RESILIENCE AS A MODERATOR BETWEEN PERCEIVED STIGMATIZATION, BURDEN AND LIFE SATISFACTION IN PSYCHIATRIC PATIENT'S PRIMARY CAREGIVERS

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Abstract

The aim of the present study was to investigate the moderating role of resilience on the relationship between perceived stigmatization burden and life satisfaction among primary caregivers of psychiatric patients. The present research sample (N=250) comprised of equal numbers of male and female caregivers with age range 20-60 years. The sample was selected by purposive convenient sampling method. Participants were approached at different hospital of Rawalpindi and Islamabad. Data was collected using Urdu translation of Resilience scale (Naz, 2011) to assess resilience, Urdu version of Perceived Public Stigma Scale (Yaqoob & Kausar, 2014) to assess public/social stigma, Urdu translation of Burden Interview (Butt & Bashir, 2014) to assess caregiver burden, and Urdu translation of Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) to assess life satisfaction. Psychometric properties of scales revealed satisfactory reliability for the study sample. For data analysis, Pearson product moment correlation, independent sample t-test and multiple regression analysis were used. Results indicated that resilience was significantly positively correlated with life satisfaction and negatively correlated to burden as well as burden and stigma were negatively correlated with life satisfaction. Multiple regression analysis showed that increase in resilience lead to decrease in public stigma. Independent sample t-test was applied on gender and socioeconomic status which revealed that females were more burdened than males and males had more life satisfaction than females and there were nonsignificant socioeconomic differences in burden among primary caregivers. Regression analysis further revealed that resilience moderated the relationship between burden and public stigma. This significant interaction proposed that positive relationship exists between burden and stigma as a result of resilience. These findings highlighted the need for intervention plans to reduce stigma and burden among caregivers for their mental health.

Key words: Resilience, Perceived Public Stigma, Burden, Life satisfaction, Primary caregivers.

DECLARATION

I hereby declared that this thesis entitled "Resilience as a moderator between Perceived Stigmatization, Burden and Life satisfaction in Psychiatric Patient's Primary Caregivers" is the result of my own research except as cited in the references. The thesis has not been accepted for any degree and is not simultaneously submitted in candidature any other degree.

Date: ____________________

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Resilience as a moderator between Perceived Stigmatization, Burden and Life satisfaction in Psychiatric Patient's Primary Caregivers

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I am highly grateful to ALLAH Subhanu wa Ta'laa, The most merciful and the most beneficent, The lord of heaven and earth, who knows all veiled and apparent, who has enabled me to complete this task successfully.

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Dedication

I would like to dedicate my work to my beloved and supportive parents, my sisters, my brothers whose prayers, guidance and support helped me to continue with studies and complete my degree and provided constant care to me.

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Chapter I

INTRODUCTION

Primary caregivers are considered as a backbone of family system. They play a significant role in the supervision of all mental illness. Most of the primary caregivers are spouses, parents, children and siblings and they are not only responsible for providing the financial support and personal care but also moral support to the patients with mental illness for a period of time ranging from months to years. The person with mental illness is fully dependent on the carer. That's why caregiving cause social, emotional, behavioral and financial problems for caregivers and cause various restrictions on their personal lives, socializing and relationships. Highly stimulating demands of time and assets are considered to lead to the undesirable physical and emotional costs for the carer. It covers a wide range, from mild irritation to drastic dysfunction that may cause severe health issues. It can include physical fatigue and deterioration of mental and physical health. This responsibility in turn can affect mental and physical health, resiliency and life satisfaction of primary caregivers of psychiatric patients. It can also lead to a burden on the whole family, such as emotional (shame, guilt, self-blame), psychological, physical and economic impact. The burden can result from stigmatizing attitudes of society towards mental patients and their families, and the lack of resiliency. Burden can also result from stigmatizing attitudes of society towards psychiatric patients and their families and lack of resilience.

According to different researchers in their early writings on the resilience, they focused on its progress in children and adolescents (Garmezy & Rutter, 1983; Werner & Smith, 1992).In recent years, there has been growing interest in the resilience in adults (Smith-Osborne, 2007) and families (McCubbin & McCubbin, 1996). Rutter (1999) was defined the concept of resilience defined as the relative resistance of the experience of psychological and social risks, and as a dynamic process that includes a positive adjustment in the context of substantial adversity (Luthar, Cicchetti, & Becker, 2000). Richardson (2002) described the resilience as "the process of dealing with difficulty, change, or opportunity in a manner resulting in the identification, strengthening and enhancement of the resilient attributes or protecting factors". Definitions of resilience in the care providers vary, (Gillespie, Chaboyer & Wallis, 2007), but they all share the trait of incapacitating difficulty to not only survive the everyday burden to care for a family members who is psychologically ill, but to succeed. That is, to grow into a stronger and more resilient people, and better person (Van Breda, 2001). Resilience theory emphasizes on the strengths owned by individuals or families that empower them to overcome adversity. The central ideas of the theory are the risk or susceptibility factors, positive or protective factors, pointers of resilience, and the outcomes of resilience.

The perception of risk factors such as events and circumstances associated with the adversity, or factors that reduce the individual's ability to resist stresses or overcoming adversity (Smith-Osborne, 2007). Potential risk factors in the care of a family member who suffers from a serious mental illness includes caregiver stress, and feelings of stigma, reliance of client, and family disintegration. Together, these factors can seriously negotiate the resilience of the caregiver (Zauszniewski, Bekhet, & Suresky, 2009). A family member in a family with a psychological illness puts the family unit and family members at risk for experiencing negative consequences in terms of physical and mental health of family members and family functioning. When psychologically ill family members living in the same place, and this may put caregivers at greater risk for health (Pickett-Schenk et al., 2006). The risk of the poor health may rise more when someone psychologically disturbed person call for constant supervision or direct personal care. If there is a lack of accessible, reachable, or inexpensive mental health facilities for families with an individual having psychological disorder has been recognized as a risk factor in several studies. (Pickett-Schenk, Cook, & Laris, 2000).

