obtainable locally (scopngbhc)	Young adults and adults	1, 3, 6, 9

Variables not included in original themes. Four factors which were originally identified as relevant variables for this research were excluded during the variable creation stage. These were: *self-identified gender*, *culture*, *experience of discrimination* and *isolation*. Data on *self-identified gender* was only collected from wave twelve and thus it could not be included within this research. No variables could be found within UKHLS that relate to cultural practices and culture in general. *Isolation* was only recorded from wave nine and *experience of discrimination* from wave eleven and thus neither of these could be included also.

Final Predictor Variables. As a result of the nonlinear PCA's the 89 UKHLS variables were merged to create 44 final predictor variables (Table 10; see Appendix E for response scales and the UKHLS variables used in each new variable). Due to the nature of the study, most variables that could be considered as confounding variables were included as factors potentially associated with distress. Therefore, if rated against the QATQS (Ciliska et al., n.d.), a strong rating would be achieved for the confounders subscale.

Table 10.

Final Predictor Variables

Intersectionality variables	Child relational variables	Young adult relational variables	Adult and young adult relational variables	Household variables
Sex	Age child wants to leave home	Age young adult wants to leave home	Spending time with partner	Suitable home environment
Sexual orientation	Child spending time with family in the evening	Young adult spending time with family in the evening	Spending time with children	Children have space to play
Disability	Child feeling emotionally supported by family	Young adult feeling emotionally supported by family	Emotionally supportive of child	
Religion	Child feels that parents support their schooling	Young adult able to talk with parents	Supporting of child's schooling	
Social class	Child arguing and fighting with siblings	Young adult feels that parents support their schooling	Affection towards partner	
Ethnicity	Child arguing with parents	Young adult arguing and fighting with siblings	Affection towards child	
Age	Child's happiness with family relationships	Young adult arguing with parents	Discipline child	
Employment	Number of child's close friends	Number of young adult's close friends	Argue with partner	

Intersectionality variables	Child relational variables	Adult and young adult relational variables
Relationship status	Child has one or more good friends	Argue with children
Highest qualification		Happiness in couple relationship
Income		Has caring responsibilities
		Number of adult's close friends
		Local social support available
		Supportive friendships
		Belonging to a community organisation

Data Analysis

IBM SPSS was used to analyse the data for this research. The data analysis was separated into two phases, data preparation and data analysis. For all research questions, the dependent variable was psychological distress, and the independent variables are those presented in Table 10.

Data Preparation.

Data from the raw UKHLS *youth*, *indresp* and *hhresp* files were merged so that all responding members of the household were included in one dataset. A distressed individual was chosen by identifying the person in the household who first became distressed. If two people became distressed in the same wave, the one with the highest GHQ-12 score was chosen as the distressed individual. The wave at which the adult began experiencing distress above the cut off score was treated as timepoint zero, and the following year timepoint one. Data from the family members was included for, at most, seven timepoints, using waves one to nine. Separate files were created for the different relationships to the distressed person i.e., partner, offspring and other family member. Files were created in wide format due to the aim of this research being to explore overall trends in the data. The responses *missing*, *inapplicable*, *proxy*, *refusal* and *don't know* were all treated as missing data.

Original UKHLS variables that were to be merged into new variables were recoded and reverse scored where necessary, but kept as close to the original responses as possible. Dummy variables were created for non-ordinal categorical variables that contained more than two categories. A mean score variable for each of the relational variables over timepoints three and four were computed. Due to decreasing sample size through the timepoints, and SDQ scores being collected during alternate waves, new psychological distress variables

were computed. These involved the GHQ or SDQ scores from timepoint five and when these were not available, the score from timepoint six. Timepoint seven was not used as the majority of the data during this timepoint was missing.

Analysis methods

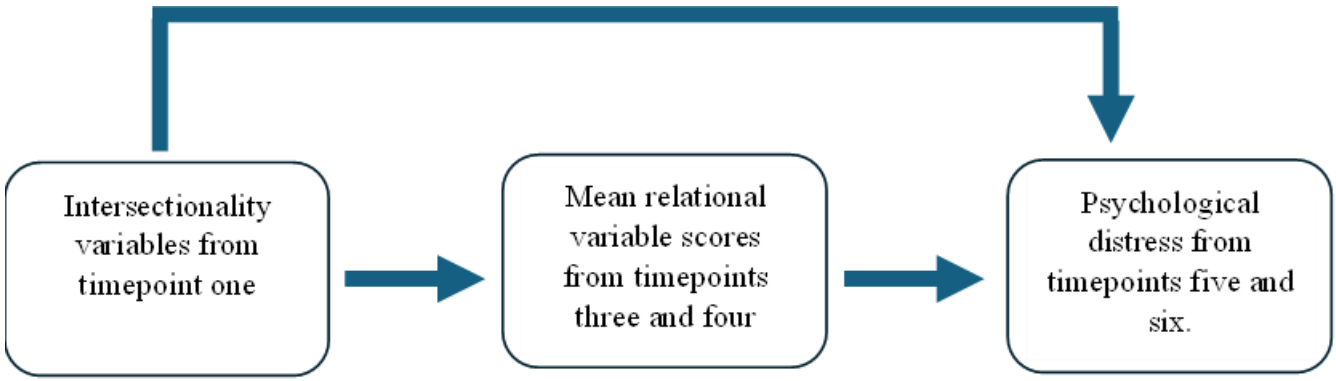
Ordinary Least Squares (OLS) regression was used to analyse the data for all three research questions. OLS regression is commonly used within longitudinal family research (Acock, 1999) and was used in most of the research guiding this study. This enables results to be directly compared to previous findings. OLS regression was chosen due to it being able to manage multiple variables and systematically control for covariates (Acock, 1999). OLS linear regression is generally considered a robust model and thus can be used for this data which does not completely meet the assumptions of panel data methods. The simplicity of OLS linear regression enhances the interpretability of the results and may be considered more accessible for a broad audience. This feels particularly important given that this research is intended for professionals from multiple disciplines who may find themselves working with families. All variables applicable for each participant group were inputted into an OLS regression model, with psychological distress being the dependent variable. Following this, further regression models were run, with all applicable intersectionality variables as the predictor variables and the significant relational variables (from the previous regression) as the dependent variables. The exact variables and process of analysis is discussed in further detail within the results section for each participant group.

Based on the hypothesis that families are doing their best in a society that is not always set up for them to succeed, it is important to consider indirect effects that sociodemographic contexts may have on relational factors impacting distress. Sobel tests (Sobel, 1982) were therefore used to evaluate the significance of indirect effects of

intersectionality/mediation effects of relational factors. Sobel tests were carried out on variables which were significantly associated, as determined by the OLS regressions. Figure 2 describes how the data was explored longitudinally.

Figure 2.

Longitudinal Analysis Plan



Note. Intersectionality taken from timepoint one to explore intersectionality of families once distress began. Relational variables taken from timepoints three and four to allow for change since distress began, multiple time points used due to not all variables being collected during the same timepoint. Psychological distress taken from timepoints five and six, to allow for change over time. Two timepoints used to increase sample size. Timepoint seven excluded due to small sample size.

Path analysis was originally considered for the purpose of research questions one and two. This was chosen due to its ability to examine the strength of both direct and indirect effects of variables, disentangling the processes underlying a specific outcome (Lleras, 2005), in this case psychological distress within the family. However, due to the categorical and ordinal nature of majority of the variables, Bayesian methods would be most appropriate (Zhang et al., 2015). Using Bayesian methods would have meant being unable to get a model fit or significance statistics. This along with this research being more exploratory in nature rather than testing a model, led to the conclusion that a path analysis was not suitable (Streiner, 2005). Given that path analysis is an extension of multiple regression (Streiner, 2005), multiple regression was accepted.

Ethical Considerations

Ethical approval for the UKHLS has been provided by the University of Essex Ethics Committee (Appendix F). All participants provided their consent to partake in the research prior to each interview (see Appendix G and H for information sheets and consent information). Participants were aware of their right to refuse to answer specific questions or segments of the questionnaire in addition to their right to withdraw from the study entirely.

Further ethical approval to use the data was not required. Access to the special licence data was applied for via the UK Data Service by completing the Special Licence Project Application (Appendix I) and Special Licence end user agreement (Appendix J). The security standards are higher for Special Licence data and the Research data handling and security guide (UK Data Archive, 2023) was followed to meet these standards. To maintain the confidentiality of the participants, dates of birth, school names, employer names and geographical identifiers are not included in the downloadable data set.

Dissemination

This research has been written as a thesis for the Doctoral Programme in Clinical Psychology at the University of Essex and therefore will be available through th e university online library. In addition to this, the thesis will be submitted to journals as a series of reports. Potential journals include the British Journal of Clinical Psychology, British Journal of Family Medicine, the British Medical Journal and Human Systems: Therapy, Culture and Attachment.

The research has already been presented at the University of Essex, Health and Social Care, Staff and Student Conference in June 2022 and June 2023 as a poster. In October 2023 it was presented during a Doctoral Programme Staff and Student Conference. It will be

presented again at the University of Essex, Health and Social Care, Staff and Student Conference in June 2024.

Researcher Reflections

Whilst determining my methodology, I experienced difficulties in relation to wanting to give justice to the families' experiences. I was aware that in using secondary data and not co-producing the methods of this research meant that the voices of families across the UK were lost. I reflected on my own family often with regards to the methodology to consider real lived experience. Whilst this enabled me to identify the lenses I bring into this research; it was important for me to acknowledge that my own experiences do not represent those of every family in the UK. I struggled when having to exclude variables due to limitations with the dataset, as this would prevent me from fully exploring intersectionality and went against my values. As a result, whilst applying for the Special Licence data postponed my data analysis, it felt important to have, not just for the research aims and ensuring that I could include as many intersectionality factors as possible, but also for my own personal values. What helped in accepting that certain variables such as self-identified gender, could not be included in the research was something I remembered from my systemic teaching. I remembered an exercise whereby I identified four areas of intersectionality that are most important to me and from here reflected on areas that I may not think about as often. It was explained that whilst it is important to hold these neglected areas in mind, in practice, with everything a therapist needs to think about, it is unrealistic to expect that all areas of intersectionality will always be covered. Whilst this helped me to move on with my methodology, I aim to keep in mind the variables that were not able to be included to ensure that they are not completely lost.

Chapter 3: Results

Chapter Overview

This chapter presents the data analysis of secondary data extracted from the UK Household Longitudinal Study (UKHLS). Data was analysed with the purpose of answering three research questions: (1) what factors appear to influence psychological distress of families when one member is already experiencing distress, (2) are there specific factors that help or hinder families and (3) do factors effecting distress remain the same during the COVID-19 pandemic? Variables were chosen based on prior research discussed within the introduction. This chapter is separated into several sections. First, participant characteristics are presented, followed by descriptive statistics. The analysis of the data from each participant group is then discussed in turn, including Ordinary Least Squares (OLS) regressions and Sobel tests. The results chapter ends with the data analysis for research question three, again discussing OLS regressions for each participant group in turn.

Participants

This study included participants over seven timepoints. Across all timepoints, the total number of observed cases was 93,029. Participants' ages ranged from nine years to 101 years, 53.03% (N = 49,333) of observed cases were male and 47.64% (N = 44,321) were female.

Participants differ across timepoints due to various reasons including but not limited to dropping out, death, moving out of a core sample household or joining a core sample household. Table 11 shows the sample size, age, sex and ethnicity of participants per timepoint used in this study, per group. It should be noted that those in the offspring group were not necessarily children. The most common religion across the sample was Christianity,

(including all denominations; 62.17%). Of participants who reported on their religion, 15.14% were Muslim, 3.88% were Hindi, 2.20% were Sikh, .67% were Jewish, .56% were Buddhist and 2.20% followed another religion. Children were given the option to select no religion during the interview, which 1962 (13.19%) did.

Table 111.

Participant Demographics Per Group, Per Timepoint Included in the Study. Including Sample Size, Mean Age, Sex and Ethnicity.

		N	Mean Age (*SD*)	Sex N (valid %)	Ethnicity N (valid %)
Timepoint one	Offspring	6843	16.88 (8.28)	Male = 3645 (53.3%) Female = 3196 (46.7%)	White = 3266 (75.06%) Black = 222 (5.1%) Asian = 649 (14.92%) Mixed = 170 (3.91%) Other = 44 (1.01%)
	Spouse	8902	49.50 (15.94)	Male = 5411 (60.8%) Female 3491 (39.2%)	White = 7296 (86.53%) Black = 195 (2.31%) Asian = 786 (9.32%) Mixed = 88 (1.04%) Other = 67 (.79%)
	Other	12738	37.63 (19.46)	Male = 5946 (46.7%) Female = 6791 (53.5%)	White = 8468 (75.92%) Black = 543 (4.87%) Asian = 1781 (15.97%) Mixed = 264 (2.37%) Other = 98 (.88%)
Timepoint three	Offspring	3413	18.60 (7.79)	Male = 1815 (53.2%) Female = 1598 (46.8%)	White = 1903 (76.12%) Black = 109 (4.36%) Asian = 385 (15.4%) Mixed = 90 (3.6%) Other = 13 (.52%)
	Spouse	5698	51.92 (15.07)	Male = 3457 (60.7%) Female = 2241 (39.3%)	White = 4908 (88.24%) Black = 98 (1.76%) Asian = 474 (8.52%) Mixed = 42 (.76%) Other = 40 (.72%)

		N	Mean Age (*SD*)	Sex N (valid %)	Ethnicity N (valid %)
	Other	7485	40.95 (19.18)	Male = 3478 (46.5%) Female = 4007 (53.5%)	White = 5413 (77.32%) Black = 304 (4.34%) Asian = 1058 (15.11%) Mixed = 168 (2.4%) Other = 58 (.83%)
Timepoint four	Offspring	2209	19.55 (7.72)	Male = 1167 (52.8%) Female = 1042 (47.2%)	White = 1357 (77.5%) Black = 73 (4.17%) Asian = 275 (15.71%) Mixed= 39 (2.22%) Other = 7 (.40%)
	Spouse	4401	53.09 (14.65)	Male = 2659 (60.4%) Female = 1742 (39.6%)	White = 3841 (88.08%) Black = 59 (1.35%) Asian = 364 (8.35%) Mixed = 33 (.76%) Other = 29 (.66%)
	Other	5509	42.59 (18.90)	Male = 2541 (46.1%) Female = 2968 (53.9%)	White = 4064 (77.25%) Black = 219 (4.16%) Asian = 814 (15.47%) Mixed = 119 (2.26%) Other = 45 (.86%)
Timepoint five	Offspring	1295	20.54 (7.58)	Male = 660 (51%) Female = 635 (49%)	White = 909 (77.1%) Black = 41 (3.48%) Asian = 177 (9.92%) Mixed = 45 (3.82%) Other = 7 (.59%)
	Spouse	3167	54.29 (14.34)	Male = 1905 (60.2%) Female = 1262 (39.8%)	White = 2789 (89.16%) Black = 28 (.90%) Asian = 264 (8.44%) Mixed = 22 (.70%) Other = 25 (.80%)
	Other	3763	44.04 (18.38)	Male = 1753 (46.6%) Female = 2010 (53.4%)	White = 2791 (76.38%) Black = 151 (4.13%) Asian = 594 (16.26%) Mixed = 83 (2.27%)

					Other = 35 (.96%)
		N	Mean Age (*SD*)	Sex N (valid %)	Ethnicity N (valid %)
Timepoint six	Offspring	641	21.92 (7.90)	Male = 318 (49.6%) Female = 323 (50.4%)	White = 440 (74.32%) Black = 24 (4.05%) Asian = 111 (18.75%) Mixed = 15 (2.53%) Other = 2 (.34%)
	Spouse	1942	55.29 (14.01)	Male = 1170 (60.2%) Female = 772 (39.8%)	White = 1713 (88.89%) Black = 17 (.88%) Asian = 168 (8.72%) Mixed = 11 (.57%) Other = 18 (.93%)
	Other	2121	45.33 (17.67)	Male = 988 (46.6%) Female = 1133 (53.4%)	White = 1631 (77.93%) Black = 83 (3.97%) Asian = 311 (14.86%) Mixed = 49 (2.34%) Other = 19 (.91%)

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Grouping ethnicity into *White*, *Black*, *Asian* and *Other*, whilst common practice, oversimplifies the diversity within each group and may perpetuate stereotypes and biased assumptions. Table 12 therefore presents the specific ethnicities reported in this study for timepoint one. Whilst the participants do differ across timepoints, the general spread of ethnicities remains similar. It should however be noted that categories are still relatively broad, and that *other* categories are still used. This leads to lack of visibility of certain groups and limitations into how this research may help with the understanding of less well-known ethnicities. For further demographic information see Appendix K.

Table 12.
Ethnicity of Sample During Timepoint One (N and Percentage).

	Offspring		Spouse		Other	
	N	%	N	%	N	%
White British	3123	71.78%	6867	81.4%	8006	71.78%
Irish	77	1.77%	156	1.7%	216	1.94%
Any other White background	66	1.52%	273	3.2%	246	2.21%
White and Black Caribbean	65	1.49%	30	.4%	90	.81%
White and Black African	23	.53%	11	.1%	36	.32%
White and Asian	41	.94%	23	.3%	70	.63%
Any other mixed background	41	.94%	24	.3%	68	.61%
Indian	209	4.8%	305	3.6%	559	5.01%
Pakistani	258	5.93%	233	2.8%	646	5.79%
Bangladeshi	135	3.1%	127	1.5%	385	3.45%
Chinese	9	.21%	41	.5%	36	.32%
Any other Asian background	38	.87%	80	.9%	155	1.39%
Caribbean	70	1.61%	76	.9%	198	1.78%
African	136	3.13%	113	1.3%	318	2.85%
Any other Black background	16	.37%	6	.1%	27	.24%
Arab	31	.71%	33	.4%	47	.42%
Any other ethnic group	13	.3%	34	.4%	51	.46%

Descriptive Analysis

Mean scores and standard deviations for each of the relational variables and outcome variables were calculated per dataset and reported in Table 13. Child variables were not included within the spouse dataset and therefore there is no descriptive data in relation to this. There were also no observations for the variables: *young adult spending time with family*, *young adult feeling supported by family*, *young adult feeling that parents support their schooling* and *young adult arguing with their siblings* within the spouse data. Within the offspring dataset, there were no observations for *belonging to a community organisation*.

General Health Questionnaire (GHQ) scores were highest in other family members of someone who is distressed, followed by offspring and spouses. Despite the scores seeming

generally similar, only the mean GHQ scores of the other family members fall over the suggested cut off indicating distress. The Strengths and Difficulties Questionnaire (SDQ) score was also higher in the other family members than offspring. However, there were only 37 other family members who completed the SDQ. The mean SDQ scores are all within the normal range. Within the offspring data there was a significant correlation between GHQ and SDQ scores (r = .44, p = .01). However, these were not significantly correlated within the other family member data (r = -.07, p = .91).

At the start of the pandemic GHQ scores across all family members increased (offspring: M = 14.03, SD = 6.45; spouse: M = 11.43, SD = 5.59; other: M = 13.12, SD = 6.12). Offspring experienced the largest increase in distress, with mean scores now falling above the cut off.

Table 13.

Mean Relational Variable Scores (Timepoints 3 and 4) and Psychological Distress Scores (Timepoints 5 and 6).

Factor	Participant Group	Mean (SD)
Age child wants to leave home	Offspring	20.35 (3.65)
	Other	20.44 (3.25)
Child spending time with family	Offspring	2.13 (.52)
	Other	2.07 (.55)
Child feeling emotionally supported by family	Offspring	1.86 (.21)
	Other	1.85 (.22)
Child feels parents support schooling	Offspring	3.82 (.34)
	Other	3.67 (.53)
Child arguing and fighting with siblings	Offspring	1.76 (.65)
	Other	1.65 (.61)
Child arguing with parents	Offspring	1.72 (.83)
	Other	1.63 (.85)
Child's happiness with family relationships	Offspring	1.74 (1.0)
	Other	1.86 (1.09)
Number of child's close friends	Offspring	7.41 (10.48)
	Other	7.17 (8.29)
Child has one or more good friends	Offspring	2.90 (.34)

	Other	2.88 (.39)
Factor	Participant Group	Mean (SD)
Age young adult wants to leave home	Offspring	21.76 (2.77)
	Other	22.74 (5.41)
Young adult spending time with family	Offspring	2.23 (.59)
	Other	2.24 (.60)
Young adult feeling emotionally supported by family	Offspring	1.93 (.18)
	Other	1.91 (.21)
Young adult able to talk with parents	Offspring	2.50 (.92)
	Spouse	1.5
	Other	2.47 (.92)
Young adult feels that parents support their schooling	Offspring	3.80 (.46)
	Other	3.75 (.60)
Young adult arguing and fighting with siblings	Offspring	1.52 (.62)
	Other	1.50 (.60)
Young adult arguing with parents	Offspring	1.67 (.80)
	Spouse	1.5
	Other	1.57 (.74)
Number of young adults close friends	Offspring	5.74 (5.90)
	Spouse	4 (1.41)
	Other	5.02 (3.89)
Spending time with partner	Offspring	3.53 (.84)
	Spouse	3.55 (.83)
	Other	3.50 (.82)
Spending time with child(ren)	Offspring	3.19 (.75)
	Spouse	3.19 (.61)
	Other	3.17 (.62)
Supportive of child's schooling	Offspring	2.45 (1.44)
	Spouse	2.50 (1.35)
	Other	2.57 (1.39)
Emotionally supportive of child	Offspring	1.48 (.85)
	Spouse	1.66 (.90)
	Other	1.63 (.90)
Affection towards partner	Offspring	1.94 (1.37)
	Spouse	2.005 (.56)
	Other	2.56 (1.38)
Affection towards child	Offspring	3.81 (.45)
	Spouse	3.79 (.45)
	Other	3.77 (.46)
Discipline child	Offspring	1.86 (.59)
	Spouse	2.01 (.56)
	Other	2.03 (.57)

Factor	Participant Group	Mean (SD)
Argue with partner	Offspring	2.39 (.81)
	Spouse	2.48 (.80)
	Other	2.55 (.83)
Argue with child(ren)	Offspring	2.70 (1.15)
	Spouse	2.53 (1.13)
	Other	2.50 (1.15)
Happiness in couple relationship	Offspring	5.07 (.70)
	Spouse	4.95 (.71)
	Other	4.88 (.77)
Number of adult's close friends	Offspring	4.96 (3.35)
	Spouse	5.33 (7.31)
	Other	4.86 (4.44)
Social support from the community	Offspring	3.32 (.90)
	Spouse	3.60 (.79)
	Other	3.54 (.87)
Supportive friends	Offspring	3.27 (.56)
	Spouse	3.15 (.60)
	Other	3.16 (.60)
Psychological Distress - GHQ	Offspring	11.28 (5.65)
	Spouse	10.51 (4.84)
	Other	12.02 (5.57)
Psychological Distress - SDQ	Offspring	10.88 (5.54)
	Other	11.59 (5.67)

Factors Influencing Psychological Distress

OLS regressions were carried out to explore factors influencing psychological distress in families where one member was already experiencing psychological distress. The distressed person was excluded from the analysis. Given that the literature review revealed that the psychological distress of different family members is influenced by different factors, separate regressions were conducted for offspring of the distressed person, spouses of the distressed person and other family members. Assumptions of the regression were met. However, given the number of regression models that were required in this research, due to the exploratory nature, I was concerned about risk of type one error. Therefore, using a crude

Bonferroni correction, the alpha level was adjusted from the conventional value of .05, to .001. In the results, variables that reach a p-value of less than or equal to .05 will still be mentioned as these may warrant further exploration within future research.

Offspring of Distressed Person

The OLS regression analysis was conducted in two blocks. Block one included *sex*, *age*, *disability status*, *religion*, *social class*, *ethnicity*, *sexual orientation*, *employment*, *relationship status*, *highest qualification*, *carer status*, *whether child(ren) in the home have space outdoors to play* and *whether the home environment is considered suitable*. Data from these variables were taken from timepoint one. Block two included relational variables collected from waves three and four from children, young adults, and adults in the sample. Child variables included: the *age the child wants to leave home*, *child spending time with family*, *child feeling emotionally supported by their family*, *child feels that parents support their schooling*, *child arguing and fighting with siblings*, *child arguing with parents*, *child's happiness with family relationships*, *number of child's close friends* and *child has one or more good friends*. Young adult only variables included: *age young adult wants to leave home young adult spending time with family*, *young adult feeling emotionally supported by family*, *young adult able to talk with parents* and *number of young adult's close friends*. Adult variables included: *number of adult's close friends*, *social support from the community and social support from friends*.

The GHQ and SDQ scores from waves five and six were treated as the dependent variables within the model. As only young adults and adults completed the GHQ only variables that they directly answered were included as when GHQ was the dependent variable. This was the same with the SDQ which was only asked to children.

The dummy variable *social class: armed forces* was not included in the analysis due to no participants being within this social class category. Several relational variables (all asked to adults) were not included in the regression model due to the number of observed cases being less than 200. These were: *spending time with partner*, *spending time with child*, *supportive of child's schooling*, *emotionally supportive of child*, *affection towards partner*, *affection towards child*, *discipline child*, *argue with partner*, *argue with child*, *happiness in couple relationship* and *belonging to a community organisation*. The variable *space outside for child to play* was not included in the adult offspring analysis due to most participants in this group not having children and this variable leading to a substantial reduction in the sample size.

Some dummy variables from *ethnicity* (*Black*, *other ethnicity*), *social class* (*professional occupation*), *employment* (*retired, other*), *relationship status* (*married, widowed, divorced, separated*), *sexuality* (*not heterosexual, prefer not to say*) and *highest qualification* (*other qualification*) had a small number of people within each of these categories. However, they were still included in the analysis to better consider intersectionality. The small sample sizes will be considered when making conclusions.

Psychological Distress measured via GHQ. Model one (Appendix L) explained 1.2% of variance in psychological distress measured via the GHQ whilst model two (Table 14) explained 2.6% of variance. Both models were significant in predicting psychological distress, F (33, 7994) = 2.76, $p < .001$; F (44, 7983) = 4.70, $p < .001$. The sample size for the final model was 7984, reasons people were excluded from this analysis included drop out from UKHLS or not answering the questions related to the included variables.

Table 14.

Adjusted Mean Differences (95% CI) in GHQ-12 Scores of Offspring for the Fully Fitted Model, Timepoints 1-6 (UKHLS Waves 3-8) (n = 44, 7983)

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex: Female		.26	.05	.15 - .36	<.001
Age		.004	.01	-.01 - .02	.44
Disability: Not disabled		-.07	.11	-.28 - .14	.51
Household income		-6.51	.000008	-.00002 - .00001	.42
Suitability of home environment		.05	.15	-.25 - .35	.73
Religion	Dominant	-.61	.25	-1.11 – -.11	.02
Social class	Professional occupation	-.15	.40	-.94 - .64	.71
	Managerial & Technical	-.04	.16	-.35 - .27	.80
	Skilled manual	-.10	.18	-.44 - .25	.59
	Part skilled	-.07	.15	-.36 - .22	.64
	Unskilled	-.28	.27	-.81 - .24	.28
Ethnicity	Mixed ethnicity	.74	.23	.30 – 1.18	.001
	Asian	-.10	.12	-.33 - .14	.43
	Black	.11	.19	-.25 - .48	.55
	Other ethnicity	-.44	.39	-1.20 - .32	.25
Employment	Unemployed	.35	.12	.12 - .59	.003
	Retired	-.38	.78	-1.91 – 1.15	.62
	Student	.15	.10	-.04 – .35	.11
	Other employment	.72	.39	-.05 – 1.48	.07
Marital status	Married	.20	.23	-.26 - .66	.39
	Living as couple	-.10	.22	-.54 - .34	.66
	Widowed	.13	2.37	-4.53 – 4.78	.96
	Divorced	.50	.33	-.14 – 1.14	.13
	Separated	-.32	.50	-1.30 - .67	.53
Sexual Orientation	Heterosexual	-1.14	.65	-2.42 - .13	.08
	Not heterosexual	.69	.50	-.29 – 1.68	.17
	Prefer not to say	-1.60	.77	-3.10 - -.10	.04

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Education	Degree	-.11	.14	-.38 - .15	.40
	Other higher	-.08	.17	-.40 - .25	.65
	GCSE	.01	.10	-.18 - .19	.96
	Other qualification	.12	.24	-.35 - .59	.61
	No qualification	.02	.09	-.17 - .20	.87
Carer status		.07	.13	-.18 - .32	.57
Age young adult wants to leave home		-.04	.02	-.08 - .01	.09
Young adult spend time with family		-.08	.10	-.28 - .11	.41
Young adult feels emotionally supported		-1.50	.33	-2.15 - -.85	<.001
Young adult talks to parents		.09	.07	-.06 - .23	.23
Young adult feels parents support schooling		-.32	.37	-1.05 - .40	.38
Young adults argue with siblings		.52	.12	.28 - .76	<.001
Young adults argue with parents		.02	.08	-.14 - .19	.78
Young adult's number of close friends		-.04	.01	-.06 - -.02	.001
Adult's number of close friends		.03	.02	-.01 - .06	.16
Social support from the community		-.32	.07	-.45 - -.20	<.001
Supportive friendships		-.69	.19	-1.07 - -.31	<.001
Constant		19.59	1.84	15.97 – 23.20	<.001

Note. Light colour represents significance at the conventional alpha level, dark represents significance at the adjusted alpha level.

Results showed that at the adjusted significance level of .001, distress scores were found to be higher in females (b = .26) and those with mixed ethnicity (b = .74). With regards to the relational variables psychological distress was found to be higher when young adults argue with their siblings (b = .52). Psychological distress was lower when young adults felt emotionally supported by their parents (b = -1.50), had more close friends (b = -.04) and when adults felt more supported by their community (b = -.32) and their friends (b = -.69).

Secondary analyses involved further OLS regressions to explore whether intersectionality variables from timepoint one were associated the significant relational variables from timepoints three and four.

Young Adult Feels Emotionally Supported. Based on the conventional alpha level, higher emotional support from parents may be related to *suitability of the home environment* (b = .01, SE = .01 [.0003- .02], p = .04) and the young person being a student (b = .01, SE = .003 [.0003- .01], p = .04). No intersectionality factors were related to lower amounts of emotional support and no relationships were significant at the .001 alpha level.

Young Adult Arguing with Siblings. Higher frequency of arguing with siblings may be related to the young adult being female (b = .01, SE = .01 [.002 - .02], p = .02) and having no qualifications (b = .02, SE = .01 [.01 - .04], p = .01). No intersectionality factors were related to a lower frequency of arguments, and no relationships were considered significant.

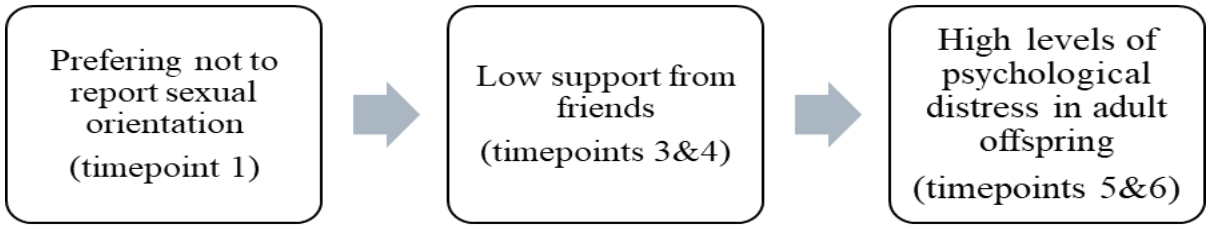
Young Adult's Number of Close Friends. Young people having a lower number of close friends may be associated with being female (b = -.15, SE = .05 [-.25 - .04], p = .01). No intersectionality factors predicted a young adult having a greater number of close friends and no relationships were significant.

Social Support from the Community. Better social support from the community may be associated with participants having no qualifications (b = .05, SE = .02 [.02 - .08], p = .003). However, only being Asian was significantly associated with better social support from the community (b = .08, SE = .02 [.04 - .13], p < .001). Lower amounts of social support from the community may be associated with being a student (b = -.05, SE = .02 [-.08 - -.02], p = .003), but this did not reach significance.

Supportive Friends. Lack of support from friends may be associated with being in the skilled manual social class group (b = -.02, SE = .01 [-.04 - -.0002], p = .05). However, lack of support from friends was only significantly associated with being Black (b = -.04, SE = .01 [-.06 - -.02], p < .001) and sexual orientation (*prefer not to say:* b = -.28, SE = .04 [-3.64 - -.19], p < .001; *heterosexual:* b = -.17, SE = .04 [-.24 - .10], p < .001; *not heterosexual:* b = -.16, SE = .03 [-.22 - -.10], p < .001). No factors were found to be associated with better support from friends.

Indirect Effects. Sobel tests were conducted to assess the significance of the potential indirect effects on psychological distress. Sobel tests were only carried out on relationships that reached significance. Being Asian may have an indirect effect via *social support from the community* (Z = -2.97, p = .003). Being heterosexual (Z = 2.72, p = .01), not being heterosexual (Z = 2.92, p = .003) and being Black (Z = 2.64, p = .01) also had potential indirect effects via *support from friends.* However, none of these reached significance. The only factor significantly indirectly effecting adult offspring distress was preferring not to report sexual orientation (Z = 3.20, p = .001) via *support from friends* (Figure 2).

Figure 3.
Indirect Effect of Preferring Not to Report Sexual Orientation



Psychological Distress Measured via SDQ. Model one (Appendix M) explained .5% of variance in psychological distress of child offspring as measured via the SDQ and model two (Table 15) explained 3.7% of variance. Both models were significant in predicting psychological distress of child offspring (F (11, 7942) = 3.78 $p < .001$; F (20, 7961 = 15.21, $p < .001$). The sample size for the final model was 7962, reasons people were excluded from this analysis included drop out from UKHLS or not answering the questions related to the included variables.

Results of the regression found six of the included variables were significantly associated with psychological distress of child offspring. In relation to intersectionality variables, psychological distress scores as measured by the SDQ were found to be higher when child offspring were female (b = .08) and were of mixed ethnicity (b = .43). When individuals expressed wanting to leave home at an older age, their psychological distress scores were higher (b = .04). An increase in arguing with siblings (b = .24) was also related to higher scores of psychological distress as was and arguing with parents (b = .33). Lower psychological distress scores were associated with the child having one or more good friend (b = -.60).

As with the adult offspring data, further OLS regressions were run, exploring effects of demographic variables on the significant relational variables.

Table 15.

Adjusted Mean Differences (95% CI) in SDQ Scores of Offspring for the Fully Fitted Model, Timepoints 1-6 (UKHLS Waves 3-8) (n = 20, 7961)

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex: Female		.08	.02	.04 - .12	<.001
Age		<.001	.001	-.002 - .003	.74
Household income		-1.42	.000003	-.000007 - .000006	.10
Outdoor space for children to play		.01	.09	-.17 - .19	.90
Suitability of home environment		.04	.06	-.09 - .16	.55
Religion	Non-Dominant	.03	.12	-.21 - .27	.80
	No religion	.10	.05	-.01 - .20	.08
Ethnicity	Mixed ethnicity	.43	.11	.21 - .65	<.001
	Asian	-.17	.08	-.32 - -.03	.02
	Black	-.01	.12	-.24 - .23	.95
	Other ethnicity	.01	.25	-.49 - .51	.97
Age child wants to leave home		.04	.01	.01 - .06	<.001
Child spending time with family		<.001	.05	-.09 - .09	.99
Child feels emotionally supported by parents		.31	.13	.05 - .57	.02
Child feels parents support schooling		-.14	.08	-.31 - .02	.09
Child argues with siblings		.24	.05	.15 - .33	<.001
Child argues with parents		.33	.03	.26 - .40	<.001
Child's happiness in family relationships		.01	.03	-.04 - .06	.66
Number of child's close friends		-.004	.002	-.01 - .001	.11
Child has one or more good friends		-.60	.08	-.76 - -.45	<.001
Constant		10.59	.51	9.59 – 11.59	<.001

Note. Light colour represents significance at the conventional alpha level, dark represents significance at the adjusted alpha level.

Age Child Wants to Leave Home. *Non-dominant religion* (b = -.47, SE = .14 [-.74 - .21], $p < .001$) and *no religion* (b = -.42, SE = .06 [-.54 - -.30], $p < .001$) were significantly related to the child wanting to leave home at a younger age. Being Asian, may be associated with the child wanting to leave home at an older age (b = .22, SE = .08 [.05 - .38], p = .01), but this did not reach significance.

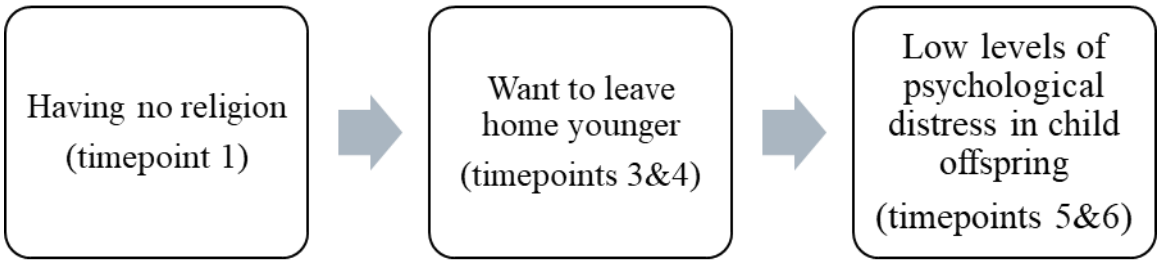
Child Arguing with Siblings. No areas of intersectionality were found to be significantly associated with child offspring arguing with their siblings.

Child Arguing with Parents. Being Black may be associated with lower frequencies of arguing with parents (b = -.09, SE = .04 [-.17 - -.05], p = .04); however, this was not considered significant. No factors were significantly associated with higher frequency of arguing with parents.

Child Has One or More Good Friend. Being Mixed Race was significantly associated with children not having at least one good friend (b = -.05, SE = .02 [-.09 - -.02], $p < .001$). No factors were significantly associated with child offspring having one or more good friends.

Indirect Effects. Sobel Tests revealed that belonging to a non-dominant religion (Z = 2.53, p = .01) and being of mixed ethnicity (Z = 2.35, p = .02) may indirectly affect psychological distress via *age a child wants to leave home* and *having one or more friend* (respectively); however, these were not considered significant. Having no religion was found to significantly affect psychological distress via *age child wants to leave home* (Z = -3.45, p = .001; Figure 3).

Figure 4.
Indirect Effect of Having No Religion.



Spouse of Distressed Person

As with the offspring data, OLS regression was carried out in two blocks. Block one included all the intersectionality and household variables from timepoint one, with the exception of *child has space outdoors to play*. Block two included: *spending time with partner*, *affection towards partner*, *arguing with partner*, *happiness in couple relationship*, *adult number of close friends*, *social support*, and *supportive friends*. These variables were taken from timepoints three and four. The GHQ scores taken from timepoints five and six were added to the model as the dependent variable.

Several dummy variables were not included in the analysis due to having no observations in these categories. These were *social class: armed forces*, *widowed*, *divorced*, *separated*, and *never married*. With regards to the relational variables, all the young adult variables and *belonging to a community organisation* were not included due to the observed cases being less than 200. The variables related to the spouse having a child were also removed as a missing data analysis revealed that most participants in this dataset did not have children and thus including them would substantially reduce the sample size.

Some dummy variables including: *social class* (*unskilled*), *employment* (*student, other*), *sexual orientation* (*not heterosexual, prefer not to say*) and *ethnicity* (*mixed, black,*

other) had small sample sizes. However, they were included in the analysis to better consider intersectionality. These small sample sizes will be considered when making conclusions.

Model one (Appendix N) predicted 3% of variance in psychological distress and model two (Table 16) predicted 5.6%. Both the first (F (29, 9204) = 9.82, p <.001) and second (F (36, 9197) = 15.17, p <.001) models contributed significantly to the prediction of psychological distress. The sample size for the final model was 9198, reasons people were excluded from this analysis included drop out from UKHLS or not answering the questions related to the included variables.

Table 16.

Adjusted Mean Differences (95% CI) in GHQ-12 Scores of Spouses for the Fully Fitted Model, Timepoints 1-6 (UKHLS Waves 3-8) (n = 36, 9179)

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex: Female		.19	.06	.07 - .32	.002
Age		-.01	.003	-.01 - -.003	.003
Disability: Not disabled		-.61	.07	-.74 - -.48	<.001
Household income		-1.06	.00001	-.00003 - .000005	.19
Suitability of home environment		.39	.35	-.29 – 1.07	.27
Religion	Non-dominant	.06	.20	-.33 - .45	.75
Social class	Professional occupation	.15	.15	-.14 - .44	.30
	Skilled non-manual	.12	.11	-.15 - .27	.58
	Skilled manual	-.12	.10	-.32 - .07	.22
	Part skilled	.01	.12	-.23 - .25	.94
	Unskilled	-.11	.22	-.54 - .31	.61
Ethnicity	Asian	-.03	.17	-.26 - .20	.80
	Mixed ethnicity	.35	.29	-.22 - .92	.23
	Black	.05	.20	-.33 - .44	.79
	Other ethnicity	-.25	.33	-.91 - .41	.46
Employment	Unemployed	.72	.10	.52 - .92	<.001
	Retired	-.02	.10	-.22 - .18	.85

	Student	-.01	.36	-.71 - .69	.97
	Other employment	.24	.50	-.73 – 1.21	.63
Marital status	Living as couple	.16	.08	.01 - .31	.04
Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sexual orientation	Heterosexual	-.55	.63	-1.79 - .68	.38
	Not heterosexual	-.03	.47	-.95 - .89	.95
	Prefer not to say	-.66	.73	-.2.10 - .77	.37
Education	Other higher	.04	.10	-.16 - .24	.66
	A-Level	-.03	.09	-.20 - .15	.78
	GCSE	.11	.09	-.07 - .29	.23
	Other qualification	-.11	.12	-.34 - .12	.36
	No qualification	.12	.11	-.10 - .34	.29
Carer status		.13	.09	-.02 - .29	.09
Spend time with partner		-.14	.06	-.26 - -.02	.02
Affectionate towards partner		-.07	.03	-.14 - -.01	.03
Argue with partner		-.19	.08	-.34 - -.05	.01
Happiness in couple relationship		-.75	.07	-.88 - -.62	<.001
Adult number of close friends		-.01	.01	-.02 - .01	.26
Social support from the community		-.22	.06	-.33 - -.11	<.001
Supportive friends		-.49	.14	-.77 - -.21	<.001
Constant		18.76	1.14	16.52-20.99	<.001

Note. Light colour represents significance at the conventional alpha level, dark represents significance at the adjusted alpha level.

Results showed several factors were significantly related to the psychological distress of spouses over time. In relation to intersectionality variables psychological distress was found to be higher when spouses were unemployed (b = .72) or had a disability (b = -.61).

With regards to the relational variables, distress of spouses was found to be lower the happier they were in their relationship (b = -.75). In addition, the more supportive spouses

found their community (b = -.22) and their friends (b = -.49) the lower their psychological distress over time.

The second step of this analysis involved running further OLS regressions to explore whether intersectionality variables from timepoint one were associated the significant relational variables from timepoints three and four.

Happiness in the couple relationship. An increase in spouse-rated happiness in the couple relationship, may be associated with the spouse being older (b = .001, SE = .001 [.0003 - .002], p = .02), but this was not considered significant. A decrease in happiness in the couple relationship may be related to having a disability (b = .04, SE = .01 [.01 - .06], p = .01), living as a couple (b = -.04, SE = .01 [-.06 - -.01], p = .01) and being a student (β = -.19, SE = .07 [-.32 - .06], p = .004). However, these associations were also not significant. The only significant factor related to happiness in the couple relationship was *sex*, whereby a decrease in happiness was related to being female (b = -.07, SE = .01 [-.09 – .05], p = <.001).