Some studies on the demographic features of the family caregivers of individual with psychological illness may increase their exposure to risk to their health, including age (Murray-Swank et al., 2006) and the level of education (Pipatananond et al., 2006). Studies proposed that elder family members and those with less education may be more susceptible to health problems and disturbances in the family performance.

Family caregivers who assess their condition where the threat is believed to be at greater risk as much as (Fortune, Smith, & Garvey, 2005). They may comprehend that caregiving as cumbrous or burdensome, (Perlick et al., 2008 ; Zauszniewski, Bekhet, & Suresky, 2009) and they may report the grander feelings of stress (Zauszniewski, Bekhet & Suresky, 2009) Life events more stressful, (Wang, Rong, & Chen etal., 2007), increasing the imbalance in the family performances. Perlick and colleagues (2008) identified a high use avoidance coping techniques by family members of persons who have psychological disorder. Even though avoiding coping may be a less than optimal level of handling the stress, it is likely that this method may also be protecting. Consequently, risk factors may be in one context and protective in another (Ungar, 2004).

The study was designed to discover the resilience of caregivers of individuals diagnosed with schizophrenia and bipolar disorder, as well as to examine whether the resilience affect the quality of an individual's life. For this purpose, a sample of 50 caregivers (25 from each group) lives with patients, aged 20-70 years were selected from the Department of Psychiatry at hospitals, organizations and clinics to deal with psychologically disturbed people situated in Delhi, National

Capital Region, India. Two standardized tools were used for this study, World Health Organization quality of life and Connor Davidson resilience scale. Results indicated resilience to be the same in both groups of care providers, i.e., there was no significant difference between the resilience in the care providers of patients with schizophrenia and patients of bipolar disorder. There was significant correlation between quality of life and resilience in the care providers of individuals diagnosed with schizophrenia and bipolar disorder caregivers. The results of the study was not compared which were obtained with the normal group of individuals to see whether and how the quality of life and the resilience vary from that of caregivers (Jain & Singh, 2014).

Since time centuries old, psychological disorders affect the lives of individuals throughout the world. There cure, treatment and care have been distress for the patient themselves, and also for their government, society and care providers. People live in a family setup, when any family member ill, it is family members who spontaneously appointed to take a good care of the individual during his disorder. Furthermore, as a result of de-institutionalization and the increasing transformation of the mental health care community, and the role of family care providers has increased significance (Kaushik & Bhatia, 2013). Thus, the responsibilities of care providers significantly increase because they must take care of the medical, financial and social needs of the patient along with their own personal needs. They, as members of the family of psychologically ill patient feel a lot of burden and pressures in the management of individual diagnosed with the disorder.

There have been many studies to determine the burden of care and reduce the resulting colonel in the resilience and quality of life (Marsh, Kersel, Havill, & Sleigh, 1998; Masten et al., 2004; Saarni et al., 2010). Social support has been recognized that may also mediate in the response of burden of care (Brooks et al., 1987). Talsma (1995), in a cross-sectional study evaluated a theoretic model of resilience. She noted that the chronic stress was one of the risk factors that have had an unfavourable effect on the resilience of the individual. In India, Math, Reddy, Chandrshekar, and Gururaj (2008) emphasized that the family burden and economic load was considerably higher in people with schizophrenia compared with other mental disorders. Kaushik and Bhatia (2013) presented a study on the burden and quality of life in partners of patients with schizophrenia and bipolar disorder. The results showed significant effects of gender and family type on the partner's burden. The quality of life of partner of people with psychological disorder to be slightly less than that of the general population. These studies make available to us with vision into the problems of care provider, yet, there are insufficient number of research studying the quality of life and resilience of care providers for individuals living with mental illness such as schizophrenia and bipolar disorder. Furthermore, a comparison between the combination of these two variables (QOL and resilience) together and how they affect the caregivers has not been tried. Therefore, this research was conducted to discover these aspects.

Stigma defined as an imperfection that is caused by personal or physical attribute that is perceived as socially intolerable (Blaine, 2000). And "the stigma associated with seeking psychological health facilities, therefore, is the belief that the person seeking psychological management is not desirable or socially unacceptable" (Vogel, Wade, & Haake, 2006). The presence of a public stigma (i.e., negative views of a person by others) surrounding psychological disorder and the pursuit of psychological services is clear. Previous studies have found that the public often describe people who suffer from psychological illness in terms of the undesirable (Angermeyer & Dietrich, 2006). For example, research survey showed that the most of the respondents of community report negative attitudes to the people who suffer from a specific disorder (Crisp et al., 2000), and tend to avoid and identify as serious those who have been regarded as a hospitalized previously (Link, Cullen, Frank, & Wozniak, 1987).

Most of the studies on stigma related with psychological illness have focused on people who suffer from schizophrenia or psychological ailment of severe illness. Nonetheless, there are some suggestions that people who suffer from bipolar disease can also be stigmatize (Faden, Bebbington, & Kuipers, 1987).

The research results revealed that the care provider stigma upsurges the burden of the caregiver in the case of Alzheimer's disease. Using this information, psychosocial involvements have to mark the stigmatic views so that the burden of the caregiver may reduce to some extent. (Werner, Mittelman, Goldstein, & Heinik, 2011).