Social Support from the Community. An increase in how supportive the spouse finds their community was significantly associated with the spouse being female (b = .07, SE = .01 [.05 - .09], p = <.001) and being older (b = .002, SE = .001 [.001 - .003], p = <.001). Whilst not considered significant, being retired (b = .05, SE = .02 [.01 - .09], p = .01), having a qualification that was considered *other* (b = .04, SE = .02 [.001 - .09], p = .04), being in the *skilled manual* social class group (b = .04, SE = .02 [.003 - .09], p = .03) and being a carer (b = .03, SE = .01 [.004 - .06], p = .03) may also be associated with an increase in how supportive spouses find their community.

A decrease in how supportive the spouse finds their community may be associated with the spouse having a disability (b = .03, SE = .01 [.01 - .06], p = .01), and being a student

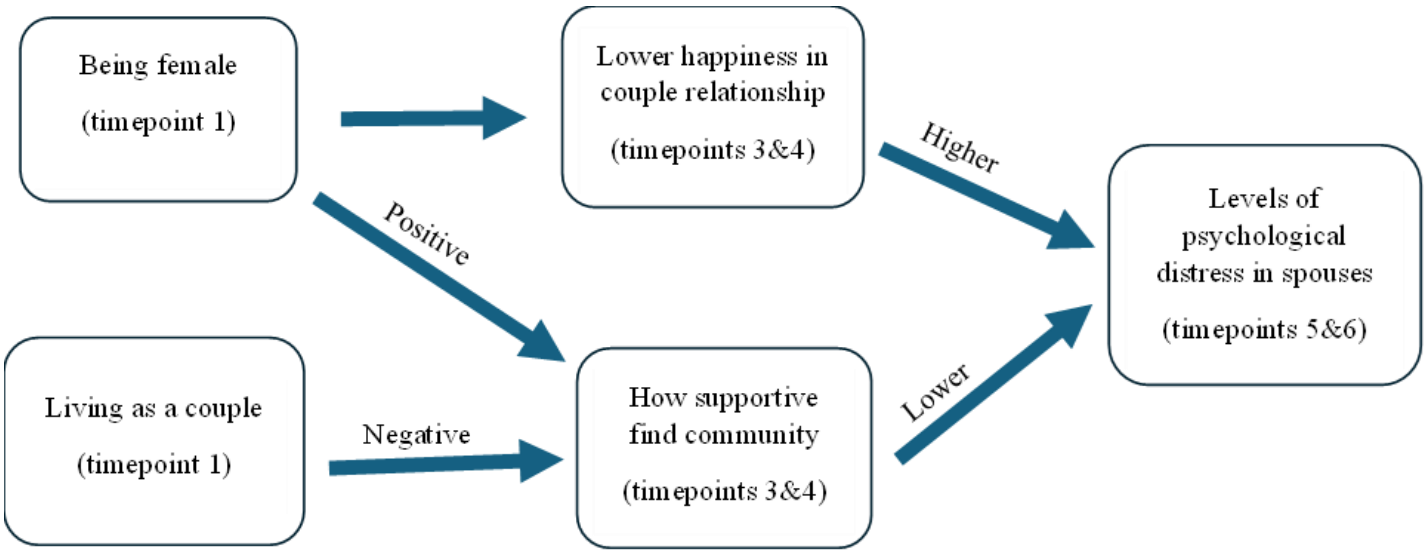
(*b* = -.20, *SE* = .07 [-.32 - -.07], *p* = .003). However, these relationships were not significant. A decrease in how supportive spouses find their community was only significantly associated with living as a couple (*b* = -.07, *SE* = .01 [-.09 - -.04], *p* = <.001).

Supportive Friends. An increase in how supportive spouses found their friends was significantly associated with being female (*b* = .03, *SE* = .01 [.02 - .04], *p* = <.001). Whilst not significant at the adjusted alpha level, an increase in how supportive spouses find their friend may also be associated with having an employment type in the *other* category (*b* = .07, *SE* = .04 [.001 - .15], *p* = .05). A decrease in how supportive spouses find their friends may be associated with spouses being Asian (*b* = -.02, *SE* = .01 [-.04 - -.001], *p* = .04), or having an *other higher qualification* (*b* = -.02, *SE* = .01 [-.03 - -.003], *p* = .02).

Indirect Effects. Sobel tests revealed that, *sex* had significant an indirect effect on psychological distress via *support from the community* (*Z* = -3.22, *p* = .001) and via *happiness in the couple relationship* (*Z* = 5.84, *p* < .001). *Living as a couple* also had significant an indirect effect on psychological distress via *support from the community* (*Z* = 3.22, *p* = .001). *Sex* may also indirectly affect distress via *support from friends* (*Z* = -2.23, *p* = .03); however, this was not considered significant. Figure 5 presents the significant indirect effects.

Figure 5.

Indirect Effects of Sex on Psychological Distress



Other Family Member of Distressed Person

It was initially planned that SDQ scores would be a dependent variable as with the offspring data. However, due to only 37 participants completing the SDQ during the relevant timepoints, this analysis was not conducted. Therefore, only one regression was carried out with GHQ scores from timepoints five and six being the dependent variable. Variables were added in two blocks. Block one included all intersectionality and household variables. Block two included all relational variables from timepoints three and four except for the child variables, young adult variables and *belongs to a community organisation*.

Child variables were excluded as children did not complete the GHQ. *Belongs to a community organisation* was excluded due to having less than 200 observations. Young adult variables were not included due to a missing values analysis showing that most of the sample were not young adults/ did not answer these questions. Therefore, including them would have substantially reduced the sample size. The social class category *armed forces* was also excluded due to there being no people in this category. There were small sample sizes for some dummy variables from, *ethnicity* (*other*), *employment* (*other*) and *sexuality* (*not*

heterosexual, prefer not to say). These were still included in the analysis to enable consideration of intersectionality. The small sample sizes are to be considered when making conclusions and generalising this research.

Model one (Appendix O) predicted 1.5% of variance of psychological distress in adult *other* (non-offspring and spouse) family members of people experiencing psychological distress. Model two (Table 17) predicted 3.2% of variance. Both models were significant in predicting psychological distress in this population (F (34, 19164) = 8.57, $p < .001$; F (47, 19151) = 13.30, $p < .001$). The sample size for the final model was 19152, reasons people were excluded from this analysis included drop out from UKHLS or not answering the questions related to the included variables.

Table 17.

Adjusted Mean Differences (95% CI) in GHQ-12 Scores of Other Family Members for the Fully Fitted Model, Timepoints 1-6 (UKHLS Waves 3-8) (n = 47, 19151)

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex: Female		.17	.05	.07- .26	<.001
Age		-.01	.002	-.01 - -.002	.002
Disability: Not Disabled		-.52	.05	-.62 - -.42	<.001
Household income		-6.65	.00001	-.00002- .00001	.27
Outdoor space for children to play		-.06	.22	-.50 - .37	.78
Suitability of home environment		.19	.18	-.17 - .54	.30
Religion	Non-dominant	-.09	.13	-.35 - .18	.52
Social class	Professional occupation	.15	.13	-.11 - .41	.26
	Skilled non-manual	.15	.08	-.01 - .31	.07
	Skilled manual	.01	.09	-.16 - .19	.88
	Part skilled	.22	.09	.04 - .40	.02
	Unskilled	-.15	.17	-.48 - .18	.38
Ethnicity	Asian	-.07	.08	-.23 - .08	.37
	Mixed ethnicity	.31	.17	-.03 - .64	.07

	Black	-.08	.11	-.30 - .15	.49
	Other ethnicity	.02	.25	-.47 - .52	.93
Employment	Unemployed	.48	.07	.35 - .61	<.001
	Retired	.05	.08	-.12 - .21	.57
	Student	-.08	.10	-.28 - .11	.41
	Other employment	.35	.31	-.27 - .96	.27
Marital status	Living as couple	.04	.08	-.12 - .19	.64
	Widowed	-.04	.15	-.33 - .24	.77
	Divorced	.11	.12	-.12 - .34	.35
	Separated	-.01	.19	-.39 - .36	.95
	Never married	.01	.08	-.14 - .16	.87
Sexual orientation	Heterosexual	-.17	.47	-1.10 - .75	.71
	Not heterosexual	-.14	.39	-.90 - .61	.71
	Prefer not to say	.31	.54	-.75 – 1.36	.57

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Education	Other higher	.03	.08	-.14 - .19	.76
	A-Level	-.01	.07	-.15 - .14	.94
	GCSE	.002	.07	-.14 - .15	.98
	Other qualification	.06	.10	-.13 - .25	.52
	No qualification	-.06	.09	-.24 - .12	.52
Carer status		.12	.06	.004 - .24	.04
Spend time with partner		-.23	.05	-.33 - -.12	<.001
Spend time with child(ren)		-.13	.09	-.32 - .05	.16
Support child(ren)'s schooling		-.02	.06	-.14 - .11	.79
Emotionally supportive of child(ren)		.14	.07	-.01 - .28	.06
Affectionate with partner		-.01	.03	-.07 - 05	.78
Affectionate with children		.22	.13	-.03 - .48	.09
Disciplines child		.01	.11	-.20 - .22	.92
Argue with partner		.02	.06	-.10 - .15	.70
Argue with child		-.17	.06	-.28 - -.06	.003
Happiness in couple relationship		-.56	.06	-.68 – -.44	<.001
Adult number of close friends		-.01	.01	-.03 - .004	.14

Social support from the community	-.23	.04	-.31 - -.15	<.001
Supportive friends	-.46	.11	-.68 - -.25	<.001
Constant	18.22	1.13	16.01 – 20.34	<.001

Note. Light colour represents significance at the conventional alpha level, dark represents significance at the adjusted alpha level.

Several intersectionality and relational factors were found to be significantly associated with psychological distress in adult *other* family members of someone who is already distressed. Scores of psychological distress, as measured by the GHQ, were found to be higher when the participant was female (b = .16), had a disability (b = -.52), and were unemployed (b = .48). Psychological distress scores were lower when participants spent more time with their partners (b = -.23), when there was greater happiness in the couple relationship (b = -.56), with an increase in supportive from the community (b = -.23) and increased support from friends (b = -.46).

Secondary analyses involved further OLS regressions to explore whether intersectionality variables from timepoint one were associated the significant relational variables from timepoints three and four.

Spending Time with Partner. Participants spending more time with their partners may be associated with income (b = 2.31, SE <.001, p = .02) and being retired (b = .03, SE = .01 [.001 - .05], p = .04) but not at a significant level. Participants spending less time with their partners may be associated with children having space outdoors to play (b = -.08, SE = .04 [-.15 - -.01], p = .03), being in the social class category *part skilled* (b = -.03, SE = .02 [-.06 - -.003], p = .03), or *unskilled* (b = -.07, SE = .03 [-.12 - -.01], p = .02), living as a couple (b = -.03, SE = .01 [-.05 - -.001], p = .05) and having an *other higher qualification* (b = -.03, SE = .01 [-.06 - -.01], p = .02). However, these were also not significant.

Variables that were significantly associated with spending less time with partners were having a higher qualification which was *A-level* (b = -.06, SE = .01 [-.09 - -.04], p < .001), *GCSE* (b = -.08, SE = .01 [-.11 - -.06], p < .001), *other qualification* (b = -.10, SE = .02, [-.14 - -.07], p < .001), or *no qualification* (b = -.13, SE = .02 [-.16 - -.10], p < .001).

Happiness in Couple Relationship. Increased happiness in the couple relationship may be associated with the participant being older (*b* = .001, *SE* = <.001 [<.001 - .001], *p* = .04) and higher income (*b* = .01, *SE* = <.001, *p* = .01). However, these associations were not significant. Increased happiness in the couple relationship in this sample, was only significantly associated with being retired (*b* = .04, *SE* = .01 [.02 - .07], *p* < .001). At the conventional alpha level, decreased happiness in the couple relationship may be associated with the participant being female (*b* = -.02, *SE* = .01 [-.04 - -.01], *p* = .002), being Asian (*b* = -.02, *SE* = .01 [-.05 - -.001], *p* = .05), being Black (*b* = -.05, *SE* = .02 [-.09 - -.02], *p* = .004), and having *GCSE* as their highest qualification (*b* = -.03, *SE* = .01 [-.06 - -.01], *p* = .003). However, decreased happiness in the couple relationship was only considered to be significantly associated with *living as a couple* (*b* = -.07, SE = .01 [-.09 - -.04], *p* < .001) and being a carer (*b* = -.03, SE = .01 [-.05 - -.02], *p* < .001).

Social Support from the Community. Increased social support from the community may be associated with being a carer (*b* = .02, *SE* = .01 [.002 - .04], *p* = .03) and being retired (*b* = .05, *SE* = .02 [.02 - .08], *p* = .002); however, these relationships were not considered significant. At the adjusted alpha, increased social support from the community was significantly associated with being female (*b* = .07, *SE* = .01 [.05 - .08], *p* < .001), being older (*b* = .002, *SE* =.0004 [.002 - .003], *p* < .001), and being Asian (*b* = .05, *SE* = .01 [.02 - .08], *p* < .001).

Decreased social support from the community may be associated with having a *non-dominant religion* (*b* = -.05, *SE* = .03 [-.10 - -.002], *p* = .04), having an *other* ethnicity (*b* = -.09, *SE* = .05 [-.18 - .004], *p* = .04), and never being married (*b* = -.04, *SE* = .01 [-.07 - -.02], *p* = .002). However, decreased social support was only significantly associated with having a disability (*b* = .04, *SE* = .01 [.03 - .06], *p* < .001), living as a couple (*b* = -.07, *SE* = .01 [-.10 -

.04], $p < .001$), being widowed ($b = -.09$, $SE = .03$ [-.14- -.04], $p < .001$), and being divorced ($b = -.12$, $SE = .02$ [-.16 - -.08], $p < .001$).

Supportive Friendships. Increased support from friends was significantly associated with being female ($b = .03$, $SE = .003$ [.02 - .03], $p < .001$). It may also be associated with being separated from partner ($b = .03$, $SE = .01$ [.01 - .06], $p = .01$); however, this was not considered significant. Decreased support from friends may be associated with being within the social class category *part skilled* ($b = -.02$, $SE = .01$ [-.03 - -.004], $p = .01$), being widowed ($b = -.02$, $SE = .01$ [-.04 - -.001], $p = .04$), not being heterosexual ($b = -.07$, $SE = .03$ [-.16 - -.02], $p = .01$) and preferring not to report sexual orientation ($b = -.09$, $SE = .04$ [-.16 - -.02], $p = .01$). However, none of these associations were significant.

Indirect Effects. Sobel tests revealed that having *A-Level* as the highest level of education had significant indirect effects on psychological distress via *spending time with partner* ($Z = 3.62$, $p < .001$), as did *GCSE* ($Z = 3.97$, $p < .001$), having an *other qualification* ($Z = 3.35$, $p = .001$) and having *no qualification* ($Z = 3.73$, $p < .001$). Being retired had significant indirect effects on psychological distress via *happiness in the couple relationship* ($Z = -3.66$, $p < .001$) as did *living as a couple* ($Z = 5.58$, $p < .001$). Being a carer may have an indirect effect on distress via *happiness in the couple relationship*; however, this was not considered significant ($Z = 2.84$, $p = .004$).

Age was found to have significant an indirect effect on psychological distress via *social support from the community* ($Z = -3.74$, $p < .001$), as was being Asian ($Z = -3.74$, $p < .001$), having a disability ($Z = -3.25$, $p = .001$), living as a couple ($Z = 4.42$, $p < .001$) and being divorced ($Z = 4.12$, $p < .001$). Being widowed may have had an indirect effect on distress via *support from the community* however, this did not reach significance at the ($Z = 2.63$, $p = .01$). Sex had a significant indirect effect on distress via both *social support from*

the community ($Z = -4.42$, $p < .001$) and *support from friends* ($Z = -3.84$, $p < .001$). Figures 6, 7, 8 and 9 display significant indirect effects on the distress of other family members.

Figure 6.

Indirect Effects on Psychological Distress via Spending Time with Partner

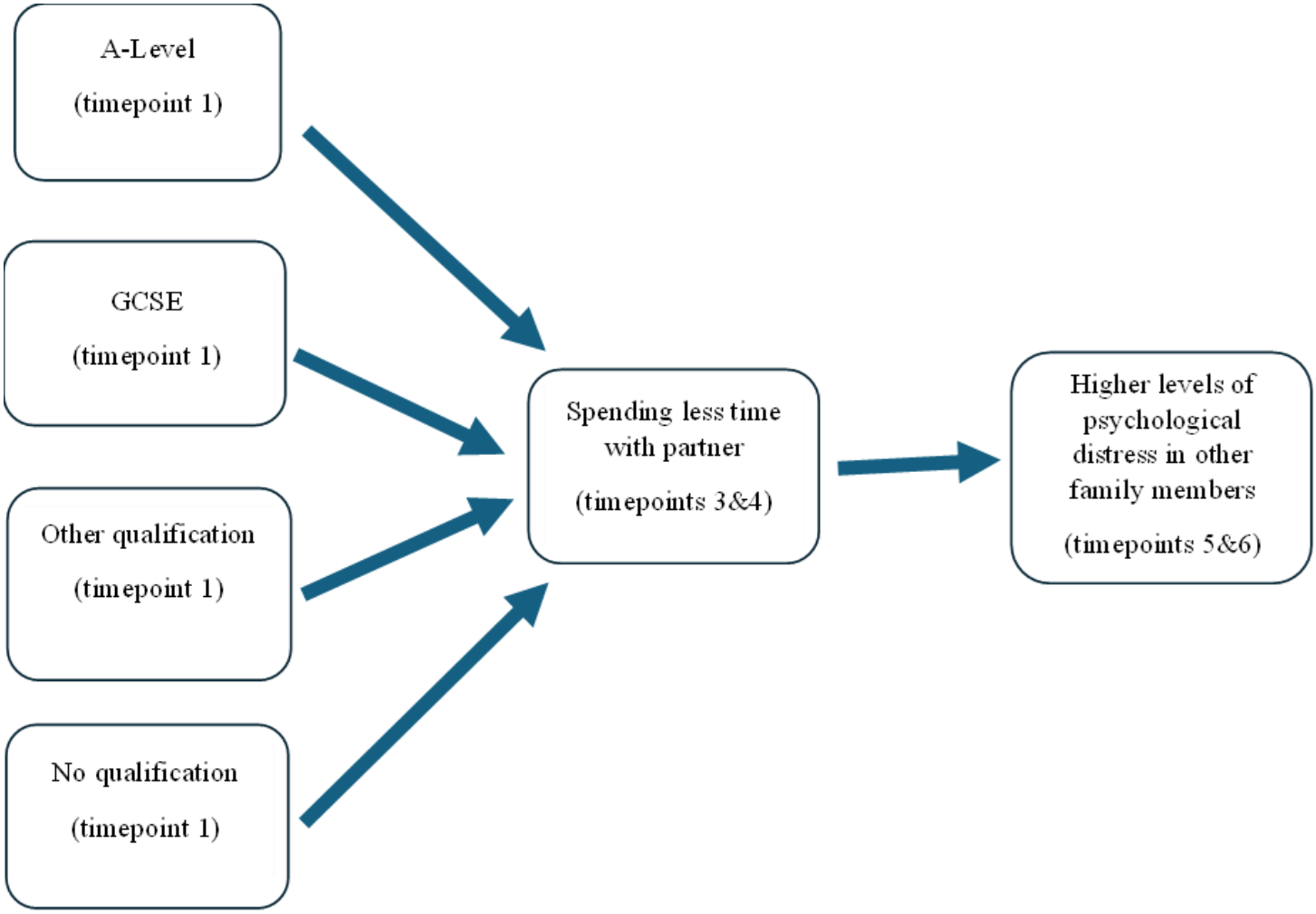


Figure 7.

Indirect Effects on Psychological Distress via Happiness in Couple Relationship

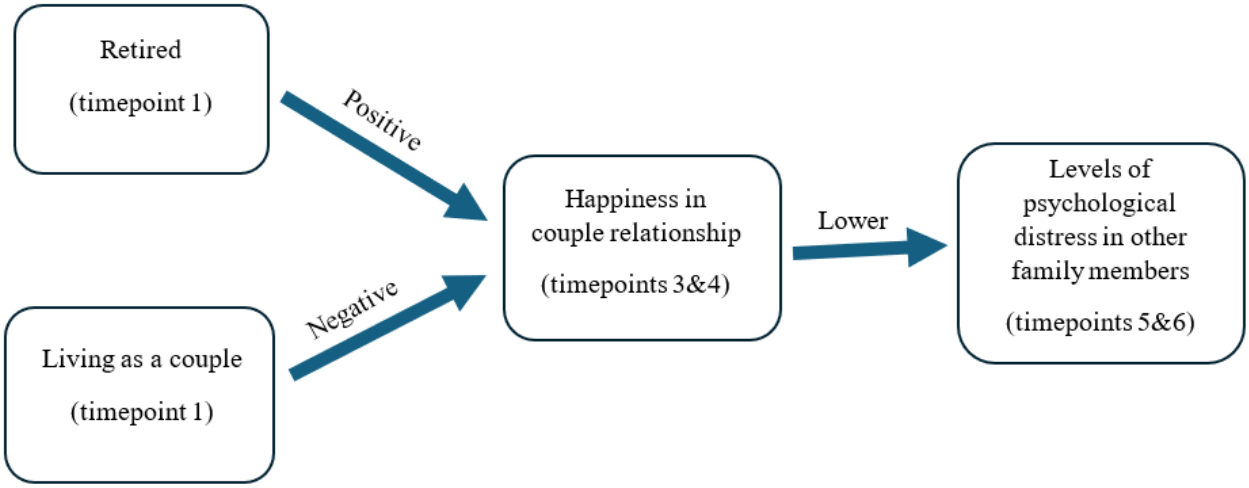


Figure 8.