People who suffer from psychological ailment are one of the most stigmatized layers of our society. According to Elliott and his colleagues, the public stigma related with psychological illnesses makes it psychological ill illegal socially. And it is seen that they are unable of usual interaction, hazardous and unpredictable, and these observations lead to their segregation from society (Elliott, Ziegler, Altman, & Scott, 1982). Therefore, they are facing a challenge not only because of their ailment but also the stigma and stereotypes that are accompanying with them by society. In Asian countries, and is estimated to constitute neuropsychiatric disorders that are comprise of 11.9% of the total burden of disease (WHO, 2008). In developing countries, less than 35% of psychiatric patients receive care (WHO, 2001). In spite of the accessibility of psychological health care (although minute), individual frequently do not ask the basic treatment because they fear the stigma of public shame and disgrace. Accordingly, we were stimulated the psychiatrists who treat the psychologically ill people to address the social framework, the nature of negative experiences, self-image and attitude of the society about the mental illness. Recognizing the adverse attitudes on the way to psychological illness is the first footstep in the planning of proper mental health policies and plans for the treatment of mentally ill people (Byrne, 2000). Not to recognize the public stigma and its consequences can result in the segregation of psychologically ill persons from the society (Goffman, 2009). Moreover, persons with psychological ailment who justify prejudice and accept self-stigma, which can lead to stress and can affect their ability to live independently (Corrigan, Patrick & Pennsylvania, 1999). Their increase in the tension may also lead to the mental complications such as depression (Link et al., 1997), and anxiety (Farina, 1981), and low self-esteem (Link, 1987).

Recognizing that the burden of care providers "is a global issue, the World Federation of Mental Health issued a report in the favour of that care for those people who have chronic illness have need of untiring exertions, energy, consideration and incontestably and significantly affects the daily lives of caregivers of psychiatric patients. More frequently, primary care providers are given to be little appreciation for this respectable act, and policies in most of the countries do not arrange for economic sustenance for care services they afford. The physical and emotional health of primary caregivers of psychiatric patients is frequently disregarded when they struggle to achieve a balance between work and family and caregiving. In relation with the lack of personal, economical and emotional assets, many caregivers regularly face enormous pressure, depression, and / or anxiety in the year after the start of provision of caring their patients with psychological ailment (World Federation for mental Health, 2010).

The negative effects for the care of family members suffering from chronic psychological ailment have been studied since the early 1950s, when psychiatric foundations began settling patients to the society (Chan, Mackenzie, Ng & Young, 2000; Reine et al., 2003). A burden on the family denotes to the significances for those who are in close contact with someone with a severely distressed person with psychological health issues. Some authors differentiate well between the objective and subjective burden. Objective burden respect to the symptoms of patient, behaviour, societal and demographic features, and factors such as changes in family routine, family or social relationships, work, and relaxation, psychological and physical health and subjective burden id self-distress and distress among family members (Raine et al., 2003). From the 1970s to the 1980s, the term burden has been used to define the negative effects of mental disorders to primary caregivers. It has been studied about the burden of care providers to determine the possibility of discharging the patient in the public to enhance the progress or to improve the concept of caregiving and its fundamental construction and subjects (Chien, Chan, & Morrissey, 2007). In recent years, view of the burden of providing care has been expanded to involve the physical, mental, societal and economic problems of the families caring for a nearby with a chronic or severe psychological illness. The acceptance of this opinion by the international community (World Federation for Mental Health, 2010).

Research evidence from various countries on family caregivers of people with schizophrenia commonly support that there is insufficient assistance and support to primary caregivers (Chan, et al., 2009). Research has regularly designated that primary caregiver's statement a high level of burden on care for their family members living with psychological illness. Mental health of family caregivers may become seriously weakened (Cuijpers & Stam, 2000). Many family caregivers reported the lack of knowledge and skills necessary to take care the responsibilities of providing sustenance to these patients of family having psychological disorder. Thus, they are not able to deal with a large amount of the roles and responsibilities of care (Chan et al., 2009). Families frequently face the daily pressures of behaviours that are unexpected and strange of their relatives with schizophrenia, external pressures of stigma and segregation of the family and emotional obstruction, such as guilt and isolation, and family struggles in the care procedure. Often, noticeable adverse impacts are stated by the primary care providers, including depression, anxiety, grief, and physical complaints. Setback client and re-input are very common of the clients (Chan & Yu, 2004; Martens & Addington, 2001).

The burden that was observed in the family caregivers of people who suffer from schizophrenia in different regions and cultures. In Europe, Canive et al. (1996) Spanish study defined various major effects of caring the patients with psychological ailment, which included the deprived health of family caregivers, and the disturbance of social and recreational events and resident practices, and a decline in household earnings. In Italy, Magliano et al. (1999) examined the burden and coping strategies of the main relatives of patients with schizophrenia and found that levels of the burden on the primary relations did not differ much from those that on other relations. They concluded that it is essential to arrange for maintenance strategies to the largest possible number of relatives. In Switzerland, Lauber et al. (2003) determined that the most important predictor of the burden is the connection between care providers and patients with aggravating schizophrenia. There are substantial modifications in the affiliation during the chronic phase of the illness. Other factors of burden include dangers, harassment, time, social and recreational accomplishments. Lauder et al. proposed that the families should be trained to deal with the burden. They have to learn how to deal with annoying behaviour and conduct and make necessary modifications in the relationship of caregiver with the patient. Relatives have to be involved in determining whether a patient have to be taken to hospital or not. In a Swedish study (Ostman, Hanson, & Anderson, 2000), it has been investigating about the family burden and involvement in the care of people to both willingly and forcibly admitted patients with mental illness. It was found that interventions to create a network that is well established, work well in families where relatives have seen mental health problems are useful. A different Swedish study of Hjarthag, Helldin, Karilampi, and Norlander (2010) recognized that the increase in the burden of family may be linked to the increasing severity of the patient's symptoms of illness, and considered that the decreased functioning was the single greatest influence on burden on the family members. It was noted that specialized maintenance to control psychiatric symptoms and increase the daily functioning of the patient can decrease the burden of the family.

It is proposed in a comparative study of the European American and Latinos (Jenkins & Schumacher, 1999) that the kinds and stages of burden of family members can be associated to the circumstantial features including sexual role, race, diagnosis, and living conditions. Mexican Americans study (Magaña, RamirezGarcia, Hernandez, & Cortez, 2007) reports that between 12% and 18% of family care providers come across the deadline for being at a danger of having depression. The younger age care providers, low educational levels of caregivers, and higher levels of patient symptoms of psychological complaints were prognostic of sophisticated levels of symptoms of depression. Perceived burden of care providers intermediated the association between psychological symptoms of patients and depression of care providers. "Was associated stigma largely seen for caregivers," Caregivers symptoms of depression. In a US study (Biegel, Shafran, & Johnson, 2004), it was explained that the pace of customer behavioural symptoms and decrease the amount of support seen from family members, and developed the level of the overall burden of care provider.

In the Asian regions, so many communities are controlled by Confucian ideologies, with a strong focus on the explicit characters and sound relationships between family members, and thus keep the balance. Occurrence of psychological ailment in a family member commonly results in mental and emotional conflicts for the whole family (Chien & Chan, 2005). A study in Malaysia (Chang & Horrocks, 2006) described that family care providers have to deal with the impact of the stigma of psychological illness of their relatives. A research of the Hong Kong Chinese families described that a large part of the burden was associated to the stigma and a lack of psychological health services and therapeutic facilities. And included the significances of the care is families social segregation and economic problems. And social stigma causes personal burden as a result of stressors, anxiety, low self-esteem, hopelessness and dependence occur (Tsang, Tam, Chan, & Zhang, 2003). In Thailand, people desired to take care of the psychologically ill patients at their home. The qualitative study described that families however considered caring of their mentally ill relatives as suffering. "Suffering" denotes to the undesirable that is giving to mentally ill relatives including Somatic burdens, emotional suffering, financial problems and the stigma about psychological ailment, and the deficit of information about psychological disorder and its indications (Sethabouppha & Kane, 2005). In India, Gururaj, Math, Reddy, and Chandrashekar (2008) study indicated that the burden of the family and economic burden both were considerably higher in people suffering from schizophrenia as compared with other psychological disorders, such as OCD (obsessive-compulsive disorder). And this maximized the burden and that was caused of disturbance in routine of family activities and entertainment.

So all the evidences showed that the difficulty of the family burden of caring for those relatives having schizophrenia disorder is a task in both highly advanced and emerging nations. It seems that the main effects of providing care, such as emotional disturbance and depression, and decrease in the opportunities for social interaction, economic problems, are communal in different nations. Psychological disorder originates with the supplementary burden of the undesirable tag. It is most frequently stated that the burden of care crosswise the researches is the stigma associated with psychological ailment. Stigma against psychological ailment is still a worldwide phenomenon and it is an exact and actual difficulty for those people who have any psychological disorder and their families. The stigma can cause a threat to the self-image, interaction with others, and occupation of a person who have schizophrenia disorder. It can also cause similar extortions to family members of the patient. Predisposition and judgement can cause as a result of stigma. It can also disappoint the family care providers to ask for help. So it is very necessary to help care providers of family and people who suffer from schizophrenia so that they can deal with the stigma. Minimizing stigma also needs public psychoeducation and the desire of persons to encounter the stigma related with psychological ailment.

Idstad, Ask, and Tambs (2010) described their study which is related to the burden of living with someone who is mentally ill, and more explicitly the relationship between psychological illness in the individual and symptoms of anxiety and depression and personal well-being in the significant other. Altering for numerous variables involved, and record of the people who suffer from considerably less on the personal well-being and considerably higher on the indications of anxiety and depression, as compare to those people who are without psychological illness. In spite of the utmost importance, there was a moderation in the effect sizes, corresponding to a difference in the standard deviations ranging from 0.34 to 0.51. And it supports the idea that there is an relationship between psychological disorder in one partner and the burden in the partner, but not as much as that has been stated in previous studies, as the entire results didn't specify that a huge amount of the couples reach the level of symptoms of anxiety and depression, which reveals psychological illness.

Researchers usually reach a decision that psychological illness denotes a burden on the care providers and the family of the person who is suffer from psychological disorder (Ohaeri, 2003; Baronet, 1999). Interest emerged in the burden of care provider when psychiatric patients commenced to be deinstitutionalized (Kuipers & Bebbington, 2004). The burden of care provider states to an excessive contract of stress and complications faced by the family or care provider of the psychologically unwell people, containing a wide array of mental, emotional, communal, somatic and economic complications (Kaufer, Borson, Kershaw, & Sadik ; Magliano et al., 2005).

Different studies on the burden of care provider has conventionally concentrated on the relatives of persons who suffer from chronic psychological disorders such as schizophrenia (Saunders, 2003; Awad & Voruganti, 2008), bipolar disorder (Ogilvy, Morant, & Goodwin, 2005), dementia (Cuijpers, 2005).

Rose, Mallinson, and Gerson, (2006) studied on the means for psychological health care, family interferences need to assess those ranges that respond to the needs of families that are conveyed. Even though the burden of the family has been acknowledged, it does not know much about the areas of distress that families feel they need to direct support with, to be an active care provider for those family members who suffer from psychological illness. Telephone interviews were arranged with 30 family members of the psychologically unpleasant people. The evaluation of the burden, and a sense of mastery, and care providing situations was done. Flexible questions were raised for the additional considerations of care providing apprehensions. The greatest identifiable burden was "have to worry about the future." The most apprehension was "to deal with grief and sadness." So they were recommended in the study to evaluate the family's concerns.