Indirect on Psychological Distress via Support from Friends

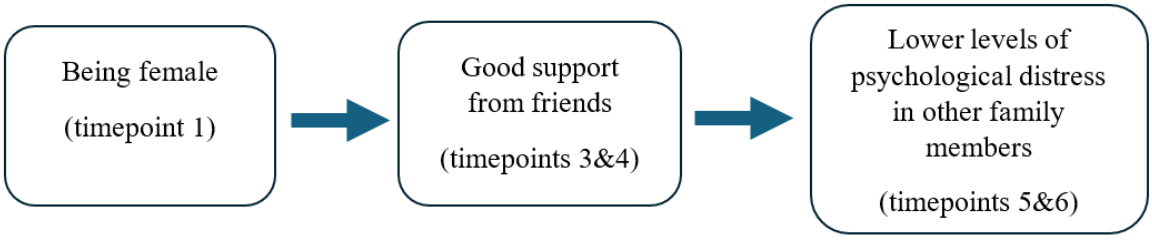
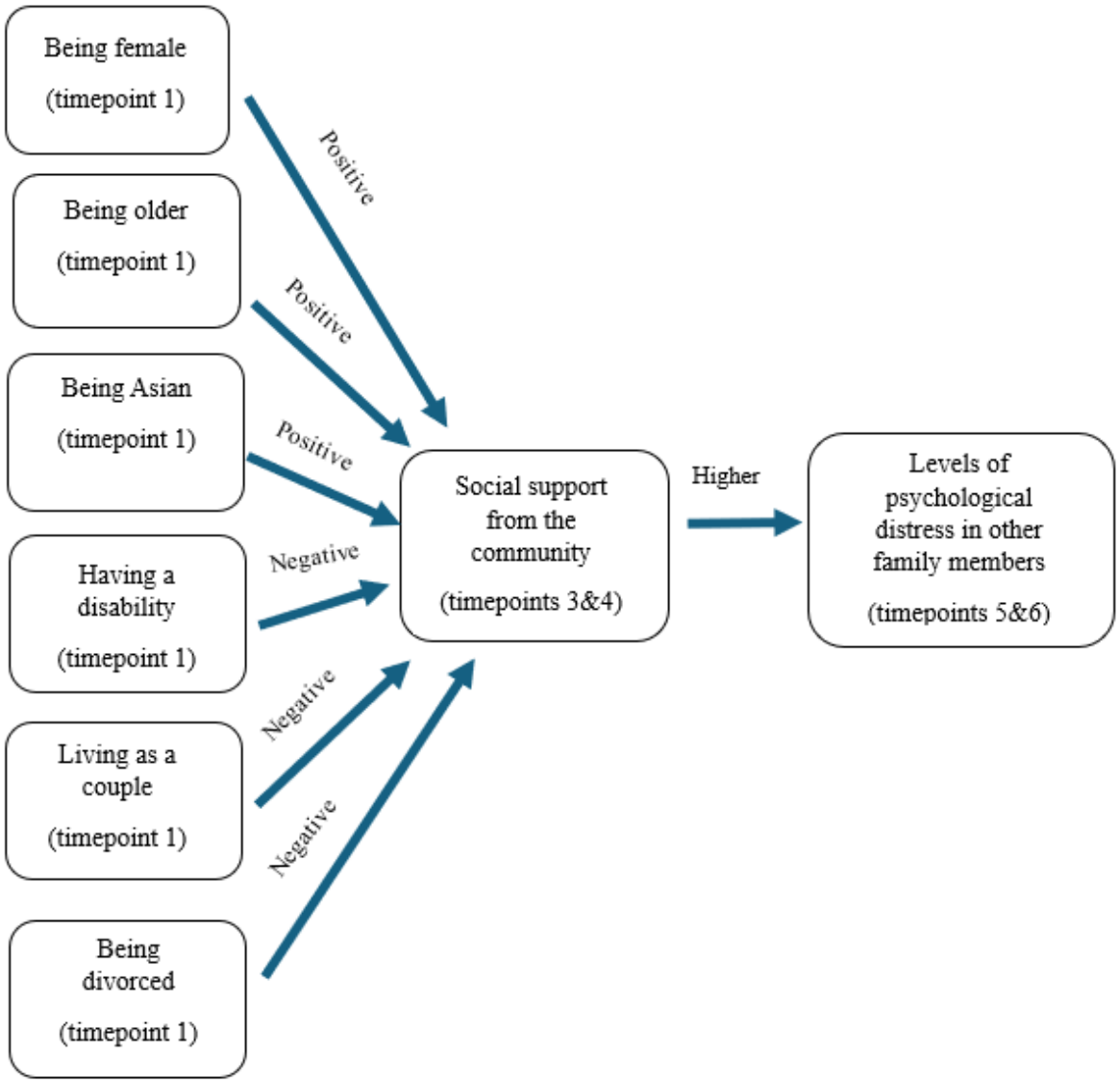


Figure 9.

Indirect Effects on Psychological Distress via Support from Community



Effect of COVID-19

The primary OLS regression models were repeated with GHQ scores from the COVID-Survey as the dependent variable. New regression models, containing the same variables (intersectionality from timepoint one and relational from timepoints three and four), were compared with the pre-COVID-19 models exploring whether there was a change in the significance of the direct relationships and the coefficient values. SDQ scores were not collected during the first COVID-19 UK lockdown and thus it was not possible to explore the effect of the start of COVID-19 on child distress. Variables were entered in one block.

Adult Offspring

The pre-COVID-19 predictor variables explained 1.7% of variance in psychological distress scores at the start of the COVID-19 pandemic. This was a reduction by .9%. The model was still significant in predicting psychological distress (F (44, 7946) = 3.06, $p <$ .001).

Only *sex* remained significantly associated with psychological distress of adult offspring during the start of the pandemic (b = .43, SE = .06 [.32 - 53], $p <$ .001), with its impact increasing. Being of mixed ethnicity (b = .54, SE = .23 [.09 - .99], p = .02), and all previously significant relational variables, were no longer significantly related to distress at the start of the pandemic (*young adult feels emotionally supported*: b = -.18, SE = .34 [-.84 - .48], p = .60; *arguing with siblings*: b = -.07, SE = .12 [-.31 – .18], p = .60; *young adult's number of close friends*: b = .002 , SE = .01 [-.02 - .02], p = .89; *social support from community*: b = -.12, SE = .07 [-.25 - .01], p = .08; *support from friends*: b = .02, SE = .20 [-.37 - .41], p = .91). No new significant relationships were found.

Spouse

Pre-COVID-19 predictor variables explained 3.2% of variance in psychological distress during the COVID-19 pandemic. This was a decrease of 2.4% explained variance. This model was still significant in predicting psychological distress at the start of the pandemic (F (36, 9164) = 8.44, p < .001).

Disability (b = -.56, SE = .08 [-.72 - -.41], p < .001) and *happiness in couple relationship* (b = -.48, SE = .07 [-.62 - -.33], p = < .001), remained significantly associated with psychological distress of spouses during the pandemic. The impact of both variables decreased. *Unemployment* (b = .16, SE = .12 [-.07 - .40], p = .16), *social support from the community* (b = .10, SE = .07, [-.03 - .24], p = .14) and *support from friends* (b = -51, SE = .19 [-.89 - - .13], p = .01) were no longer significantly associated with psychological distress of spouses. Whilst not reaching significance prior to COVID-19, *sex* (b = .47, SE = .07 [.33 - .62], p < .001), *age* (b = -.02, SE = .003 [-.02 - -.01], p < .001) and *adult's number of close friends* (b = -.02, SE = .01 [-.04 - -.01], p = .001) became significantly associated with distress at the start of the COVID-19 pandemic. Being female and being younger were associated with higher levels of psychological distress of spouses. Having a higher number of close friends was associated with lower levels of psychological distress.

Other Family Members

The pre-COVID-19 predictor variables explained 2.5% of variance in psychological distress during COVID-19 pandemic. This was a decrease of .7% explained variance. The model was significant in predicting distress during the start of the pandemic (F (47, 19151) = 10.30, p < .001).

Sex (b = .51, *SE* = .05 [.41 - .61], p < .001), *disability* (b = -.37, *SE* = .06 [-.48 - -.26], p = < .001), *happiness in the couple relationship* (b = -.39, *SE* = .07 [-.52 - .26], p < .001) and *social support from the community* (b = -.22, *SE* = .05 [-.30 - -.13], p < .001), remained significantly associated with the psychological distress levels of other family members. The impact of *sex* and *happiness in the couple relationship* increased whilst the impact of *disability* decreased. The impact of *social support from the community* remained the same.

Unemployment (b = .19, *SE* = .07 [.04 - .33], p = .01), *spending time with partner* (b = -.05, *SE* = .06 [-.17 - .07], p = .39) and *support from friends* (b = -.24, *SE* = .19 [-.47 - -.01], p = .05) were no longer significantly associated with psychological distress. However, *age* (b = -.01, *SE* = .002 [-.02 - -.01], p < .001), being a carer (b = .22, *SE* = .06 [.10 - .35], p < .001) and being Asian (b = .28, *SE* = .09 [.11 - .45], p = .001) became significantly associated with psychological distress of this sample group at the start of the pandemic. Being younger, being a carer and being Asian were all associated with higher levels of distress.

Chapter 4: Discussion

Chapter Overview

This chapter summarises the main findings of this research, answering each of the research questions in turn. Results will be discussed in relation to existing literature and theory included within the background and systematic literature review, presented in Chapter one. More specifically I consider the results of this research in relation to systemic theory and intersectionality. Following this, I present the strengths and limitations of this research and keeping in mind the aims, discuss implications and recommendations. My own final reflections on this thesis are included prior to the final conclusions. Given that this research is

driven by systemic theory and ideas, I share curiosities and hypotheses (in the systemic therapy sense) where they feel relevant. The reader of this research is invited to reflect on these in relation to their own research and/ or practice, keeping in mine their own contexts.

Revisiting the Research Questions

This research aimed to consider intersectionality and relational factors to provide insight into the ways in which families respond to adverse situations. For example, a family member experiencing psychological distress and the COVID-19 pandemic. To achieve this aim three research questions were generated:

1. What factors appear to influence psychological distress of families when one member is already experiencing distress?
2. Are there specific factors that help or hinder families?
3. Do variables effecting distress remain the same during the COVID-19 pandemic?

Summary of Findings

Ordinary Least Squares (OLS) regressions and Sobel Tests were used on data obtained from the UK Household Longitudinal Study (UKHLS) to answer the research questions. In light of lack of high quality research in this field, this research was exploratory in nature. Each research question is discussed in turn followed by a summary in the context of systemic theory and intersectionality.

What factors appear to influence psychological distress of families when one member is already experiencing distress?

Significant direct and indirect associations from the regressions and Sobel tests were interpreted as factors influencing psychological distress in this sample. Various factors were

found to be associated with the psychological distress of family members of someone already experiencing distress. As with the findings of the literature review, different factors were important for different family members. These are each presented in turn with the direction of these relationships being discussed later, in relation to the second research question.

Sex. Sex was found to be an important factor in predicting distress across all participants, no matter their relation to the original distressed person. Sex was however only indirectly related to the distress of spouses. Whilst Essau et al. (2013) also found sex to be an important predictor, Bore et al. (2016) found that when other variables are added into the regression, the impact of sex becomes non-significant. Whilst this present study, like Bore et al. (2016) included factors on social support, the lack of factors on emotional resilience may explain why sex remained a constant predictive factor, rather than becoming non-significant when further variables were added.

Ethnicity. Being Asian was indirectly associated with the distress of other family members but not offspring or spouses. Being of mixed ethnicity however was directly associated with the distress of offspring (adult and child). The significance of ethnicity in both adults and children within this study broadly support previous findings (Curci et al., 2021; Essau et al., 2013). However, due to being unable to look at specific ethnicities due to small sample sizes, I was unable to explore these effects in more detail. Considering ideas of intersectionality, I wondered whether different ethnicities having different effects on different family members could be associated with culture, which was not measured within this study. For example, Familismo is a cultural value specific to being Hispanic influencing the psychological distress levels of people from these communities (Ayón et al., 2010). It could therefore be that differing cultural practices may intersect with ethnicity leading to these findings. I also wondered whether ethnicity may intersect with discrimination and adversity

related to being non-white in the UK whereby these factors, which were unable to be explored in this study, have been found to be relevant in predicting psychological distress (Arreola et al., 2022; Khalil et al., 2023). It may also be important however to bear in mind that prior research using UKHLS has found that in general, White children had higher levels of psychological distress than children of other groups (Miall et al., 2023).

Employment. Unemployment was directly associated with the distress of spouses and other family members. Given that this study did not explore the difference between male and female participants, it is possible that this finding is influenced by the male participants. For example, King et al. (2020) found that unemployment is only relevant to males in the couple relationship. The importance of unemployment in relation to psychological distress of spouses may also be understood in the context that unemployment in female partners has been found to increase the risk of domestic violence (Anderberg et al., 2014), which may lead to psychological distress. Unemployment in males however decreases this risk. Being retired was indirectly associated with the distress of other family members. No other employment statuses were found to be significantly associated with distress. It is wondered whether employment may intersect with the participant's financial situation and work family conflict, which have both been considered, in prior literature, to be important factors related to distress (Acri et al., 2017; Ayón et al., 2010; Curci et al., 2021; Huffman et al., 2017; Wen & Goh, 2023).

Sexual Orientation. Preferring not to report on sexual orientation was indirectly associated with the distress of adult/young adult offspring only. Sexual Orientation was not discussed within the research included in the literature review, with couple dyads being heterosexual and sexual orientation of children not being asked. I could also not find any relevant research into distress of individuals who prefer not to report sexual orientation.

However, more generally, this finding may offer support to prior research whereby sexual orientation has been found to be related to psychological distress in an adolescent sample as well as with adults (Platt & Scheitle, 2018; Ueno, 2005). Platt & Scheitle (2018) found that the intersection between ethnicity, gender and sexual orientation was particularly important. This highlights that although each factor is discussed in turn within this discussion, they should be considered in terms of intersectionality. This indirect effect of sexual orientation was mediated by support from friends. Whilst this was in relation to people who did not wish to report their sexual orientation, this finding may provide corroborating evidence for the idea that social support is important in protecting non-heterosexual individuals against distress, providing security and comfort (Ueno, 2005). However, I do not wish to assume that those who did not wish to report their sexual orientation identify as non-heterosexual. It should also be noted that there were only a small number of participants in the offspring group who did not wish to disclose their sexual orientation and this may have impacted results.

Education. Having no qualifications was indirectly associated with the psychological distress of other family members. As was someone's highest qualification being GCSE, A-level or a qualification that was considered *other*. These indirect associations were all related to the amount of time participants spent with their partner. The finding that education may be an important factor associated with psychological distress supports prior research from the systematic literature review and more generally (e.g., Ayón et al., 2010; Brännlund & Hammarström, 2014; Ross & Wei Zhang, 2008). What is interesting however is that in this study, it was only an important factor for the other family member sample suggesting that one's education is less important to one's distress when their parent or spouse is experiencing distress.

Religion. Not being religious was indirectly associated with the distress of child offspring. There was no evidence to suggest that specific religions were associated with distress supporting Weisman et al. (2005). This also partially supports Sonuga-Barke and Mistry (2000) whereby religion was not associated with "anxiety" but was related to "depression". Unlike prior research, this research combined different religions into the groups *dominant religion* and *non-dominant religion due to small sample sizes*. This meant that any niche differences between the distress of people from different religious groups was lost e.g., between Muslim and Hindu groups (Sonuga-Barke & Mistry, 2000). In addition, using the General Health Questionnaire (GHQ)-12, meant I was only able to explore whether religion was associated with distress in general, as opposed to prior research which explored associations with different diagnoses (Sonuga-Barke & Mistry, 2000).

Relationship status. Relationship status was indirectly associated with the distress of other family members only. Specifically, this was in relation to living as a couple and being divorced, which was associated with how supportive someone found their community. Whilst Friedemann and Webb (1995) found that adding marital relationship to their regression model improved the variance explained by the model, relationship status was not explicitly explored as a factor within the literature review papers. The relevance of relationship status may support previous findings of associations of distress between couples but also findings that emotional support (which you might expect in a relationship) may be associated with levels of distress (Secinti et al., 2019).

Disability. Physical disability was directly associated with the distress of spouses, and both directly and indirectly associated with the distress of other family members. This factor was not included within the literature review papers, despite some participants being of ill physical health. More generally however, the finding that disability is associated with

psychological distress is supported by the literature (e.g., Okoro et al., 2009; Turner & McLean, 1989). It is likely that disability intersects with many other parts of someone's identity such as age, employment, and isolation as well as relational factors (e.g., Paul et al., 2006). This current research specifically suggests that in other family members, disability interacts with how supportive they find their community.

Age. Age was indirectly related to the distress of other family members via how supportive they find their community. Whilst differences were found between children and adults within the literature review, no papers explicitly explored age as a factor. Given that both age and disability indirectly affected distress via the same relational variable, these findings may support the idea that the intersection between age and disability may be important in predicting psychological distress, particularly in old age (Paul et al., 2006).

Age Wanting to Leave Home. The age that a child wanted to leave home was directly associated with child offspring psychological distress. I could not find any research which either supports or argues against this finding. However, this finding may offer support to family systems theory (Bowen, 1966) with the age that someone wishes to leave home, potentially relating to family cohesion and flexibility which then impacts distress. This may also be associated with ideas of the family life cycle whereby children leaving home is a transition that the family must navigate and find a way to adjust to in order to avoid distress (Dallos, 1991). The age someone may want to leave home may also reflect attachment relationships within the family, which are important in predicting psychological distress (Mikulincer & Florian, 2003).

Family Spending Time Together or Apart. Spending time with one's partner was the only variable in this original theme which was found to be significantly associated with distress, and this was only for other family members. Given that closeness and distance is

such a large part of family systems theory (Bowen, 1966), it was interesting that only spending time with partner was relevant in predicting psychological distress in this population. This may therefore support my perspective that the idea of being "too close" or "too distant" within a family in a way that leads to distress is subjective and may be better explained by the quality of the time people spend together or the reasons they may be distant.

Supportive Family. The only factor from this theme associated with psychological distress was emotional support from parents in young adult offspring. The importance of psychological distress supports the wider literature (e.g., Boudreault-Bouchard et al., 2013). Whilst this may be related to ideas of attachment, this may also be associated with ideas of triangulation whereby the young adult may form a strong, supportive relationship with one parent as a way of managing with distress related to their relationship with their other (maybe the distressed) parent. This may also be associated with the idea of role expectations within systemic theory whereby parents may be expected to fulfil the role of the supportive figure, meaning that its presence or absence may impact levels of distress. What was interesting is that emotional support from parents was not a significant factor associated with child offspring distress and thus it may be that this specific group rely on other relationships (e.g., friendships) when their parent is experiencing distress.

Arguing and Fighting in the Home. Arguing with siblings was found to be directly associated with the psychological distress of both adult and child offspring. These findings support prior literature (Dirks et al., 2015; Hutton, 2000). Arguing with parents was found to be directly associated with psychological distress of child offspring only. This suggests that whilst emotional support is more important in relation to young adult mental health, conflict with parents is more important in relation to child mental health. It is wondered whether this may indicate that young adults are better equipped to manage conflict with parents. It may

also be hypothesised that this relates to societal norms and discourses. For example, young adults arguing with their parents may be expected and accepted in relation to them trying to navigate finding independence but also within British culture, whereas children arguing with their parents may not.

Happiness in Family Relationships. Happiness in the couple relationship was the only significant predictor from this theme whereby it was found to be directly associated with spouse and other family member distress. This was also associated with sex which may be related to ideas of self-efficacy (Schafer et al., 1996). Family systems theory emphasises the importance of happiness in the couple relationship when thinking about the distress of the family, and thus this finding may offer support to the theory.

Wider Support Network. Support from the community and support from friends were found to be directly related to the psychological distress of adult offspring, spouses and other family members. Having one or more close friend directly influenced child offspring distress and the number of close friends someone has was found to directly influence psychological distress levels of adult offspring. These findings support results of the literature review (Götze et al., 2017; Novello et al., 2011; Samuelsson, 1994; Secinti et al., 2019). This finding also supports ideas of Bronfenbrenner's ecological systems theory whereby friends and the community form a part of someone's microsystem, associated with risk and protective factors of psychological distress (Eriksson et al., 2018). These findings may also work in support of theories of social support, whereby social resources are important factors in managing life stressors (Thoits, 1995). Wider support networks may also intersect with ethnicity, gender, relationship status and disability, as supported by this research, which are all important factors considered within second and third order cybernetics in systemic theory.

Are there specific factors that help or hinder families?

In relation to the direct effects, several factors were found to be related to higher levels of psychological distress among different family members of a distressed person. These, included being female, being of mixed ethnicity, being unemployed, having a disability, arguing with siblings, and parents and a child wanting to leave home at a later age. These intersectionality variables being associated with higher levels of distress, supports prior literature (Essau et al., 2013; Garcia et al., 2019; King et al., 2020; Okoro et al., 2009; Turner & McLean, 1989). Generally, literature suggests that females do not have worse mental health than males although may be more at risk of things such as domestic violence which does impact psychological distress. It is also suggested that the ways in which females experience, and express distress may be different to males, intersecting with both race and social class (Rosenfield & Mouzon, 2013). What this finding may therefore reflect is the ability for the GHQ-12 to pick up on psychological distress of males in this sample.

Arguing with siblings, arguing with parents and child wanting to leave home at a later age being associated with higher levels of psychological distress relate to ideas within systemic theory. For example, conflictual relationships may interrupt the equilibrium of the family system, leading to distress. A child not wanting to leave home until a later age may signify enmeshment whereby there may be difficulties in relation to individuals within families developing their own identities. It may also link to triangulation, whereby the child feels as if they cannot leave the home as they are needed to keep their parents' relationship at an equilibrium. The family life cycle may also apply whereby not reaching this milestone would be hypothesised to lead to distress. In relation to the family life cycle, wanting to leave home at a later age may reflect anticipation that the child or parents will not being ready for the child to be independent until they are older. It should also be noted however, that cultural

and societal factors may influence the age someone wants to leave home and shouldn't necessarily be seen as always leading to distress in these circumstances. What is important is knowing that this could be a risk factor, and exploring why the family are choosing to manage in this way, and how it may bring about homeostasis.