Earlier studies have revealed that care providers who are familiar to the patients suffering from psychological disorder in Europe, (Angermeyer, Schulz, & Dietrich, 2003), Australia (Winefield & Harvey, 1994), Asia (Zahid & Ohaeri, 2013), and Africa (Elmahdi et al., 2011) face the modest to greater levels of care provider burden. On the other hand, the socio-demographic and clinical features accompanying with the burden of care providing differ through researches. Factors that incline to be constantly connected with a greater burden levels through the studies including the psychological illness of the patient and rigorousness of symptoms (Awad & Voruganti ; Zahid & Ohaeri, 2010), and low academic achievement in the care providers (Caqueo-Urízar & Gutiérrez-Maldonado, 2006; Zahid & Ohaeri, 2010) and the lack of social support (Magliano, Faden, & Madianos, 1998; Ohaeri, 2005).

Shah, Wadoo and Latoo (2010) reviewed some studies about the burden of care providers in psychological disorders. Families face the main duty for this care. Caregiver experience the psychologically disturb health as a straight results of the role of their care and face greater amount of psychological ill health then the overall inhabitants. Production burden on care providers is a difficult procedure and is linked to sex, age, and fitness, position in the society, indigenous and cultural association, and lack of social support, managing style, in spite to the pressures of the same disorder. It seems that caregivers suffer from at least modest levels of mental symptoms of any psychological disorder. The behavioral difficulties accompanying with psychological disorders also upsurge the anxiety levels of caregivers. The results of the review of carrying a widespread understanding of the situation of care provide with its results, and applied implications in the development of effective policies to support the family care provider.

According to the World Health Organization (WHO), around 450 million people suffer from mental illness (WHO, 2010). People who suffer from mental illness and their families frequently suffer from the stigma, social seclusion, poor quality of life and a numerous psychological, social and socioeconomic complications (Chan, 2011). Widespread figure of research which is published revealed that the severe mental illness have a disastrous effect on huge numbers of people all over the world, and these situations are forecasting to many social and psychological effects which is negative for people as well as for their families (Hanzawa et al., 2010). There are different cases of the negative effects that patients and their care providers were experience different levels of burdens, stain, discrimination, and poor personal relations (Tan et al., 2012); low professional performance or loss of social support; (Hanzawa et al., 2010), and the poor quality of life (Boyer et al., 2013). In fact, the complication of the treatment and the difficulties which are come across with various mental illness makes it difficult to clearly regulate the optimum level of quality of life can be achieved among patients who suffer from these diseases and their care providers.

Many prolonged diseases subsidize in the overall burden of disorder. Nonetheless, prolonged mental illness subsidize to 14% of the total overall burden of disorder (WHO, 2010). Even though there are fruitful and beneficial treatments known for most of the mental illnesses, still most of the affected population, and up to 75% in many under developed countries, do not have even avail such treatments (WHO, 2012). It can includes lack of resources and care, and the lack of trained health care providers and social stigma associated with mental illness that are the obstacles to successful psychotherapy and psychological treatment (Chan, 2011; Tan et al., 2012).

According to numerous studies, the negative effects of disgrace and discrimination on both the patients and their families. A research Study conducted in Jordan confirmed that the stigma related to mental illness is a major concern for family members. Stigma experienced by family members in their daily livings may inhibit with the better outcome and quality of life of the caregivers who are ill, as well as for their families (Dalky, 2012). Furthermore, perception of stigma between family members, as well as for the patients. Subsequent in fear, low self-esteem, shame, embarrassment, privacy, (Satorius, 2012) isolation and distrust, anger and an inability to adapt, and despair, or disability (Dalky, 2012).

Further, perceived caregiver burden has been associated with premature institutionalization and patient reports of unmet needs (Bastawrous, 2012). All over the world, family care providers are considered to be responsible for long lasting care to those patients who are chronically ill. It has been renowned as an activity to provide care with the benefits and burdens (Bastawrous, 2012). Many research studies have been stated the presence of different types of burden as seen by family caregivers. The burden of providing care has different definitions that depends on the views of cultural and family look of a group of the population which is under observation. In this research, it has been activated as the sum of points on the caregivers' index scale in Arabic version by Kamel et al. (2012). And consequently, care providers may be susceptible to several physical, psychological and social problems including depression, sadness, fatigue, changes in social relations (Bastawrous, 2012; Bauer et al., 2012; Chan, 2011). Moreover, the perceived burden of care was related with institutionalization and the patient's previous records of unmet desires (Bastawrous, 2012).

Some research studies have used the term quality of life (QOL), well-being and functioning interchangeably with life satisfaction (Post, Witte, & Schrijvers, 1999). Life satisfaction is frequently denoted as the global quality of life (QOL) (Veenhoven, 2000 ; Elawsky, et al., 2005). In the main emphasis of treatment for prolonged illnesses, the present health care system has perceived significant modifications. The main purpose of handling prolonged illnesses has modified from improving symptoms to increasing and preserving the quality of life of patient and several social events (Sidlova et al., 2011). Therefore, the notion of quality of life has become one of the main indicators for the evaluation of treatment efficiency for all kinds of illnesses. In the field of clinical psychiatry, the level of QOL has been evaluated as an sign of the treatment efficacy of or schizophrenic reintegration and other psychological illnesses. Indeed, considering quality of life of both primary caregivers' and patients' will enhance and offer required facts for clinicians, for the development of different interventional plans that can improve the health outcome of patient and caregiver.