Factors directly related to lower levels of distress were: having emotional support from parents, having one or more close friend, having greater support from friends and the community, being happy in the couple relationship, number of close friends and spending time with one's partner. These results offer support to prior findings suggesting that isolation and lack of support lead to higher levels of distress (Novello et al., 2011; Samuelsson, 1994; Secinti et al., 2019). These findings also offer support to family systems theory (Bowen, 1966) which highlights the importance of happiness in the couple relationship, interconnectedness, and independence in relation to psychological distress in families. Yet, with the finding that the more time someone spends with their partner, the lower their psychological distress, the idea of being "too close" proposed by family systems theory could be argued against. However, this study measured spending time with partner on a Likert scale with "very often" being the highest rating. This could be considered relatively subjective and may not represent what the theory might describe as being "too close". Results may support theories relating to the role of social support in that close friendships allow for experience sharing and bring a sense of belonging, which are both associated with lower levels of distress (Kitchen et al., 2012; Lindstrom et al., 2021; Sargent et al., 2002).

There are also several factors which indirectly support or hinder families in relation to their psychological distress. For adult offspring, preferring not to report sexual orientation was associated with lower support from friends and therefore these individuals may be more vulnerable to high levels of psychological distress. Research exploring the mental health of

people who do not wish to report their sexual orientation revolves around people who identify as not heterosexual but do not want to tell others. This has been found to be related with higher levels of psychological distress (Schrimshaw et al., 2013) through mediators such as social support. However, as aforementioned, I do not wish to assume that the population in this sample are non-heterosexual.

For child offspring, not being religious is related to children wanting to leave home earlier, which is related to lower levels of psychological distress. This finding may support the earlier mentioned hypothesis that the age people wish to leave home may be associated with cultural and religious factors. Therefore, may offer explanation to findings from prior UKHLS research that individuals from minority religions, had higher levels of distress than those with no religious affiliation (Aksoy et al., 2022). However, this current study's finding that being non-religious is a protective factor in relation to distress, does not imply that religion is a risk factor, in fact prior literature suggests that having strong religious beliefs may be associated with lower levels of distress (Ross, 1990). Prior findings regarding people following a minority religion having higher levels of distress, may be more associated with ideas of discrimination or as mentioned above, factors such as the age people leave the family home.

For both spouses and other family members, being female was associated with better support from the community, which is then associated with lower levels of psychological distress. This is particularly interesting given that if explored directly, this research shows that being female is a risk factor for high levels of distress. Adding to this, being female was also found to be associated with lower levels of happiness in the couple relationship, which then also makes them vulnerable to high levels of distress. These mixed findings regarding whether being female is a risk or protective factor, offers support to thinking about difference

in relation to intersectionality (Crenshaw, 1989) rather than the Social GRRRAAACCEEESSS model (Burnham, 2018).

For other family members of someone experiencing distress, having no qualification, having their highest qualification as A-level, GCSE or a qualification that was considered *other* was associated with spending less time with their partner and subsequently placed them at risk of high levels of psychological distress. I was unable to find any evidence which support or refute these results, and thus further research is recommended in relation to this. Being retired was associated with higher levels of happiness in the couple relationship and therefore lower levels of psychological distress whereas living as a couple was associated with less happiness in the couple relationship and thus higher levels of distress. Prior research however suggests that retirement does not affect quality of the couple relationship alone and instead interacts with gender, gender-role attitudes and provider-role attitudes (Szinovacz, 1996).

Being older and being Asian were both associated with greater levels of support from the community and thus lower levels of psychological distress. However having a disability, living as a couple or being divorced was associated with less community support and therefore high levels of distress. Brossoie (2003) suggest that factors such as community capacity, ease of connecting with others and having an informal support network are what is associated with having a sense of community rather than factors such as age. This might explain all these indirect associations via community support. For example, the older and Asian participants in this sample may have had these above factors; whereas those who were disabled, living as a couple or widowed may have not.

The findings that many social demographic/intersectionality factors indirectly effect psychological distress through relational factors highlights the importance of working with

families rather than thinking about distress through an individualistic lens. This also supports working with people within their societal and cultural contexts as emphasised by the second and third phases of systemic theory.

Do variables effecting distress remain the same during the COVID-19 pandemic?

Change within variables effecting distress was only able to be explored in the adult sample. Being female remained associated with distress at the start of the pandemic for adult offspring and other family members and became significantly associated with spouse distress. The impact of sex increased, which may support the finding that females were more vulnerable to heightened psychological distress at the start of the pandemic (Pierce et al., 2020), for example through school closures (Blanden et al., 2021). Having a disability also remained associated with distress but with a decrease in impact. This suggests that disability is persistently associated with psychological distress over time, despite additional stressors that may develop. The reduction in impact may be associated with a change in living during this time. For example, being unable to leave the house during the lockdown may have meant that people with disabilities no longer had the pressure of navigating communities which are inaccessible. This decrease in impact may also reflect time, whereby the participants may have developed coping strategies over the seven years which were lessening the impact of having a disability on psychological distress. Further research however is required to explore these hypotheses.

Happiness in the couple relationship remained significantly associated with psychological distress at the start of the pandemic, with the impact of this factor decreasing for spouse distress and increasing for other family members. Again, this may suggest the consistency of the association between happiness in the couple relationship and psychological distress in the presence of crises such as the COVID-19 pandemic. It could be hypothesised

that given the importance of happiness in the couple relationship in systemic theories, this may have been what enabled families to begin to adapt during the pandemic (Eales et al., 2021) in a way that reduced their distress levels. Support from the community also remained significantly related to the psychological distress levels of other family members with a similar impact. However, was no longer associated with the distress of adult offspring and spouses. This might suggest a shift in where offspring and spouses sought support at the start of the pandemic, whereby they may have become less reliant on community support (which was disrupted) during the first COVID-19 lockdown. The fact that community support remained associated with lower levels of distress for other family members highlights that there may be unique stressors and needs within this population. This may also suggest that these family members feel less integrated within the family system thus need to continue to seek support elsewhere.

Having mixed ethnicity, being unemployed, arguing with siblings, emotional support from parents, support from friends, number of close friends and spending time with partner were no longer significantly associated with psychological distress of family members of someone experiencing distress. This might reflect that the pandemic was a destabilising event, impacting the homeostasis of families regardless of demographics and relational factors. With prior research highlighting that people began adapting to the pandemic (Chandola et al., 2022; Daly et al., 2022), these variables no longer being associated with distress may indicate the start of the family members finding a "new normal" or equilibrium.

At that start of the pandemic, being Asian became significantly associated with higher levels of psychological distress of other family members. This was of particular interest given that prior to the pandemic, being Asian was considered an indirect protective factor for this group of participants, via social support from the community. This likely reflects the

discrimination and stigmatisation the Asian population, particularly the Chinese population, faced in the UK and across the world (Xu et al., 2021) during this time. Being a carer also became associated with high levels of distress in other family members, supporting Whitley et al. (2023). Despite this research finding that being a carer was not significantly associated with psychological distress prior to the pandemic, earlier research has suggested that it may be associated with high levels of distress in young people (Lacey et al., 2022). Within a literature review, Muldrew et al. (2021) highlight, how the pandemic both magnified the pre-existing difficulties family carers faced, but also created additional stressors. This offers explanation as to why it become a significant factor in this research at the start of the pandemic. Pre-existing difficulties may relate to lack of friendships (Lacey et al., 2023), unemployment and education (King et al., 2023; Xue et al., 2023), all factors that this research found to be relevant in relation to psychological distress.

Age became significantly directly associated with spouse distress and other family member distress at the start of the pandemic, with increase in age being associated with lower levels of distress. This seems to support prior research findings which suggest 18 to 34 years as the most vulnerable age group to distress at this time(Pierce et al., 2020). Lastly, spouses' number of close friends became associated with their psychological distress levels, with a larger number of close friends being associated with lower levels of distress. This may reflect prior findings that social support in adults was important in protecting against psychological distress during the pandemic (Sommerlad et al., 2022).

Despite prior research from the literature review (Borelli et al., 2021; Weisman et al., 2005), and the findings from research questions one and two highlighting the importance of relational factors on psychological distress, at the start of COVID-19 only three relational factors were relevant. Whilst this may be that other factors, not included in this research may

be better associated with distress at this time, it is also wondered if this relates to ideas of homeostasis and the family life cycle.

Strengths and Limitations

This research is the first to consider how such a large number of factors may impact psychological distress of families. In addition, it is the first to consider how these many factors may interact to affect psychological distress. Being longitudinal, this research is better able to account for the dynamic nature of families, the contexts in which they sit and their ways of coping and adapting. In addition, this research has explored families (those which live together) in their entirety, rather than a dyad or triad of family members, which is the case in most of the prior research in this field. However, the definition of family within this study (as with most secondary data research (Hill & Callister, 2006)) is limited and thus may not account for families within the UK who define themselves differently (e.g., extended families). Despite the limited definition, this research meets criteria to be considered family research in that it includes multiple persons, measures change over time, cuts across generations and exists within a geographical context (Hofferth, 2005). To my knowledge, this is also the first study in this field to make direct links with systemic theory and the framework of intersectionality in a way that can directly inform clinical practice and guidelines. When scored against the Quality Appraisal Tool of Quantitative Studies (QATQS), this research is considered strong, with no weak ratings in any area. Only one of the included studies within the systematic literature review achieved this rating (King et al., 2020), demonstrating the need for strong quality research in this area.

Over seven timepoints of data, this research included a large sample of participants from across the lifespan. Whilst most participants were white and of a Christian religion, using UKHLS data meant that there was a spread of participants from different ethnicities

and religions which was representative of the UK population. The number of males and females within the study was almost equivalent meaning that this research, unlike most of the previous research in this area was able to capture men's psychological distress as well as women's. Choosing families where one person is experiencing psychological distress above a cut off score, meant that the sample likely mimic families who would qualify for support from NHS mental health services.

As discussed in the introduction and methodology of this thesis, the current research utilised secondary data. Hofferth (2005) discusses the strengths and limitations of using such data in family research and these will be discussed here in the context of this current study. Firstly, and potentially most importantly, due to time and cost limitations associated with this research being completed as a thesis for the Doctoral Programme in Clinical Psychology, without the availability of secondary data, this research would not have been possible. In addition, the use of secondary data enabled me to include a large sample, necessary when exploring multiple influences on families and wanting to produce a guidance which would be relevant to a large proportion of UK families. Using data with multiple time points enabled me to investigate families in relation to specific times of interest such as during the first COVID-19 lockdown. Whilst it is recommended that multiple data sets are explored to ensure good fit with the research questions (Hofferth, 2005), the UKLHS data set, in this case, was selected due to availability. Despite this, family research is one of the most common key domains of publication resulting from the UKHLS data (Understanding Society, 2020) highlighting it's potential strength in this domain. Whilst this is the case, to my knowledge, prior family research has not been conducted in direct relation to systemic theory and intersectionality, adding to the uniqueness of this specific research. With regards to systemic theory, the interactions between family members during the interview process would have

been relevant however, as with most secondary datasets, these observations were not included (Hofferth, 2005).

Using secondary data comes with a risk of data mining, with the data driving the research. However, in this case the research questions were generated, and systematic literature review was conducted prior to the data being explored. This ensured that the research was driven by theory and clinical contexts. However, this led to other problems in that there was high amounts of missing data within my chosen variables, and some factors, highlighted as important withinin prior literature, were not available. For example, specific factors related to culture as its own construct were not included within UKHLS. Therefore, despite prior research suggesting that culture is related to psychological distress (Ayón et al., 2010; Curci et al., 2021; Essau et al., 2013), this is missing from my final models. This also meant I was unable to explore the interaction between culture and gender (Essau et al., 2013), maternal role expectations (Curci et al., 2021), and family structure (Sonuga-Barke & Mistry, 2000). Discrimination and isolation were also not able to be included within the models, despite evidence suggesting their relevance (Ayón et al., 2010; Novello et al., 2011; Secinti et al., 2019). However, various relational variables (*number of child's close friends*, *child has one or more good friend*, *number of young adult's close friends*, *number of adults close friends*, *local social support available* and *supportive friendships*), may tap into the idea of isolation, which within the systematic literature review was grouped into a theme of social connection.

Gender identity was also not included within this study due to it only being recorded at wave twelve. Instead, the binary construct of sex was used. With regards to the statistics and data, at wave twelve when asked about gender identity .22% (N= 65) of all participants in the UKHLS sample refused to answer, .04% (N= 13) said they did not know and .2% (N= 58)

stated that their gender was not on the binary scale (Understanding Society, n.d.-a). Of these 58 individuals, .45% identified as non-binary, .17% identified as gender fluid, .10% identified as a person, .10% stated that they were unsure or confused, .02% identified as transgender, .02% identified as queer and .12% of this group provided responses which were "not codable" (Understanding Society, n.d.-b). Therefore, not including this variable may not have had a large impact on my results.

Despite this, I am aware that in only using the binary construct of sex in my model, this research may perpetuate the idea of this binary construct being the norm, and seemingly overlooks the social and cultural construction of gender. This in turn may perpetuate the idea of gender identity which does not fit on the binary scale being "disordered" (Newman, 2002). Wiseman and Davidson (2012) discuss how the need to be certain about one's gender and the idea that it is unchanging, silences the distress and grief that individual's may feel in relation to their gender. I acknowledge that it is difficult for many to express their gender identity and research guiding clinical practice, ignoring gender identity may only increase this difficulty, especially within mental health services. I held this in mind whilst conducting this research, trying to remain curious about how it may feel for someone who does not identify with their assigned sex at birth to read this. I also tried to think about the power of research and my role as a researcher and practicing psychologist, being mindful of how I am contributing to narratives and discourses around gender.

Not including gender identity (even though the statistics state that most UKHLS participants identified with the binary scale) is therefore considered a weakness of this research and one that needs to be thought about by anyone taking guidance from this paper. I highlight again that it is important to remember that the absence of these factors (culture, discrimination, isolation, and gender identity) within the model does not mean they are not

relevant. Practitioners guided by this research should not be restricted to only consider factors included in my analysis and should instead consider anything that is important to the client, using this research as guidance only.

The UKHLS measured psychological distress via the GHQ-12 and the Strengths and Difficulties Questionnaire (SDQ). Both questionnaires are widely recognised, commonly used measures within mental health services (Böhnke & Croudace, 2016; S. Brown et al., 2018; Rothenberger & Woerner, 2004; Ruby, 2020). The GHQ was used within two studies discussed within the literature review, as was the SDQ (Essau et al., 2013 [SDQ]; Huffman et al., 2017 [GHQ-12]; King et al., 2020 [SDQ]; Vostanis et al., 1998 [GHQ-28]). By using these measures, this research therefore has practical relevance to mental health services in the UK. In addition, by utilising commonly used measures, the findings from this research can be directly compared with prior research and may have better implications for policy makers and stakeholders.

As aforementioned in the methods, the GHQ-12 is considered both reliable and stable across diverse populations (Picardi et al., 2001), has been translated into different languages and used across several countries (Endsley et al., 2017; Iheanacho et al., 2015; Ju et al., 2017; Tseliou et al., 2018). However, there are limitations to this measure that should be considered when interpreting results and making conclusions. For example, when using UKHLS data from 1991-2016, Brown et al. (2018), found that the GHQ-12 may result in a conservative estimate or under evaluation of the relationship between psychological distress and economic outcomes. They also found that overreporting experiencing no psychological distress, can lead to an underestimation of the impact distress has on educational attainment, employment and financial vulnerability (Brown et al., 2018). Whilst this current research is interested in the inverse relationship (effect of factors on psychological distress) these findings are still

important to consider, especially as these relationships are likely to be circular. Another important finding of note is that older males are more likely to misreport on over half (seven) of the subcomponents of the GHQ-12 and females are more likely to misreport on three of these subcomponents (Brown et al., 2018). The reason for misreporting in these instances is unknown. Having a relatively equal sample of men and women may mitigate any potential bias caused by gender; however, further research utilising different measures may be required to better generalise the results.

With regards to the SDQ, this current research used self-reports of psychological distress. This removes the bias that has been found in maternal reports of the SDQ when the mother is experiencing low mood (Collishaw et al., 2009; Ringoot et al., 2015), with parents experiencing "depression" being theorised to hold more negative views regarding their child's behaviour (Richters, 1992; Richters & Pellegrini, 1989). It should however be noted, that Madsen et al. (2020) found that the agreement between mother-teacher and mother-child, in relation to hyperactivity/inattention and conduct problems, was better when maternal "depression" was present. Less agreement was found in relation to the child's emotional symptoms (Madsen et al., 2020). In general, the hyperactivity scale is considered more reliable with parent-reports than self-report (Becker et al., 2004). Whilst the SDQ has been found to be reliable across multiple countries (Becker et al., 2004; di Riso et al., 2010; Goodman, 1997; Hawes & Dadds, 2004; Koskelainen et al., 2000; Lai et al., 2010; Muris et al., 2003), there are mixed findings in relation to the construct consistency across different ethnicities and countries (Ruby, 2020). There are also groups in which the invariance of the SDQ has not been explored, such as Black British youth (Ruby, 2020). Whilst the number of Black youth is unknown, the sample size of Black participants was relatively small which may mean that this did not have a large impact on results. The reliability and validity of the

SDQ is difficult to explore completely as the studies in this area use different respondents (Ruby, 2020).

The GHQ-12 and SDQ total difficulties score fit with my position highlighted in the introduction on the use of diagnostic labels being unhelpful and thus my choice to explore psychological distress in general. Using these measures therefore will hopefully contribute to professionals avoiding label driven interactions with their clients which might perpetuate stigma (Rubington & Weinberg, 2008) and lead to a loss of the person's unique identity and experiences. Instead, it is hoped that they will take the stance of thinking about what has happened to the individual or family rather than what is wrong with them as per the power threat meaning framework (Johnstone & Boyle, 2018). However, in doing this I have been unable to explore some of the findings discussed within the literature review whereby different factors appear to be associated with different forms of distress. For example, deportation fear being associated with "depression" but not "anxiety" (Arreola et al., 2022). This was also found in relation to economic hardship, sociodemographic risk, and family hardiness (Arreola et al., 2022; Wen & Goh, 2023). What should also be noted is that the GHQ-12 and SDQ are individual measures of psychological distress and that in further exploring familial mental health, future research should create a mean family psychological distress score, or use measures which measure distress at the family level.

The ethnicity of the interviewers in the UKHLS is unknown. Research highlights that participants belonging to an ethnic minority felt more comfortable in discussing ethnicity and culture when they were in a homogenous group (Greenwood et al., 2014). It is therefore possible that if a person belonging to an ethnic minority was interviewed by a White British interviewer, they may have felt uncomfortable answering questions which related into their ethnicity and culture such as family practices and as a result may have "scaled down" their

responses (Dera, 2021). It should also be noted that it was unknown as to whether families or individuals within families were receiving therapy at the time points included in this study and therefore this is a potential confounding factor that was not able to be considered.

Implications and Recommendations

One of the aims of this research was to begin to create a map (in the loosest sense) which helps us to understand families, making it easier to work systemically, considering intersectionality. This research also contributes to the evidence base of systemic theory and adds to the rationale of providing family interventions within mental health services in the UK. I continue to hold the perspective that families are doing their best in a society that is not always set up for them to succeed (that they're working with the card's they're dealt), and thus recommendations to mental health services, policy and future research have been made with this in mind.

Invitations for Mental Health Services and the Practitioners Within Them

Integrating systemic theory with other therapeutic modalities and perspectives appears to be the future of family therapy (Dallos & Draper, 2015). This research supports this, in that it highlights the sociodemographic and relational influences on individual mental health whilst still maintaining a family lens. This research highlights that there is an individual factor in relation to psychological distress, in that different factors are of differing importance to offspring, spouses and other family members' levels of distress. Therefore, I am not recommending ignoring the dominant psychological models such as Cognitive Behavioural Therapy. However, this research provides support to family systemic ideas in that psychological distress is influenced by relationships and societal contexts. It therefore appears counter intuitive to work with individuals out of context, whereby they may make

changes which are incongruent with their family and/or culture. Doing so could mean that either homeostasis in the family is disrupted effecting distress levels of other family members, or individuals are unable to sustain any positive changes they make. Whilst I advocate for family work, this does not mean insisting that clients bring their families. Instead, it may mean having an open invitation to family members, or just keeping the family in mind in individual sessions (chair work may be particularly useful for this).

Families can be "predictable and rule-bound" (Dallos & Urry, 1999). The factors highlighted in this research can therefore be used as a starting point for clinicians to begin recognising difference and how they intersect, forming a better understanding of clients and their families (Bateson, 1972). Given different findings for different family members, this research highlights that there is no 'one size fits all' model of working with families. However, this hopefully makes bringing intersectionality into clinical work feel more achievable. Keeping in mind the idea that the quicker we seek to understand people, the more opportunity there is for misunderstanding (Mason, 1993), it is important for clinicians to hold in mind the uniqueness of families shaped by culture and discourse, whilst also considering their own prejudices and lenses. It is also important to highlight that the non-significance of various factors is not equivalent to them being unimportant. Clinicians should prioritise what the clients' and family's consider are important to their unique identities.

This research highlights factors which help families in relation to psychological distress, which most of the prior literature fails to consider. Based on the solution focused ideas of systemic theory, these factors are just as important, if not more important. Mental health services and the clinicians within them should therefore seek to find resources which protect families, whether these are traits and characteristics they are born with, or helpful ways family members have learnt to interact with each other.

Given that this research found consistently that support from the community promotes lower levels of psychological distress, we should not be quick to assume that traditional methods of mental health support and therapy is the answer. Instead, clinicians should take time to explore how an individual can be supported to be better connected with the resources available to them in their local communities. Mental health services should also explore providing more community level facilities and interventions, which do not require direct clinician involvement.

Lastly, professionals reading this are invited to reflect, as I have, on how they connect with this research and what specifically stands out to them. They are invited to explore this in detail in supervision, with colleagues or maybe in private reflection, thinking about how they could apply it to their practice. In highlighting important areas of difference for our clients, I hope that this highlights how our own areas of difference may both help and hinder our practice.

Invitations for Therapy Guidelines and Policy

This current study contributes to the research supporting systemic approaches in the treatment of psychological distress. Combining the findings from this research with prior research, I hypothesise that family interventions, keeping in mind the distress of each member, rather than "training" family members to be more efficient carers, may be more effective in the treatment of psychological distress in the long-term.

Whilst research highlights that the psychological effects of the COVID-19 pandemic, levelled out over time, this research highlights that it may have affected the way families interact. Therefore, whilst we may no longer see direct effects of the pandemic on distress, there may be lingering indirect effects through relational factors. This is reflected in practice

whereby, against what the evidence suggests, I often see clients (individually and with their families) reporting that their current distress began developing because of the pandemic. I therefore invite this to be considered in reviewing how we manage crises in the UK, such as the current cost of living crisis, keeping family in mind.

This research makes me think of the metaphor that whilst it is important for people to be "pulling people out of the river", others need to "move upstream and figure out why people are falling in". The results highlight how many people may be placed at a disadvantage, meaning that attempts to improve their relational lives, may be ineffective and even insensitive. I invite policy makers to think of this when considering whether to make further cuts to community resources and instead explore how community schemes can be supported.

Invitations for Future Research

Due to the lack of high-quality research in this area, this thesis is just the start in understanding the complexities of families and intersectionality in relation to psychological distress. As such, further research is required in this field. Firstly, this research was only able to identify individual components related to psychological distress, the next step would therefore involve exploring patterns and the possibility of multiplicity of these patterns (Cecchin, 1987). Therefore, considering ideas of intersectionality, future research should also go on to consider whether the factors associated with distress differ for different types of family; whether that is based on family configuration, ethnicity, social class group, etc. It may be of use to explore this using different measures which measure familial distress rather than continuing to look at this from an individual perspective.

Whilst this study looked at longstanding associations over 5-6 years, it is possible that some factors may be more temporary in their associations with distress and thus this should also be explored. With regards to COVID-19, further research is required to expand on how families managed over the pandemic. The pandemic provides opportunities to explore how relations within families changed over time and explore whether and how they reached a new level of homeostasis as a way to expand on current systemic knowledge.

Lastly, whilst we are in need of high-quality quantitative research in thinking about systemic theory, it is recommended that qualitative research is undertaken to explore family narratives around what is associated with levels of psychological distress. This will enable the voices of families to be captured in a way that can be combined with this research to further develop person-centred practices in this area.

Final Reflections

In writing my final reflections after making recommendations, I am very aware of the power I hold as a researcher in this context. I am also aware of my lens of currently undertaking intermediate training to become a Systemic Practitioner and how this may have influenced the recommendations that I made. Despite this however, although grounded in new, novel research, these recommendations are not new. They simply emphasise what many have said before me. I felt myself experiencing frustration whilst writing them, wondering why they still need to be made and why we still need to emphasise the importance of family and community in supporting people experiencing distress. In conversations with supervisors and colleagues about this thesis, they share my shock regarding the limited research in this area and we hypothesise that may be one of the reasons we are still waiting for these recommendations to be heard.

Being a practicing psychologist, whilst also carrying out this research, I have observed a change in the way I work with clients and within multi disciplinary teams. I find myself encouraging more conversations on intersectionality and have found a new confidence in advocating for my clients in conversations which may be driven by individualistic and medical ideas of mental health. I've also found that my own family context has come to mind throughout conducting this research, especially when making recommendations. Whilst I have tried to acknowledge these and using secondary data meant that my own views did not bias the data, I cannot completely claim that recommendations are completely objective. However, I also take the social constructionist stance that no research is truly objective.

This research reminded me of my interest and passion in social justice and in writing this I am reminded of my position I shared in my initial reflections in relation to the social change ecomap (Iyer, 2020). I still very much identify as falling into the visionary role and in ending this research, find myself hoping and dreaming of better ways in which we can support families. I see in practice, people get labelled as "non-compliant" when they struggle to make changes from mental health support and for these people, I want better acknowledgement of their contexts, of the cards they have been dealt in life and praised for the ways in which they are managing and navigating as best as they can.

Reflecting on my academic learning, I am taken back to the memory of when I first chose to work with secondary data. Maths has always been a strength of mine and I have gained experience with quantitative research throughout my career and training. I recently come across a paper (Hofferth, 2005) which highlighted to me the difficulties of using secondary data and I wish I had been aware of this when planning my research. I naively started this thesis, extremely confident about the data analysis and results chapter and could often be heard preaching about the benefits of using secondary data to colleagues. However,

what I failed to consider were the limitations of using secondary data and complexities of longitudinal data. Consequently, the results became the hardest chapter of this thesis. This led to lots of feelings related to imposter syndrome, knocking my confidence and motivation. Whilst I attended courses and workshops on the data set, it took a considerable amount of time to become familiar with the data and my data analysis process involved a lot of revisiting the drawing board. This however, meant that I placed a lot of effort into my results section, and I believe that my knowledge of quantitative methodology has developed greatly. I am excited to join a community of researchers who have used UKHLS data and have formed great relationships with fellow researchers in the process. However, imposter syndrome still lingers.

Completing this thesis has led to a rollercoaster of emotions, especially being associated with a topic I am so passionate about. As I reflect on the process of carrying out this thesis and the changes it has already had to both my clinical and research practice, I am filled with a sense of pride and excitement about the new possibilities that could stem from this research.

Conclusion

In conclusion this thesis has contributed to the understanding of the psychological distress of family members of someone already experiencing distress through the lenses of intersectionality and systemic theory. The research highlights important factors associated with intersectionality and relationships, discussing how these may act as protective and risk factors for families. It is hoped that these can act as a guide for mental health practitioners wanting to work with families. This study also explored how the factors associated with distress changed at the start of the pandemic, in relation to systemic theory. This thesis lays

the groundwork for higher quality research in exploring psychological distress in families and thinking about difference in relation to intersectionality.

This thesis has been written in the context that families are doing the best they can, that they are “working with the cards they have been dealt”. It is up to mental health professionals, policy makers and fellow researchers to now reflect on findings of this research to explore how we do better by these families.

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Appendix A

Quality Ratings on the Six Component Scores Which Make up the Global Quality Rating

Author	Selection Bias	Study design	Confounders	Blinding	Data collection method	Withdrawals and dropouts
Samuelsson (1994)	Moderate	Weak	Weak	Weak	Strong	Not applicable
Friedemann & Webb (1995)	Moderate	Weak	Weak	Weak	Strong	Not applicable
Vostanis et al. (1998)	Moderate	Moderate	Weak	Weak	Strong	Not applicable
Sonuga-Barke & Mistry (2000)	Weak	Weak	Weak	Weak	Strong	Not applicable
Weisman et al. (2005)	Moderate	Weak	Weak	Weak	Strong	Not applicable
Karim et al. (2006)	Moderate	Moderate	Weak	Weak	Strong	Not applicable
Ayon et al. (2010)	Moderate	Weak	Moderate	Weak	Strong	Not applicable
Novello et al. (2011)	Strong	Weak	Weak	Moderate	Strong	Not applicable
Essau et al. (2013)	Weak	Weak	Weak	Weak	Strong	Not applicable
Gotze et al. (2017)	Moderate	Moderate	Strong	Weak	Strong	Not applicable
Acri et al. (2017)	Moderate	Weak	Weak	Weak	Strong	Not applicable
Huffman et al. (2017)	Weak	Weak	Weak	Weak	Strong	Not applicable
Secinti et al. (2019)	Moderate	Weak	Weak	Weak	Strong	Not applicable
King et al. (2020)	Strong	Moderate	Strong	Moderate	Strong	Moderate
Curci et al. (2021)	Moderate	Moderate	Weak	Weak	Strong	Not applicable
Borelli et al. (2021)	Moderate	Weak	Strong	Weak	Strong	Not applicable
Arreola et al. (2022)	Moderate	Weak	Strong	Weak	Strong	Not applicable
Wen & Goh (2022)	Weak	Moderate	Moderate	Weak	Strong	Not applicable
Khalil et al. (2023)	Moderate	Weak	Weak	Weak	Strong	Not applicable

Appendix B

Long Term Content Plan for All Questions

Long Term Content Plan –Adult Questionnaire

Theme	Module name	Wave														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
HH Composition	Household Grid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Household Questionnaire (HH)																
Consumption	HH: Consumer Durables	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	HH: Expenditure	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Environment related behaviour	HH: Environmental Behaviour	x			x						x			x		
Expenditure	HH: Fuel Type & Expenditure	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Financial behaviour & attitudes	HH: Financial Strain	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	HH: Material Deprivation	x	x		x		x		x		x		x		x	
	HH: Child Deprivation	x	x		x		x		x		x		x		x	
	HH: Pensioner Deprivation				x		x		x		x		x		x	
	HH: Food Poverty												x	x	x	x
Housing Characteristics	HH: Structural Characteristics	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	HH: Home Tenure	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	HH: Taxation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Local Neighbourhood	HH: Neighbourhood Conditions			x			x			x			x			x
Wealth & debts*	HH: assets**				x				x				x			
Individual Questionnaire																
Basic Demographics	Demographics	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Caring	Caring	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Change in Characteristics since last interview	Annual Events History (residential moves, partnership changes, pregnancies and babies, new and existing health diagnoses, education spells and training/qualifications, employment spells/job changes)		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Childcare	Childcare *(children aged 0-14)*	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Employment*	Current employment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Employees	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Self-employment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Job satisfaction	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Non-employment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Mothers Return to Work			x	x	x	x	x	x	x	x	x	x	x	x	x
	Second jobs	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Long Term Content Plan –Adult Questionnaire (cont.)

Theme	Module name	Wave														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Employment*	Gig economy											x	x	x	x	x
	Employer/workplace address											x	x	x	x	x
Expectations	Educational Aspirations		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Family Relationships	Non-resident relationships (self- comp.)			x	x	x	x	x	x	x	x	x	x	x	x	x
Financial behaviour & attitudes	Household Finances	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Student Loans												x	x	x	x
Health & social care utilisation	Health Service Use							x	x	x	x	X	x	x	x	x
Health Status	SF-12 (self-completion)	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x
	General Health	x	x	x	x	x										
	Disability	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Income & Earnings	Unearned Income and State Benefits	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Mental Health & Well-being	GHQ (self-completion)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Satisfaction	Life Satisfaction (self-completion)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Technology	Device use and online activity											x	x	x	x	x
Political & Social Engagement	Politics (self-completion from W9)	x	x	x	x	x	x	x		x		x	x	x	x	x
annual module conditional on age																
Expectations	Retirement Planning		x	x	x	x	x	x	x	x	x	x		x		x
Family Relationships	Child Development (self-completion) *(children aged 3, 5 and 8)*			x	x	x	x	x	x	x	x	x	x	x	x	x
	Parenting Styles (self-completion) *(children aged 10)*			x	x	x	x	x	x	x	x	x	x	x	x	x
Financial behaviour	Pension Drawdown									x	x	x	x	x	x	x
Expectations	Young Adult Higher Ed Expectations							x	x							
	Parental Higher Ed Expectations							x	x							
Young Adults	See below for details of modules (Page 5)			x	x	x	x	x	x	x	x	x	x	x	x	x
rotating modules																
Cognition	Cognition			x												
Employment Conditions	Commuting Behaviour		x		x		x		x		x		x		x	
	Work Conditions		x		x		x		x		x		x		x	
	Additional work conditions (self –comp.)				x								x			
Environment related behaviour	Environmental Behaviour	x			x						x			x		
	Environmental Attitudes (self-completion)	x			x						x			x		

Long Term Content Plan –Adult Questionnaire (cont.)

Theme	Module name	Wave														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Expectations	Migration Intention			x												
	Fertility Intentions					x					x					x
Family Relationships	Family networks *(children of all ages)*	x		x		x		x		x		x		x		x
	Family Access			x												
	Parents and children *(children aged 0-15)*	x		x		x		x		x		x		x		x
	Partner Relationships (self-completion)	x		x		x		x		x		x		x		x
Financial behaviour & attitudes	Charitable giving		x		x		x		x		x				x	
	Personal Pensions *		x		x		x		x		x			x		x
	Savings *		x		x		x		x		x			x		x
	Child Maintenance *(children aged 0-15; 16-19 in full time education)*			x		x		x		x		x		x		x
Health Behaviour	Nutrition		x			x		x		x		x		x		x
	Physical activity/Exercise		x			x		x		x		x		x		x
	Smoking		x			x	x	x	x	x	x	x	x	x	x	x
	Physical Work		x			x						x			x	
	Alcohol Consumption (self-completion)		x			x		x		x		x		x		x
Health Status	Social Care							x		x		x		x		x
Identity	Identity (self-completion)		x			x			x			x				
	Britishness (self-completion W6)			5m			x									
Language	Language (English)	x				5m					5m					5m
Leisure Participation	Leisure, culture and sport		x			x										
	Leisure access		x													
	Olympic games				x	x										
	Commonwealth games (Scotland only)							x								
Local Neighbourhood	Local N'bourhood (inc. service use/ quality)			x			x						x			x
	Neighbourhood Belonging (self-completion)	x		x			x			x			x			x
Mental Health & Well-being	Sleep Quality	x			x			x			x			x		
	Broad discrimination											x		x		x
	Harassment (Before W11:5m, from W11:all)	x		x		x		x		x		x		x		x
	Mental Well-Being (self-completion)	x			x			x			x			x		
	Poverty/Shame (self-completion)							x	x							
	Loneliness (self-completion)									x	x	x			x	

Long Term Content Plan –Adult Questionnaire (cont.)

Theme	Module name	Wave														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Political & Social Engagement	Groups and Organisations			x			x			x			x			x
	News & Media Use			x			x			x						x
	Political Engagement (self-comp. from W9)		5m	5m			x			x			x			x
	Political Efficacy (self-completion from W9)			x			x			x			x			x
	Attitudes towards immigration (self-comp.)											x	x			x
	Socio-political Values (self-completion)											x	x			x
	EU Membership (self-completion)								x			x	x			
Political Voting Behaviour	General election (self-completion)		x					x	x	x	x	x	x			x
	EU Election (self-completion)											x	x			
	EU Referendum (self-completion)											x	x			
	Devolved Election –Scotland (self-comp.)												x	x	x	
	Devolved Election –Wales (self-comp.)												x	x	x	
	Devolved Election –Northern Ireland (self-comp.)													x	x	x
Psychological Traits	Personality Big-5 (self-completion)			x												
	Generalised Trust (self-completion)	x														
	Attitudes to Risk (self-completion)	x														
	Self-Efficacy (self-completion)		x			x										
	Delayed Gratification (self-completion)					x										
Social & Friendship Networks	Social Networks			x			x			x						x
	3 Best friends ** (self-completion W3)			x			x									x
Social Support	Social Support (self-completion)		x			x						x			x	
Stable Characteristics	Sexual orientation (self-completion)			x						x						x
	Sex and Gender (self-completion)												x			x
Time Use	Voluntary work		x		x		x		x		x				x	
	Domestic labour		x		x		x		x		x		x		x	
Travel behaviour	Transport behaviour				x		x		x		x		x		x	
Values & Attitudes	Gender Attitudes (self-completion)		x		x						x					
Wealth & debts*	Wealth & debt (individual level)				x				x							
Important Events	Positive and Negative Events		x			x		x	x	x	x	x		x	x	x

Long Term Content Plan –Adult Questionnaire (cont.)

Theme	Module name	Wave														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Education	National Pupil Database, England	x			x	x	x	x		x	x		x	x	x	x
	Early Years Census, England							x		x	x		x	x	x	x
	Individualised Learner Records							x		x	x		x	x	x	x
	National Pupil Database, Wales	x			x	x	x	x		x	x		x	x	x	x
	Northern Ireland Education data	x			x	x	x	x		x	x		x	x	x	x
	Scottish Education data	x			x	x	x	x		x	x		x	x	x	x
	HESA					x						x				
Economic	DWP				x			x			x			x		
	HMRC					x			x			x			x	
	Financial Conduct Authority (FCA)										x			•		
Economic (cont.)	National Employment Savings Trust (NEST)											x			•	
Transport	DVLA					x										
Environment	National Energy Efficiency Data-Framework (NEED)								x					•		

Notes: 5m indicates that in these waves, these general modules were only asked of the Extra 5 Minutes Sample, that is, respondents receiving the Ethnicity Strand extra 5 minutes modules.
* Currently under review
** Additional questions were asked of the Extra 5 Minutes Sample, that is, respondents receiving the Ethnicity Strand extra 5 minutes modules
***Only asked in first 6 months of wave 1. The rest, that is, 7-24 months samples were asked the Employment status history in wave 5 and Parental education in wave 2.
*** Eligibility for data linkage consent requests depends on past consent approval and the particulars of the linkage. Please see User Guide for details. Note the wave at which consent is asked does not necessarily influence the periods for which data are available; the time periods covered by each consent will be determined by the data available and the rules of particular data owners but may extend both backwards and forward in time.

Young Adults (Aged 16-21) sub-section of Adult Questionnaire

NB. The Young Adult section of the Individual Questionnaire comprises of question items tailored towards 16-21 year olds. 16-21 year olds are asked these questions along with all the other Adult Questionnaire content appropriate for a given wave.

Theme	Wave														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Young Adults Self-Completion															
Identity			x	x	A	x		A	x	x	A	x	x	A	x
Social Networks				x	x	A	x	x	A	x	x	x	x	x	A
Family / Meals			x	x	x	x	x	x	x	x	x	x	x	x	x
Behaviour / Bullying at home			x		x		x		x		x		x		x
Family / Talking Quarrelling			x		x		x		x		x		x		x
Happiness & Self-Esteem				x		x		x		x		x		x	
Education / Aspirations			x		x		x		x		x		x		x
Education / Parental Involvement			x		x		x		x		x		x		x
Career advice			x	x	x	x	x	x	x	x	x	x	x	x	x
Behaviour / Bullying at school			x		x		x		x		x		x		x
Health/smoking			x	x	A	A	A	A	A	A	A	A	A	A	A
Health/alcohol			x	x	A	x	A	x	A	x	A	x	A	x	A
Risky behaviour/Drugs			x	x	x	x	x	x	x	x	x	x	x	x	x
Sexual orientation					x		x		A		x		x		A
Young Adults Interviewer administered															
Ethnic Identity					x			A			x			A	
Future intentions / Marriage				x		x		x		x		x		x	
Future intentions / Children				x		x		x		x		x		x	
Future intentions / Leave home		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Future intentions / Job		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Future intentions / Other events		x	x		x		x		x		x		x		x

Long Term Content Plan – Youth Questionnaire (10 – 15 year olds)

In addition to all the measures collected from parents/guardians about children of all ages, children aged 10-15 in sample households are invited to complete a specially tailored paper self-completion questionnaire. This combination of information collected from birth onwards via parents/guardians plus directly from children once they reach 10 years old is designed to gather information on what childhood and growing up is like in the UK; both as a research area in its own right but also as predictors of adult behaviours and outcomes.

Theme	Wave														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Demographic	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Leisure / TV	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Leisure / Screen and computer use	x		x		x		x			x		x		x	
Leisure / On-line social networks	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Leisure / Activities outside school (gaming, cultural and social)	x	x	x	x	x	x	x	x		x		x		x	
Family / Meals	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Family / Support	x		x		x		x		x		x		x		x
Family / Household Chores		x		x		x		x		x		x		x	
Family / Supervision	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Family /other	x		x		x		x		x		x		x		x
Family / Talking/Quarrelling	x		x		x		x		x		x		x		x
Step parent relationship			x		x		x		x		x		x		x
Behaviour / Bullying at home	x		x		x		x		x		x		x		x
Friends / Friendship Networks	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Friends / boyfriend/girlfriend		x		x		x		x		x		x		x	
Self-Esteem		x		x		x		x		x		x		x	
Behaviour / SDQ (Strengths and Difficulties Questionnaire)	x		x		x		x		x		x		x		x
Happiness	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Local neighbourhood			x		x		x		x			x			x
Fear of crime			x		x		x		x			x			x
Education / Homework		x		x		x		x	x		x		x		x
Education / Aspirations	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Education / Truancy	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Education / Misbehaviour	x		x		x		x		x		x		x		x
Behaviour / Bullying at school	x		x		x		x		x		x		x		x
Savings behaviour			x		x		x		x		x		x		x
Pocket money			x		x		x		x		x		x		x

Long Term Content Plan – Youth Questionnaire (10 – 15 year olds) (cont.)

Theme	Wave														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Earnings			x		x		x		x		x		x		x
Caring			x		x		x		x		x		x		x
Health / Disability									x	x	x	x	x	x	x
Health / Nutrition	x	x	x	x	x	x	x	x	x		x		x		x
Health / Obesity		x		x		x		x	x		x		x		x
Health / Exercise	x	x		x		x		x	x		x		x		x
Health / Smoking (from wave 7 including e-cigs)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Health / Alcohol	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Risky behaviour / Binge Drinking		x		x		x		x		x		x		x	
Risky behaviour / Drugs		x		x		x		x		x		x		x	
Risky behaviour/Attitudes		x		x		x		x		x		x		x	
Vandalism / Fighting			x		x		x			x		x		x	
Identity / Ethnicity	x		x		x		x		x			x		x	
Identity / Religion	x		x		x		x			x		x		x	
Political attitudes			x		x		x		x			x			x
Environmental behaviour /attitudes				x		x		x		x			x		
Future Intentions / Marriage		x		x		x		x		x		x		x	
Future Intentions / Children		x		x		x		x		x		x		x	
Future Intentions / 10 years		x		x		X		x		x		x		x	
Future Intentions / Leave home	x		x		x		x			x		x		x	
Future Intentions / Future Job	x		x		x		x			x		x		x	
Cognitive measures										x					

Appendix C

GHQ-12

Short General Health Questionnaire (GHQ 12)

Have you recently?