In recent times, the quality of life concept has gained more consideration from clinicians and health care givers. It is important to assess or determine the general health of patients who suffer from chronic mental illnesses, as well as their care providers (Barnes et al., 2012). Many aspects, such as stigma and burden are described to have an effect on the perception of the quality of life for carer and patients who suffer from mental illness (Bauer et al., 2012). This makes it strong that why it is very essential to examine these aspects and determine which ones are related with the quality of life for each of the families and patients who suffer from mental illness.

Psychiatric patients' de-institutionalization has great focus on management of the family in society, and those family members are frequently overwhelmed by the overloads of the patient having schizophrenia. Most studies of the burden of the family has taken in schizophrenia in developed countries. The study of family burden and related in a local area of South American countries with medium-income which includes sixty-five relatives of schizophrenia patients who were attending a ceremony of public mental health out-patient services in the Arica province, Chile, were assessed on burden of Zarit caregiver and Health Survey SF-36. The results showed the level of caregiver burden was very high, mainly for mothers and care providers who were less educated and caregivers of younger and care providers of those patients who suffer from more hospitals in the three previous years. In statistical analysis, relationship and a number of most recent hospital reserved contrast predictive variance. On SF-36 subscales, the burden was stronger predictor. It was revealed that family members of patients suffering from schizophrenia in the local areas of Chile reported high levels of the burden of functional and related to heath issues. The study shed light on the support needs of caregivers in the backgrounds of high poverty and limited health resources and community levels (Gutiérrez-Maldonado, Caqueo-Urízar, & Kavanagh, 2005).

Mental health care that focuses on the community has put increased responsibility on families to care the patients with mentally ailment. This was caused by a large and increasing number of people suffering from mental illnesses. According to the World Health Organization (1990), psychological conditions were the five out of the 10 main causes of incapacity that was measured all over the world in the years lived with a disability: depression, schizophrenia, mood disorders, alcoholism and obsessive-compulsive disorder (Murray & Lopez, 1996). It is predicted that by 2020, major depressive disorder will be flew to second place which has already at the fourth out of the ten (Brundtland, 2001). More than 450 million people in the world suffering from psychological disorders. This involves 121 million people suffer from depression, 24 million from schizophrenia, and 37 million suffer from dementia (WHO, 2001).

In reaction to the huge and increasing number of those people who are suffering from psychological disorders and their effect on family members, and began to include their families in research who suffer from mental disability. A number of reviews from previous researches have revealed that psychological illness results in a substantial burden and worry in the family (Faden, Bebbington & Kuipers, 1987; Maurin & Boyd, 1990). Vaddadi, Soosai, Gilleard and Adlard (1997) reported that 79% of care providers of people with mental illnesses shows a great deal of emotional distress / psychological disorder.

Barrowclough and Barley (1997) proposed that 57% of caregivers with high levels of psychological distress when admitting the patient to the hospital, in 30% of care providers, this psychological stress has remained with the same intensity when the patient came back to the house. In a literature view by Cummins (2001) on care providers of those people who suffer severe disabilities, he said all of these research studies analyzed higher than normal levels of distress among care providers. The main theme in these research studies the level of anxiety and depression was higher than normal.

Life Satisfaction is well-defined as a sensible, intellectual, universal sentence of one's own life. It is not a valuation that is based on superficially imposed objective values, but quite depending upon evaluation of one's life situations to one's own internal values (Pavot & Diener, 1993). Life satisfaction with respect to wellbeing by Deiner, Biswas, and Diener (2002), proposed that wellbeing or happiness has both an intellectual (judgment) and emotional (emotive) aspect. The emotional aspect comprises of low often an individual explain his positive and negative experiences. Satisfaction with life is measured to be the intellectual aspect of this wider concept.

Life satisfaction with respect to life domain differentiate between the satisfaction of life domain with explicit zones of life of an individual like employment, marital status, and socioeconomic, whereas global judgments. Life satisfaction is much wider containing of wide-ranging judgment of life of an individual (Sousa & Lyubomirsky, 2001).

Personal strength for life satisfaction is described as awareness of individuals' own distinctive strength, of how to take benefit of them, to bring happiness to the individual, and fulfilling life. An individual purpose goal to distinct capacities and strength to take advantage by expending them each and every day. (Sosusa & Lyubomirsky, 2001).

The Life Satisfaction Index A (LSI-A), is a multi-dimensional tool designed to indicate previous and present experiences of a person and the impact of these tests on the complete life satisfaction of the person (LS) as a successful aging measure (Neugarten, Havighurst, & Tobin, 1961). Al Windi (2005) revealed that the Life satisfaction, was a strong predictor of professed health beside with depression and a number of symptoms. Other factors seen from the Enkvist et al. (2012) to be associated to life satisfaction of those people whose age range from 78-98 contained within marital status, education, and functional capacity. Research studies on the life satisfaction of caregivers using the LSI-A are very few. Broe et al. (1999) showed that providing personal care by the caregivers reported less life satisfaction caused primarily caused by a stressful relationship with the person who cared for.

Bailey and Snyder (2007) conducted a research on life satisfaction and research finding revealed that satisfaction with life was significantly positively associated to optimism, self-efficacy, locus of control, self-esteem and looking for social support. Optimism, self-efficacy, locus of control, self-esteem, and looking for social support are protecting features of resilience.

Fredrickson et al. (2003) conducted a research on the relationship and life satisfaction in faction and resilience which the relationship of life satisfaction was consistent and revealed that there was positive correlation between resilience and life satisfaction and satisfaction with life was also suggestively associated to the resilience. Level of satisfaction with life of those student who were resilient, significantly high scorer than those of students who had low resilience. King (2000) concluded that resilience was not only positively correlated to satisfaction with life among individuals, but also resilience significantly predicted satisfaction with life.