1.	Been able to concentrate on what you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2.	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3.	Felt you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4.	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5.	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6.	Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8.	Been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less able
9.	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10.	Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11.	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12.	Been feeling reasonably happy, all things considered	More so than usual	About same as usual	Less so than usual	Much less than usual;

Appendix D

Self-rated SDQ for Children aged 11-17

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generally play along or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults that with people my own age			
I have many fears, I am easily scared			
I finish the work I am doing. My attention is good			

Your signature ..... Today's date.....

Appendix E

Tables Containing Final Predictor Variables, Response Scales and Original UKHLS Variables Forming Final Variables

Child variables

New variable	Response scale	UKHLS Variables
Age child wants to leave home	N/A	At what age would you like to leave home? (yplvhm)
Child spending time with family in the evening	None, little, sometimes, often	In past seven days how, many times have you eaten an evening meal together with family? (ypeatlivu) In past month, how many times have you stayed out past 9.00pm without parents knowing? (yplate)
Child feeling emotionally supported by family	No, yes	Do you feel supported by your family? (ypfamsup) Suppose you felt upset or worried, who would you turn to first within your family? (ypupset) How often do you talk to your mother about things that matter? (yptlkm) How often do you talk to your father about things that matter? (yptlkf)
Child feels that parents support their schooling	Never, hardly ever, sometimes, always or nearly.	Parents are interested in how I do at school. (ypparsch) My parents come to school parent evenings (yppareve)

New variable	Response scale	UKHLS Variables
Child arguing and fighting with siblings	Never, not much, quite a lot, a lot.	How often do your brothers or sisters hit, kick or push you? (ypsibhit) How often do your brothers or sisters take your belongings? (ypsibsteal) How often do your brothers or sisters call you nasty names? (ypsibverab) How often do your brothers or sisters make fun of you? (ypsibtease) How often do you hit, kick or push siblings? (yphitsib) How often do you take siblings belongings? (ypstealsib) How often do you call siblings nasty names? (ypverabsib) How often do you make fun of siblings? (ypteasesib)
Child arguing with parents	Hardly ever, less than once a week, more than once a week, most days.	How often do you quarrel with your mother? (ypargm) How often do you quarrel with your father? (ypargf)
Child's happiness with family relationships	Likert scale, 1 (not at all happy) to 7 (completely happy)	How do you feel about your family? (yphfm)
Number of child's close friends	N/A	Number of close friends (ypnpal)
Child has one or more good friends	Not true, somewhat true, certainly true.	I have one good friend or more (ypsdqk)

Young adult variables

New variable	Response scale	UKHLS Variables
Age young adult wants to leave home	N/A	Age you think when you leave home (lvhm)
Young adult spending time with family in the evening	None, little, sometimes, often	In past seven days how, many times have you eaten an evening meal together with family? (eatlivu) In past month, how many times have you stayed out past 9.00pm without parents knowing? (late)
Young adult feeling emotionally supported by family	No, yes	Do you feel supported by your family? (famsup) Suppose you felt upset or worried, who would you turn to first within your family? (upset)
Young adult able to talk with parents	Hardly ever, less than once a week, more than once a week, most days.	How often do you talk to your mother about things that matter? (tlkm) How often do you talk to your father about things that matter? (tlkf)
Young adult feels that parents support their schooling	Never, hardly ever, sometimes, always or nearly.	Parents are interested in how I do at school. (parsch) My parents come to school parent evenings (pareve)

New variable	Response scale	UKHLS Variables
Young adult arguing and fighting with siblings	Never, not much, quite a lot, a lot.	How often do your brothers or sisters hit, kick or push you? (sibhit) How often do your brothers or sisters take your belongings? (sibsteal) How often do your brothers or sisters call you nasty names? (sibverab) How often do your brothers or sisters make fun of you? (sibtease) How often do you hit, kick or push siblings? (hitsib) How often do you take siblings belongings? (stealsib) How often do you call siblings nasty names? (verabsib) How often do you make fun of siblings? (teasesib)
Young adult arguing with parents	Hardly ever, less than once a week, more than once a week, most days.	How often do you quarrel with your mother? (argm) How often do you quarrel with your father? (argf)
Number of young adult's close friends	N/A	Number of close friends (ypnpal)

Adult and young adult variables

New variable	Response scale	UKHLS Variables
Spending time with partner	None, little, sometimes, often, very often	How often respondent and partner work together on a project? (screlparwt) Do you and your partner engage in outside interests together? (scparoutint) How often respondent and partner have a stimulating exchange of ideas? (screlparei)
Spending time with child(ren)	None, little, sometimes, often	Frequency of leisure with child (socialkid) Frequency of eating dinner with kids (dinner)
Supportive of child's schooling	Never or hardly ever, less often than once a month, at least once a month, at least once a week, almost every day.	Parent helps their children with homework (hlphmwk)
Emotionally supportive of child	Hardly ever, less than once a week, more than once a week, most days.	How often talk about important matters with children (talkmatter)
Affection towards partner	Never, rarely, occasionally, more often than not, most of the time, all of the time.	Relation with partner: kiss partner (screlparks)
Affection towards child	Never, seldom, sometimes, very often.	How often praise child (praisekid) How often hug or cuddle child (cuddlekid)
Discipline child	Never, seldom, sometimes, very often.	How often spank or slap child (slapkid) How often shout at kid (yellkid)

New variable	Response scale	UKHLS Variables
Argue with partner	All of the time, most of the time, more often than not, occasionally, rarely, never.	How often respondent and partner calmy discuss something (screlparcd) How often do you and your partner quarrel? (screlparar)
Argue with children	Most days, more than once a week, less than once a week, hardly ever	How often quarrel with children (quarrel)
Happiness in couple relationship	Extremely unhappy, fairly unhappy, a little unhappy, happy, very happy, extremely happy	How often do you discuss or have you considered divorce, separation or terminating your relationship? (screlpards) How often do you and your partner get on each other's nerves? (screlparir) Which best described the degree of happiness, all things considered of your relationship? (screlhappy)
Has caring responsibilities	No, yes	Cares for hadicapped/other in household (aidhh) Non-resident cared for (aidxhh)
Number adults of close friends	N/A	Number of close friends (closenum)
Local social support available	Very bad, bad, ok, good, very good.	Belong to neighbourhood (scopngbha) Local friends mean a lot (scopngbhb) Advice obtainable locally (scopngbhc)
Supportive friendships	Not at all supportive, a little supportive, somewhat supportive, very supportive.	Friends let me down (scfletdwn) Can rely on friends (screfly) Friends understand the way I feel (scfundstnd)
Belonging to a community organisation	No, yes.	Active in any of listed organisations (orgat11)

Household variables

New variable	Response scale	UKHLS Variables
Suitable home environment	No, yes	Damp free home (pdeph1) Home kept warm (pdepi1) Home good state of repair (pdepf1) Children have enough bedrooms (cdephave2)
Children have space to play	No, yes	Space outdoors to play (cdelply)

Appendix F

Ethical Approval Statement

Obtained From https://www.understandingsociety.ac.uk/documentation/mainstage/user-guides/main-survey-user-guide/ethics

The University of Essex Ethics Committee has approved all data collection on Understanding Society main study and innovation panel waves, including asking consent for all data linkages except to health records. Requesting consent for health record linkage was approved at Wave 1 by the National Research Ethics Service (NRES) Oxfordshire REC A (08/H0604/124), at BHPS Wave 18 by the NRES Royal Free Hospital & Medical School (08/H0720/60) and at Wave 4 by NRES Southampton REC A (11/SC/0274). Approval for the collection of biosocial data by trained nurses in Waves 2 and 3 of the main survey was obtained from the National Research Ethics Service (Understanding Society - UK Household Longitudinal Study: A Biosocial Component, Oxfordshire A REC, Reference: 10/H0604/2). For further details on the various committees which have provided ethical approval of the Understanding Society study and its components as appropriate see below:

Main survey: Ethics approval was received from the University of Essex Ethics Committee

- By letter dated 6 July 2007 for Waves 1 and 2
- By letter dated 17 December 2010 for Waves 3 to 5
- By letter dated 20 August 2013 for Waves 6 to 8
- By letter dated 4 October 2016 for Waves 9-11
- Ethics Approval number ETH1920-0123 for Wave 12
- Ethics Approval number ETH2021-0015 for Wave 13

Linkage to health records

- National Research Ethics Service (NRES) Oxfordshire REC A (08/H0604/124): 21 October 2008
- NRES Royal Free Hospital & Medical School (08/H0720/60): 18 June 2008
- NRES Southampton REC A (11/SC/0274): 28 September 2011 and 24 November 2011

Appendix G

Link to Information Sheets for Each Wave of UKHLS

https://www.understandingsociety.ac.uk/documentation/mainstage/fieldwork-documents

Appendix H

Consent Information

Taken From https://www.understandingsociety.ac.uk/documentation/mainstage/consents

Consent information

How our participants give consent to take part in Understanding Society and how we communicate consent information with them.

The overall mechanism for gaining consent for participation in the Study is oral. Participants are sent details about Understanding Society in advance letters, information leaflets and are given information by interviewers if taking part in a face-to-face or telephone interview. These communications give participants information about the purpose of Understanding Society, how they were selected, who funds the Study, how the data will be used and how we protect participants from harm and maintain the security and confidentiality of their data. Participants indicate their consent by answering questions. Participants are also informed that Understanding Society will contact them each year to ask them to participate.

For Study components that go beyond the usual questionnaire, situation specific consent is sought. Information about specific consents is given to participants in an information leaflet and/or by the interviewer. Consent is indicated orally or is written.

You can find the information leaflets for each wave of the main survey in the main survey fieldwork documents section. Information leaflets for the Innovation Panel can be found the IP fieldwork documents section.

Information that is conveyed by interviewers can be found in the questionnaires for the relevant waves. You can find the main survey questionnaires here and the Innovation Panel questionnaires here.

Summary of consents for the main survey and Innovation Panel (IP)

All waves

Main and IP: Basic survey. *Consent: oral.*

Communications: advance letters, information leaflet, participant handbook

Wave 1

Main and IP: Link educational records of adults aged 16-24 and children age 4-15. *Consent: written.*

Communication: information leaflet

Main: Link health records of adults aged 16+ and children aged 0-15. *Consent: written.*

Communication: information leaflet

IP: Link DWP records of adults aged 16+ and children aged 0-15. *Consent: written.*

Communication: information leaflet

Wave 2

Main: Nurse visit following interview for a subset of adults in the General Population Sample component. *Consent: oral (most procedures), written for blood samples for research and/or genetic analysis.*
Communucation: information leaflet

IP: Link health records of adults aged 16+ and children aged 0-15. *Consent: written.*
Communication: information leaflet

IP: Link educational records of adults for those who turned 16 since the Wave 1 consent and those who did not consent before. Adults aged 16-24 and children aged 4-15. *Consent: written.*
Communication: information leaflet

Wave 3

Main: Nurse visit following interview for subset of adults in BHPS sample component. *Consent: oral (most procedures), written for blood samples for research and/or genetic analysis.*
Communication: information leaflet

Wave 4

Main: Link educational records of adults who turned 16 since the Wave 1 consent and those who did not consent before. Adults aged 16-24 and children aged 4-15. *Consent: written.*
Communication: information leaflet

Main: Link health records of adults aged 16+ and children aged 0-15. Those who did not consent before and those who turned 26. *Consent: written.*
Communication: information leaflet

Main: Link benefit records of adults aged 16+. *Consent: oral.*
Communication: information leaflet

IP: Link DWP records of adults aged 16+. *Consent: written*
Communication: information leaflet

Wave 5

Main: Link HMRC records of adults aged 16+. *Consent: oral.*
Communication: information leaflet

Main: Link higher education statistics agency records. Original sample member or new entrant finished higher education on 1995 or after from a UK institution, continuing sample member received a higher educational qualification since Wave 1. *Consent: oral.*
Communication: information conveyed by interviewer

Main: Link HMRC records of adults aged 16+. *Consent: oral.*

Communication: information leaflet

Main: Link records from DVLA. Adults who are licensed drivers with access to a car/van for personal use which is registered in the UK. *Consent: oral.*

Communication: information conveyed by interviewer

Wave 6

Main: Link educational records of adults for those who turned 16 since the Wave 1 consents and those who did not consent before. Adults aged 16-24 and children aged 4-15. *Consent: written.*

Communication: information leaflet

Main: Link health records of adults rising 16. *Consent: written.*

Communication: information leaflet

Wave 7

Main: Link to educational records. Respondent is a rising 16 year old, or was born after 1978 and went to school in the UK and is either a new entrant since Wave 4, has no consent information, was asked consent and rejected only once or gave consent but form is not present or is present but not valid. *Consent: oral.*

Communication: information leaflet

Main: Link to educational records. Respondent is the responsible adult of any child aged 2-15 in the household where the child is either a new entrant since Wave 4 or at this wave, there is no educational consent on record for that child, the educational consent has only been asked and rejected once for that child, or consent has been given for that child but there is no form on record, or the form is on record but is not valid. *Consent: oral.*

Communication: information leaflet

Main: Link to educational records. Respondent is currently living in England and is the responsible adult of any child in the household born in 2008 or later and NPD consent was given with a valid form on record for the sample member. *Consent: oral.*

Communication: information leaflet

Main: Link to benefits records. Adults who had not previously given consent, including new entrants. *Consent: oral.*

Communuication: information leaflet

Wave 8

Main: Link to HMRC records. Respondent is eligible for HMRC consent questions having not given consent before or is a new entrant. *Consent:oral.*

Communication: information leaflet

Main: Link to energy consumption records. If property is in England, Wales or Scotland and any household respondent is the home owner or renter of the property. *Consent: oral.*

Communication: question

IP: Link DWP records of adults aged 16+. *Consent: oral*

Communication: information leaflet

Wave 9

Main: Link to education records. Respondent is a rising 16 year old in this wave and has never completed an adult interview or was a rising 16 year old in the last wave. *Consent: oral.*

Communication: information leaflet

IP: Link records to Credit Reference Agency (CRA) records and also to be passed on to the FCA for adults aged 16+. *Consent: oral.*

Communication: question

IP: Link to DWP records of adults aged 16+. *Consent:oral.*

Communication: information leaflet

IP: Link to information about employers of adults aged 16+ in paid employment. *Consent: oral.*

Communication: question

Wave 10

IP: Link to Electoral Register of adults aged 16+. *Consent: oral.*

Communication: question

IP: Link DWP records of adults aged 16+. *Consent: oral.*

Communication: information leaflet

IP: Link to information from Twitter account of adults aged 16+ who have a Twitter account. *Consent: oral.*

Communication: question

Appendix I

Special Licence Project Application

UKdataservice.ac.uk

18 September 2023

Version: 08.01

Special Licence: Project application form

Table of contents

Definitions

Licence holder: the licence holder(s) specified in section 1.

Data depositor: depositor of the studies detailed in section 2.3.

Data: the special licence study numbers detailed in section 2.3.

Dispute arbitrator: The Economic and Social Research Council (ESRC).

How to complete this form

This application form should be completed by the project lead. The project lead will be the single point of contact for the UK Data Sevice in relation to this project both at the application stage, and through the full lifetimne of the project. The project lead will be contacted with reminders about project expiries, and must submit any extension requests, or requests to vary the project or project team members.

For a research project being undertaken by academics the project lead **does not** have to be the Principal Investigator. Where there is funding associated with a project the project lead **does not** have to be the award holder.

Our example application shows the level of information that data owners expect to see in a well written application.

If more than one person is involved in the project and will have access to the data your are applying for, list them in section 1.2 and ensure **each additional** team member completes the Special Licence additional researcher form.

Only list individuals who **will see the raw data** in Section 1.2.

If you are a student conducting research related to your studies your supervisor **only** needs to be listed in Section 1.2 if they will be consulting the raw data.

We recommend the project lead liaises with all project team members to finalise the project details and ensures all necessary documentation is gathered before submitting to the UK Data Service by email to help@ukdataservice.ac.uk.

The project lead and **all** individuals listed in Section 1.2 must **also** complete and submit a signed UK Data Service Special Licence User Agreement.

About your project

UK Data Service project number *This is found on your UK Data Service account*	249569
Project title	Working with the cards we're dealt: A longitudinal study exploring the impact of social, cultural and family factors on family mental health.
Project start date *When do you want to start working with the data?*	17/10/2023 (asap)
Project end date *When do you plan to complete your project work?*	02/04/2024
Is your project funded? *Funding is not mandatory but provides additional reassurance for the project*	Project is being completed as part of the Doctoral Programme in Clinical Psychology.
If yes, which organisation/institution is funding the research?	Health Education East of England

Project lead/project team details:

Project lead

Please list the details of the project lead as listed on the UK Data Service website.

First name(s)	Danielle
Surname	Arnold
Institution/Organisation	University of Essex
Institution/Organisation Address	Wivenhoe Park, Colchester, CO4 3SQ
Telephone number	07525298037
Email: *This must be the email address associated with your UK Data Service user account*	Da21716@essex.ac.uk
Location of access *Please state the site of access*	Data will be accessed on a PC belonging to the University of Essex.

for the project lead. Include the address of where the data will be hosted and stored, including your organisation/institution name:	Address: Wivenhoe Park, Colchester, CO4 3SQ. School of Health and Social Care, Kimmy Eldridge Building, PGR room 2s2.5.1. Data will not be stored on the PC itself but my university M drive to ensure that no one else can access the data.
Measures in place to protect the data *Refer to section 4.1.1 (on page 8) of the Research data handling and security guide for users when completing this section.*	Data will be accessed using an PC belonging to the University of Essex. Whilst accessing the data, I will not be browsing the internet. Data will not be stored on the PC itself but my university M drive. My M drive is only accessible to me and requires my university credentials to access. Anti-virus software is installed. The PGR room currently only has one PC but a second has been ordered. However, when accessing the data, the room will only be accessed by myself. The data will be encrypted using a passphrase. Research supervisors will not have access to any raw data. The PC in the PGR room has a lock screen and automatically locks prior to 15 minutes of inactivity. To unlock the PC I will need to use my university credentials and password. The room will be locked when not in use. Data will be deleted from the M drive using a secure programme. The recycle bin will also be cleared. There is no plan for backup tapes to be created at this stage; however, if this is required, they will be overwritten before being re-used of destroyed. There is no plan on creating paper copies of the data; however, if this is required, these paper copies will be destroyed using a cross-cut shredder and disposed of in a confidential waste bin. A data destruction form will be completed on destruction of the data to inform the service.

Please note: Home working access is available for some Special Licence data, see Special Licence home working arrangements, and the list of studies approved for home working access. If home working access is required, complete the Appendix of the Special Licence User Agreement.

Research team

In addition to the project lead details given above, please list the names and email address of all member(s) of your research team who **will access** the data.

- All researchers listed below should be invited to the project on the UK Data Service website.
- Each person listed below will need to complete a Special Licence additional researcher form **and** a Special Licence User Agreement.

Name	Email address

Add additional rows to the table if necessary.

Project details

The information you provide here will be used by the data owner to make a decision about whether or not to approve your application to use this data.

Abstract

Using plain language, without jargon, please include a short description of the project and its benefits.

The author of this research takes the stance that families are doing the best they can in contexts that are not always set up for them to succeed. Prior research demonstrates that psychological distress in one family member is related to the psychological distress of other family members; however, often fails to explore wider social, cultural factors that impact this relationship. When other factors are considered, this is not done with ideas of intersectionality in mind. Whilst systemic models have shifted to a more social constructionist perspective, considering intersectionality in addition to family factors, these ideas can feel abstract and thus may not translate into practice. Especially with most practitioners providing family interventions, not being systemically trained. The research proposed here aims create a map that contributes to our understanding of families in a way that guide's curiosity. The aim will be reached using growth model analysis on the data from Understanding Society: the UK Household Longitudinal Study (UKHLS). The proposed research will be conducted as a thesis for the Doctoral Programme in Clinical Psychology at the University of Essex. It is hoped that this project will be published in relevant academic journals and presented at conferences, including the Annual Psychological Services Conference within the Essex Partnership University NHS Foundation Trust.

Research proposal

Please provide a full and detailed description of the purpose for which the data are requested, describing the aims of the project. Where research is part of a larger programme, please include details below.

The aim of this research is to create a map that contributes to our understanding of families. It does not intend to search for a single truth or new theory, but guide curiosity in practitioners offering family work.

RQ1: What are the family, social, cultural and religious factors influencing the psychological distress of families when one member has started experiencing distress?

RQ2: Are there any specific factors that appear to help or hinder how families manage with psychological distress and do these differ across different families?

RQ3: Has COVID-19 disrupted the way that families previously managed when faced with psychological distress?

Data required for the project

List the UK Data Service study number and full study title.

In this section you only need to detail Special Licence studies required (data subject to the Special Licence user agreement). For example: *SN 7944 - Affluent Worker in the Class Structure, 1961-1962: Special Licence Access.*

SN 6931- Understanding Society: Waves 1-12, 2009-2021 and Harmonised BHPS: Waves 1-18, 1991-2009: Special Licence Access

Justification

Please provide a justification as to why you are requesting access to the data listed in section 2.3. You should include:

- An explanation as to why you require these data, including information about specific variables or questions of interest and how you'll use these in your research.
- An explanation demonstrating that you have considered alternative sources of data, and reasons why these data are not sufficient for your research.

IMPORTANT: when applying for social survey data, we strongly recommend that you consider using less restrictive versions of the data that are available. Please visit the UK Data Service catalogue to locate less restrictive sources, where available.

This research is looking to explore the interaction between intersectionality and family factors on the psychological distress of the people within the family. As a result this research hopes to access data on sexual orientation (sexuor) which prior research and theory suggests may be an important variable in relation to this topic. EUL data sets have been explored but do not provide the variable 'sexual orientation' (sexuor).

Does your project proposal include any linking of data sources?

If yes, please provide the following details below:

- A description of the data source(s) to be linked to the data.
- A summary of the key variables.
- A summary of the linking methodology.
- Justification for the linking.