It is taken a significant amount of time for the role of carer, which limits the time available for the chase of social and recreational activities and job opportunities. Also, care providers should deal with the recession and transforming nature of mental illness and challenging behaviour of mentally ill recipient. Discontinuous features of a psychological illness are described highly unpredictable of that is the most difficult to live with someone in such circumstance (Sveinbjarnardottir & Dierckx de Casterle, 1997), as a care provider is essential continuously readapt the caring response to this irregularity (Collings & Seminuik, 1998). In general, it can be viewed that role of caregivers could jeopardize mental health of care providers, but these are not uniform among individuals. Remarkably, even under accurately parallel circumstances, some people are capable to adjust in a better way to the role of caregivers while others easily become emotionally destroyed. One of the most important aspect that could make a big difference in the mental health of people in unfavorable conditions, but that is frequently disregarded, is the personality of the individual. It refers to permanent personal style, distinctive ideas, emotions and behaviors that describe the way of an individual adjust to the world (Santrock, 2003).

In spite of the problems related with providing care to the psychologically ill patients and a huge number of persons concerned, and experimental research on the issue meager to some extent in Nigeria (Abikoye, 2007 ; Kabir, Iliyasu, Abubakar, & Aliyu, 2004; Omonzejele, 2004). There is emerging concern that the ranks of people who need or are experiencing treatment for psychological problems and swelling at an unparalleled rate in Nigeria, but not so much has been done in the light of understanding the psychological and social issues that are involved. This signifies a great risk not only to care providers but to the community as a whole because of the consequences of ignoring this group of at-risk populations can be distressing. This study examined the effect of the core self-evaluations and demographic variables on the mental health of family caregivers of people with psychological illness in southwestern Nigeria. It was hypothesized that care providers of persons suffering from mental illness will be suggestively poorer on the mental health of people in the control group, and that would be the essence of core self-assessment and some demographic variables operations (age, sex, marital status, employment status, education) play important roles in mental health among of caregivers of people suffering from mental illnesses.

1.1. Rationale

Various studies have been conducted to examine the etiology, epidemiology and management patterns of psychological disorders and mostly focused on the patients. Less importance is given to the problems of the care providers who take care of the patients and the clinicians hardly give any consideration to their issues. As compared to the West, there are very few studies about the effects of a mentally ill member on the rest of the family in Pakistani settings. The goals of the study is to determine the psychological and emotional stress associated with the role of the carer, and the role of perceived stigma and burden of psychological ill patient on the resilience and life satisfaction of caregivers.

In Pakistan, a study was conducted on the level of depression and anxiety among eighty caregivers of Schizophrenia, substance abuse and depression. This research study was a comparative study with the aim of measuring the level of depression and anxiety among the caregivers of patients having different psychiatric illnesses. The research findings indicated that caregivers of the patients having schizophrenia, depression and substance abuse, have substantial high level of depression and anxiety and there were significant gender differences (Basheer, Niazi, Minhas & Najam, 2005).

Another study was conducted on Burden of care in caregivers of patients with Schizophrenia and Epilepsy. Result revealed that more than half of the primary caregivers showed high level of burden of care and the most of them had mental health problems. (Anjum, Chaudhry & Irfan, 2010).

This study can be effective to reduce the burden accompanied with the care of patients who suffer from mental illness. By the help of this research, the focus can be put down on anticipation, early diagnosis and immediate treatment for psychological illness. Societies can be educated about the nature of psychological illness in an effort to reduce the burdens, stigma and pressures on the development of resilience and life satisfaction through various interferences for caregivers of patients with psychological illness. Doctors can also pay attention to the needs of the care providers of patients who suffer from psychological illness. The implications of this study is to work on a therapeutic program that will emphasis on improving the psychological characteristics of the care providers that will ultimately sustain satisfaction with life, which in turn improve their resilience as well.

Keeping in view the significance of this research, it is recommended that the doctors, psychiatrists, psychologists, therapists and other health personnel will not only offer support to the patients with psychological illness but also give appropriate consideration to the caregivers of the patients. Therefore, this research is scheduled to learn about the burden of carer, and how much dramatically affect the resilience and life satisfaction of the care providers of patients with psychological illness and mental health problems associated with caregivers of patients who suffer from psychological ailment. This could be a useful way to generate statistics that can monitor the management plans about the mental health of caregivers in future.

METHOD

2.1. Objectives

Following are the objectives of the study:

1. To find out the relationship between resilience, burden, perceived public stigma and life satisfaction.
2. To study the moderating effect of resilience on burden and public stigma among primary caregivers of psychiatric patients.
3. To examine the effect of demographic variables (gender, socio economic status) on perceived stigmatization, burden, resilience and life satisfaction.

2.2. Hypotheses

1. A positive relationship exists between resilience and life satisfaction among primary caregivers of psychiatric patients.
2. A negative relationship exists between burden and resilience among primary caregivers of psychiatric patients.
3. A negative relationship exists between burden and life satisfaction among primary caregivers of psychiatric patients.
4. Perceived stigmatization negatively correlates with life satisfaction among primary caregivers of psychiatric patients.
5. More resilience leads to less perceived stigmatization among primary caregivers of psychiatric patients.
6. Perceived public stigma has positive effect on burden among primary caregivers of psychiatric patients.

7. Resilience has negative moderating effect on relationship between burden and public stigma among primary caregivers of psychiatric patients.
8. Female caregivers are more burdened then male caregivers.
9. Male caregivers have more life satisfaction then female caregivers.
10. There are socioeconomic differences in burden among primary caregivers of psychiatric patients.