No

Expected outputs

Please give details of the products/outputs that will be produced from your use of the data. This might include things like: analysis, reports, tables, journal articles, books, chapters, blog posts or theses. If applicable, please describe the impact and public benefit which you expect will occur as a result of your use of the data.

This research is being completed as a thesis for the Doctoral Programme in Clinical Psychology. It is hoped that this will be published in relevant journals. It will also be available on the University of Essex Research Repository and presented at The University of Essex, School of Health and Social Care Annual Research Conference.

Protection of confidentiality

Describe the methods you will use to determine whether the outputs listed in Section 2.6 above are disclosive and the measures you will use to protect confidentiality in those outputs.

Methods and standards specified in the Research data handling and security guide for users and Office for National Statistic's Disclosure control for tables produced from surveys must be applied to statistical outputs.

Data will be stored on a password protected PC, owned by the University of Essex. Data will be encrypted and saved on my university m drive for the duration of data analysis only.

Data will be encrypted using a passphrase.

Data will be grouped by household but this will not me matched with any other data source.

The minimal thresholds will be followed to avoid primary and secondary disclosure.

Geography will not be used as a variable in this research.

Data will be cited in the research.

The syntax used for data preparation and analysis will be retained; however, the data itself will be deleted following the completion of the project using a secure erasure programme.

There is no plan on creating paper copies of the data; however, if this is required, these paper copies will be destroyed using a cross-cut shredder and disposed of in a confidential waste bin.

Appendix J

Special Licence Agreement

UK Data Service ukdataservice.ac.uk

Special Licence User Agreement

27 February 2023

Public

Version: 08.00

1. Special Licence User Agreement

1.1 Introduction

This document represents one of the steps that prospective Registered Users of the UK Data Service must fulfil prior to being able to access data subject to the Special Licence Agreement. The Agreement must be signed by the Registered User and returned before the Registered User can access data subject to the Special Licence Agreement. The Agreement demonstrates that the prospective user understand the conditions of use, and the penalties that may be imposed for non-compliances.

1.2 The Parties

This Agreement is agreed between

1. the individual Registered User of UK Data Service; and
2. the University of Essex acting by its UK Data Archive of Wivenhoe Park, Colchester, CO4 3SQ (the "Data Service Provider").

In the event of the University of Essex ceasing to be a legal entity, this licence will be transferred to the Economic and Social Research Council (ESRC) or its successors.

IT IS HEREBY AGREED:

1.3 Definitions of terms

Data Collection: The dataset(s), documentation, metadata, occasionally code, provided by the Depositor for dissemination to the Designed User Community and curated by the UK Data Service in accordance to the Collections Development Policy and Selection and Appraisal Criteria.

Designated User Community: The UK Data Service's Designated User Community is made up of social science and related data users within Higher and Further Education in the UK, however services are designed for all users. All users are expected to have a basic understanding of social science methods and techniques relevant to the data collections being accessed.

Registered User: A user who has registered with the UK Data Service and therefore agreed online to the End User Licence Agreement.

End User Licence Agreement: The User Agreement entered into by a User when registering to access Safeguarded and Controlled data from the UK Data Service.

Special conditions: Any further conditions applicable to the use of one or more Data Collections by an End User, as notified to the End User in accordance with paragraph 5 of the

End User Licence Agreement.

Depositor: The person named on the Deposit Licence Agreement having sufficient responsibility to grant particular rights on behalf of a Data Collection. The Depositor may be the principal investigator, creator or the copyright owner of a Data Collection, or authorised to grant the Deposit Licence Agreement.

Data Team: In relation to a particular data collection, the Registering Organisation, the relevant Data Service Providers, and (to the extent that the Data Collection Metadata expressly provide) the Service Funder(s), Data Collection Funder(s) and/or Original Data Creators or Depositors.

Registering Organisation: The person(s) or organisation(s) responsible for the system that registers Users and issues them with End User Licence Agreements (being the University of Essex).

1.4 Agreement

1. To read and abide by the Research Data Handling and Security: Guide for Users.
2. To take all necessary administrative, technical and organisational measures to ensure that the data are used only in the manner stated and for the proposal specified.
3. To confirm that access to the data is required in order to meet the aims of the proposal and that the access is proportionate and not excessive to the stated purpose.
4. To not process, disseminate or otherwise allow any of the data to be made available or used for any other purpose whatsoever and to remain bound by this obligation once the period of access has expired.
5. To guarantee that none of these data will be distributed to third parties.
6. To guarantees that any duplication of the data will only be for the purpose of making personal copies to aid their own research and analysis for the proposal specified.
7. To not attempt to use these data after the period of access has expired.
8. To not attempt to identify by any means whatsoever, any individual, household or organisation in the data, nor will the licence holder claim to have done so.
9. To comply with the data security requirements in the Research Data Handling and Security: Guide for Users.
10. To guarantee that the prime focus for accessing the data is for research purposes and not for the purpose of personal or commercial gain.
11. To guarantee that any outputs made available to anyone other than those named on the Licence (who must also have signed this Declaration), will meet required standards, including the guarantee, methods and standards contained in the Code of

Practice for Official Statistics and the ONS Statistical Disclosure Control for tables produced from surveys.

12. To apply methods and standards specified in the Research Data Handling and Security: Guide for Users for disclosure control for statistical outputs.
13. To supply to the UK Data Archive the bibliographic details of any published work based wholly or in part on the data collection/s accessed. Details are to be provided on publication.
14. Any plans to match or attempt to match individual or household records to any other data source at the level of the individual or household and these plans can only be undertaken with the permission of the data depositor and the owners of the data sources.
15. Where the data depositor so requires, must supply a copy of any proposed publication, based wholly or in part on the data collections accessed, to enable the data depositor to consider it and comment as regards compliance with the conditions for disclosure protection and will make any [reasonable] changes that are required by the data depositor in order to make the proposed publication comply with these conditions.
16. To, at the end of the access period, destroy all copies of the data, including temporary copies, CDs, printed copies, personal copies, back-ups, derived datasets and all electronic copies to the standards specified in the Research Data Handling and Security: Guide for Users.
17. To report promptly non-compliance with any of the terms of this Licence.
18. To abide by any other requirements made by the UK Data Archive or the Depositor relating to this use of data.
19. The Registered User understands that the principles of the Freedom of Information Act apply and nothing provided in this Agreement is confidential to the licence holder or to the data depositor. To disclose the details of the Agreement would not be a breach of any duty of confidence and therefore the details would be made available to the public on request.
20. Data subject to the Special Licence Agreement will only be accessed at a site that has security standards that meet the requirements outlined in the document Research Data Handling and Security: Guide for Users; and that also meet the requirements of the Depositor. This may include the requirement that data must not be stored or accessed at a location outside the UK or the European Economic Area.

Non-compliance procedures

Any non-compliance with any of the provisions of this Licence will result in the immediate termination of the Registered User's access to the data, the termination of the licence and the

prohibition of any further access to the data subject to the Special Licence Agreement. It will also lead to immediate termination of the services provided by the UK Data Archive Data Team, either permanently or temporarily (as stated in section 17 of the EUL). The Registered User's institution will be informed of non-compliance.

Non-compliance with any of the provisions of this Agreement may result in sanctions being sought against the licence holder. These may include legal proceedings being taken by the data depositor for breach of obligations under statute or common law.

Dispute procedures

Any disputes arising from the use of the data and/or the terms of this licence will be resolved initially between the UK Data Archive, on behalf of the University of Essex and the Registered User. Otherwise, outstanding issues will be referred to the dispute arbitrator.

1.5 Declaration

The Declaration is to be agreed and signed by the applicant, who will be the Registered User requiring access to data subject to the Special Licence Agreement.

By signing this Declaration, I, the Registered User, confirm that:

- All the information I provide in support of an application to access data subject to the Special Licence Agreement is true and accurate.
- I have read, understood and will abide by any and all terms and conditions of this Agreement.
- I have read, understood and agreed to the End User Licence Agreement.
- I have read and understood the UK Data Service Licence Compliance Policy.
- I have read, understood and will abide by the Research Data Handling and Security: Guide for Users.

Registered User's signature	D.Arnold
Registered User's full name and title	Ms Danielle Arnold
Date	17/10/2023

Appendix: Special Licence Working from Home User Agreement

The Appendix is to be completed, agreed and signed by the applicant, who will be the Registered User requiring access from home for data subject to the Special Licence User Agreement. If the applicant does not require access from home the Appendix should not be completed.

List below all the UK Data Service study numbers and full study titles, subject to the Special Licence User Agreement, to be accessed from home, where permission from the data owner is in place as listed within our COVID-19 Special licence FAQs and permitted datasets.

Working from Home Agreement

1. I will only access Special Licence data, where data owners have agreed, as listed within our COVID-19 Special licence FAQs and permitted datasets, via my institutional PC, where my data is stored, under the terms and conditions of the Special Licence User Agreement.
2. I am signed up to an institutionally-approved secure connection method.
3. I will only connect to your institutional workstation using my institutionally-approved secure connection method.
4. I confirm that the current Operating Systems of both my organisational/institutional machine and local home PC/laptop have all recommended security updates applied. Please keep proof of these using a screen capture of the computer updates.
5. I confirm that the current Operating Systems of both my organisational/institutional machine and local home PC/laptop have anti-virus software installed and updated. Please keep proof of these using a screen capture of the anti-virus computer status.
6. While I am remotely connected to my institutional workstation I will not access anything else on the internet and will close down all other windows and applications.
7. I can confirm that I have recently completed an information security awareness training course (e.g. an online institutional course/module such as Information Security Essentials through Moodle or Blackboard. These are usually required to be taken and passed once a year). Please keep a record.

a. Please enter the name of the Information Security awareness training that you undertook.

b. Please enter the date when you completed your Information Security awareness training (dd/mm/yyyy format).

8. I will ensure that my home screen is not being overlooked by other people in my household.
9. I will comply with other key data security requirements set out in the Research Data Handling and Security: Guide for Users.
10. I understand that use of Special Licence data from home from data owners not listed within our COVID-19 Special licence FAQs and permitted datasets will constitute a breach of the existing licence previously agreed. I understand that any breaches may incur the penalties listed under this existing agreement.

Working from Home Declaration

By signing this Declaration, I, the Registered User, confirm that I agree to the terms and conditions of the Working from Home Agreement, that all information provided is accurate, and understand that penalties may be applied if a breach occurs.

Registered User's signature	
Registered User's full name and title	
Date	

www.ukdataservice.ac.uk

help@ukdataservice.ac.uk

We are supported by the Universities of Essex, Manchester, Southampton, Edinburgh, University College London and Jisc. We are funded by UKRI through the Economic and Social Research Council.

Appendix K

Descriptive Statistics for Intersectionality Variables

Factor	Participant Group	N (%)
Has a disability	Offspring	649 (17.3%*)
	Spouse	2865 (32.3%*)
	Other	6241 (34%*)
Dominant religion	Offspring	958 (11.9%*)
	Spouse	959 (75.9%*)
	Other	2177 (66.1%*)
Non-dominant religion	Offspring	342 (4.3%*)
	Spouse	304 (24.1%*)
	Other	976 (29.6%*)
No religion	Offspring	6728 (83.8%*)
	Spouse	.
	Other	142 (4.3%*)
Social class – professional occupation	Offspring	38 (2%*)
	Spouse	413 (7.2%*)
	Other	619 (5.7*)
Social class- Managerial & technical occupation	Offspring	429 (22.7%*)
	Spouse	2246 (39.1%*)
	Other	3762 (34.7%*)
Social class – Skilled non-manual	Offspring	560 (29.6%*)
	Spouse	911 (15.9%*)
	Other	2407 (22.2%*)
Social class- Skilled manual	Offspring	288 (15.2%*)
	Spouse	1318 (22.9%*)
	Other	1912 (17.7%*)
Social class- Part skilled	Offspring	479 (25.4%*)
	Spouse	686 (11.9%*)
	Other	1750 (16.2%*)
Social class – Unskilled	Offspring	95 (5%*)
	Spouse	173 (3.0%*)
	Other	379 (3.5%*)
Social class- Armed forces	Offspring	0
	Spouse	0
	Other	0
Employed	Offspring	1621 (43.1%*)
	Spouse	5858 (65.9%*)
	Other	10658 (58.1%*)

Factor	Participant Group	N (%)
Unemployed	Offspring	587 (15.6%*)
	Spouse	989 (11.1%*)
	Other	3014 (16.4%*)
Retired	Offspring	10 (.3%*)
	Spouse	1988 (22.4%*)
	Other	3089 (16.8%*)
Student	Offspring	1541 (41%*)
	Spouse	59 (.70%*)
	Other	1585 (8.6%*)
Other employment	Offspring	38 (1%*)
	Spouse	30 (.30%*)
	Other	97 (.5%*)
Married	Offspring	119 (3.2%*)
	Spouse	6896 (77.5%*)
	Other	10604 (57.9%)
Living as a couple	Offspring	122 (3.3%*)
	Spouse	2006 (22.5%*)
	Other	2051 (11.2%)
Widowed	Offspring	1 (.03%*)
	Spouse	0
	Other	508 (2.8%)
Divorced	Offspring	60 (1.6%*)
	Spouse	0
	Other	761 (4.2%)
Separated	Offspring	23 (.6%*)
	Spouse	0
	Other	267 (1.5%*)
Never married	Offspring	3420 (91.3%*)
	Spouse	0
	Other	4128 (22.5%*)
Heterosexual	Offspring	1175 (94.5%*)
	Spouse	1887 (95.3%*)
	Other	4519 (94.4%)
Not heterosexual	Offspring	55 (4.4%*)
	Spouse	74 (3.7%*)
	Other	188 (3.9%*)
Prefer not to say sexuality	Offspring	36 (2.9%*)
	Spouse	54 (2.7%*)
	Other	143 (3%*)

Factor	Participant Group	N (%)
Highest qualification- degree	Offspring	518 (6.5%*)
	Spouse	2469 (28.2%*)
	Other	4328 (23.9%)
Highest qualification- other higher	Offspring	252 (3.1%*)
	Spouse	1033 (11.8%*)
	Other	2097 (11.6%*)
Highest qualification- A-Level	Offspring	1369 (17.1%*)
	Spouse	1711 (19.5%*)
	Other	4090 (22.6%*)
Highest qualification – GCSE	Offspring	1188 (14.8%*)
	Spouse	1728 (19.7%*)
	Other	3854 (21.3%*)
Highest qualification- Other qualification	Offspring	109 (1.4%*)
	Spouse	813 (9.3%*)
	Other	1583 (8.7%)
No qualification	Offspring	4592 (57.2%*)
	Spouse	1007 (11.5%*)
	Other	2143 (11.8%)
Household income	Offspring	2909 (98.5%)
	Spouse	8874 (95%)
	Other	19100 (99.5%)
Carer	Offspring	419 (11.5%*)
	Spouse	2128 (22.8%*)
	Other	3371 (18.5%*)
Suitability of home environment	Offspring	2328 (29%)
	Spouse	1684 (18%)
	Other	3960 (20.6%)

Appendix L

Regression Model One for Adult Offspring

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex		.27	.05	.17 - .38	<.001
Age		.004	.01	-.01 - .02	.44
Disability		-.10	.11	-.32 - .11	.35
Household income		-6.73	.000008	.00002 - .00001	.41
Suitability of home environment		.04	.15	-.26 - .34	.80
Religion	Non-Dominant	.59	.26	.09 – 1.08	.02
Social class	Professional occupation	-.14	.41	-.94 - .66	.73
	Managerial & Technical	-.04	.16	-.35 - .27	.78
	Skilled manual	-.10	.18	-.44 - .25	.59
	Part skilled	-.09	.15	-.38 - .21	.56
	Unskilled	-.29	.27	-.81 - .23	.28
Ethnicity	Mixed ethnicity	.73	.23	.29 – 1.18	.001
	Asian	-.12	.12	-.36 - .12	.33
	Black	.13	.19	-.23 - .50	.47
	Other ethnicity	-.39	.39	-1.15 - .37	.32
Employment	Unemployed	.36	.12	.12 - .60	.003
	Retired	-.43	.79	-1.97 – 1.11	.59
	Student	.16	.10	-.04 - .35	.11
	Other employment	.65	.39	-.12 – 1.42	.10
Marital status	Married	.19	.24	-.27 - .65	.43
	Living as couple	-.08	.23	-.52 - .36	.73
	Widowed	.16	2.39	-4.52 – 4.85	.95
	Divorced	.48	.33	-.16 – 1.12	.14
	Separated	-.35	.51	-1.34 - .64	.49

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sexuality	Heterosexual	-1.12	.65	-2.40 - .16	.09
	Not heterosexual	.76	.50	-.23 – 1.75	.13
	Prefer not to say	-1.46	.77	-2.96 - .05	.06
Education	Degree	-.10	.14	-.37 - .16	.46
	Other higher	-.08	.17	-.41 - .25	.63
	GCSE	-.01	.10	-.19 - .18	.96
	Other qualification	.12	.24	-.36 - .59	.63
	No qualification	.03	.09	-.15 - .21	.73
Carer status		.07	.13	-.19 - .32	.61
Constant		12.13	.78	10.60 – 13.67	<.001

Appendix M

Regression Model One for Child Offspring

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex		.09	.02	.04 - .13	<.001
Age		<.001	.001	-.002 - .003	.73
Household income		-8.51	<.001	<.001 - <.001	.80
Outdoor space for children to play		.04	.09	-.14 - .23	.65
Suitability of home environment		.04	.06	-.08 - .17	.50
Religion	Non-Dominant	.04	.12	-.20 - .28	.75
	No religion	.08	.05	-.03 - .19	.14
Ethnicity	Mixed ethnicity	.44	.11	.22 - .67	<.001
	Asian	-.17	.08	-.32 - -.02	.02
	Black	-.06	.12	-.30 - .18	.63
	Other ethnicity	.03	.26	-.48 - .54	.91
Constant		10.59	.17	10.25 – 10.93	<.001

Appendix N

Regression Model One for Spouses

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex		.22	.06	.09 - .34	<.001
Age		-.01	.003	-.02 - -.01	<.001
Disability		-.64	.07	-.78 - -.51	<.001
Household income		-1.24	.00001	-.00003 -.000004	.13
Suitability of home environment		.45	.35	-.24– 1.14	.20
Religion	Non-dominant	.10	.20	-.29 - .49	.62
Social class	Professional occupation	.12	.15	-.18 - .41	.44
	Skilled non-manual	.06	.11	-.16 - .27	.62
	Skilled manual	-.11	.10	-.31 - .09	.27
	Part skilled	.004	.12	-.24 - .25	.98
	Unskilled	-.07	.22	-.50 - .36	.75
Ethnicity	Asian	-.02	.12	-.25 - .22	.90
	Mixed ethnicity	.37	.29	-.20 - .95	.20
	Black	.05	.20	-.34 - .44	.81
	Other ethnicity	-.24	.34	-.90 - .42	.48
Employment	Unemployed	.74	.10	.54 - .94	<.001
	Retired	-.06	.10	-.26 - .15	.58
	Student	.18	.36	-.53 - .89	.61
	Other employment	.19	.50	-.79 – 1.18	.70
Marital status	Living as couple	.20	.08	.05- .35	.01
Sexuality	Heterosexual	-.68	.64	-1.93 - .57	.28
	Not heterosexual	-.19	.47	-1.12 - .73	.69
	Prefer not to say	-.70	.74	-2.15 - .74	.34

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Education	Other higher	.07	.10	-.14 - .27	.53
	A-Level	.004	.09	-.18 - .18	.96
	GCSE	.14	.09	-.04 - .32	.13
	Other qualification	-.09	.12	-.33 - .14	.44
	No qualification	.16	.11	-.06 - .38	.16
Carer status		.10	.08	-.06 - .25	.21
Constant		11.45	.97	9.56 – 13.34	<.001

Appendix O

Regression Model One for Other Family Members

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sex		.16	.05	.06- .25	<.001
Age		-.01	.002	-.01 - -.004	<.001
Disability		-.54	.05	-.65 - -.44	<.001
Household income		-9.54	.00001	-.00002-.000002	.12
Outdoor space for children to play		-.01	.22	-.45 - .42	.96
Suitability of home environment		.18	.18	-.18- .54	.33
Religion	Non-dominant	-.09	.14	-.35 - .18	.52
Social class	Professional occupation	.14	.14	-.13 - .40	.31
	Skilled non-manual	.16	.08	-.01 - .32	.06
	Skilled manual	.02	.09	-.15 - .20	.80
	Part skilled	.24	.09	.06 - .43	.01
	Unskilled	-.08	.17	-.41 - .25	.63
Ethnicity	Asian	-.07	.08	-.23 - .08	.35
	Mixed ethnicity	.32	.17	.-.02 - .65	.07
	Black	-.04	.12	-.27 - .19	.73
	Other ethnicity	.06	.25	-.43 - .56	.80
Employment	Unemployed	.49	.07	.36 - .63	<.001
	Retired	.001	.08	-.16 - .17	.99
	Student	-.09	.10	-.29 - .11	.36
	Other employment	.35	.32	-.27 - .97	.27
Marital status	Living as couple	.10	.08	-.05 - .26	.18
	Widowed	.01	.15	-.28 - .30	.96
	Divorced	.12	.12	-.11 - .35	.31
	Separated	-.04	.19	-.42 - .34	.83
	Never married	.01	.08	-.14 - .16	.92

Factor		Coefficient	Standard error	95% Confidence interval	P-value
Sexual orientation	Heterosexual	-.20	.48	-1.13 - .73	.68
	Not heterosexual	-.13	.39	-.89 - .63	.74
	Prefer not to say	.30	.54	-.76 – 1.36	.58
Education	Other higher	.03	.08	-.13 - .20	.69
	A-Level	.02	.07	-.12 - .16	.79
	GCSE	.04	.07	-.10 - .19	.56
	Other qualification	.10	.10	-.09 - .29	.28
	No qualification	-.01	.09	-.19 - .17	.89
Carer status		.13	.06	.02 - .25	.03
Constant		12.69	.67	11.39 – 14	<.001