2.3. Operational Definitions

2.3.1. Primary caregiver:

It is defined as giving concrete care, support and mutual sustenance to those family members who are experiencing any type of psychological complications and they are not even capable to accomplish certain responsibilities at their own. In these circumstances, Care providing is the addition of astonishing care that goes away from of normal care (Arunima & Ranjee, 2013). In this research, these will be the person among the family members who is mostly taking care of patient.

2.3.2. Psychiatric patient:

It is defined as a person who's having mental disorder, a syndrome considered by clinically significant disturbance in cognition, emotion regulation, or behavior of an individual that reveals a dysfunction in the psychological, biological, or developmental courses underlying psychological functioning. Psychiatric disorders are usually related with substantial disturbance in social, occupational, or other significant accomplishments. Psychiatric patient will be a diagnosed person by a psychiatrist working at a psychiatric/mental health setting.

2.3.3. Perceived Public Stigma:

It is the person's negative estimate. It is a smudge or flaw that is a result of an individual, mental or physical characteristic that is noticed as publically intolerable (Blaine, 2000). In the present study, individuals' high scores on scale of perceived public stigma will show rate of perceived public stigma in primary caregivers.

2.3.4. Caregiver Burden:

It can be defined as the existence of difficulties, complications, resulting distress or adversative effects which affect the lives of caregivers of psychiatric patient e.g. members of family (Platt, 1985). In the present study, individuals' high scores on scale of Caregiver burden will show the level of burden in primary caregivers.

2.3.5. Resilience:

It is defined as the process of handling with difficulty, transformation, or opportunity in such a way that the outcomes in the identification, strengthening, and improvement of qualities of resilient or shielding aspects and dealing or coping with the problems with different strategies (Richardson, 2002). In the present study, individuals' high scores on scale of resilience will show rate of resilience in primary caregivers.

2.3.6. Life Satisfaction:

It is well-defined as a sensible, intellectual, universal sentence of one's own life. It is not a valuation that is based on superficially imposed objective values, but quite depending upon evaluation of one's life situations to one's own internal values (Pavot & Diener, 1993). It shows that one has a settled life with contentment. In the present study, individuals' high scores on scale of life satisfaction will show rate of satisfaction with life in primary caregivers.

2.4. Instruments

2.4.1. Perceived Devaluation–Discrimination Scale:

This scale was developed to measure the Perceived public stigma. It consists of 12 items (Link et al., 1987), reporting scale in a Likert-type fashion from 1 (strongly agree) to 6 (strongly disagree). Representation of higher scores is greater perceived stigma. It has internal consistency range from .76 to .88 among clinical and community samples (Link et al., 2001). For this study, the Urdu translated version of Perceived Public Stigma Scale by Yaqoob and Kausar (2014) was used.

2.4.2. Zarith Burden Interview (ZBI):

This scale was developed to assess caregiver burden in relatives of patients with chronic mental illnesses. It is a 22-item reporting scale in a Likert-type. This measure includes those features which were most frequently stated by the caregivers as problematic zones while caring for mentally ill patients. The features contain the health of caregiver, socioeconomic, psychological wellbeing, societal life, and relationship between caregiver and recipient (patient). The instrument has a scoring range of 0 to 88, depending on the responses of caregiver. Zarit (1986) originally suggested 61 to 88 score range as severe burden, 41 to 60 as moderate to severe, 21 to 40 mild to moderate burden, and at less than 21 little or no burden. Depending upon the level of distress, responses are rated from 0 to 4,. The validity of the ZBI is assessed at .74 and .66 (Bedard et al., 2001) and internal consistency; Cronbach's alpha = 0.83 and 0.89 (Zarith, 1980). For this study, Urdu translated version of Burden Interview (Butt & Bashir, 2014) was used to assess caregiver burden.

2.4.3. Connor-Davidson Resilience Scale (CD-RISC):

This measure was developed by Connor and Davidson (2003), to measure resilience. It is a 25 items scale, in a Likert-type fashion and self-reporting scale and each item was rated from "not true at all" (1 point) to "true nearly all the time" (5 points). Internal consistency of the Connor-Davidson Resilience Scale is (Cronbach's Alpha = 0.94). Urdu translated version of Resilience scale (Naz, 2011) has used to assess resilience for this study.

2.4.4. Satisfaction with Life Scale (SWLS)

This measure of life satisfaction was developed by Ed Diener and colleagues (Diener, Emmons, Larsen & Griffin, 1985). It is in a Likert-type and self-reporting scale, consisting of 5 items. Each item was rated from "strongly disagree" (1 point) to "strongly agree" (5 points). Scoring range of 31 to 35 for continuous extremely satisfied, 26 to 30 for satisfied, 21 to 25 for slightly satisfied, 20 for neutral, 15 to 19 for slightly dissatisfied, 10 to 14 for dissatisfied and extremely dissatisfied from 5 to 9. Internal consistency of satisfaction with life scale is (Cronbach's Alpha = 0.87). Urdu translated version of Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) was used to assess life satisfaction for this study.

2.4.5. Demographic Profile

A demographic datasheet was created to collect the data from the caregivers.it consists of those variables which are related to the characteristic of the sample population as used in the research study. This datasheet included information about age (patient and caregiver), gender (patient and caregiver), education, disorder of patient, Duration of illness, relationship with patient, socio-economic status, time spend with the patient, any medical illness (Patient and caregiver), Number of caregivers.

2.5. Participants

In the present research, the sample consisted of 250 (males=125 and females=125) primary caregivers (parents, spouses, children and siblings) of diagnosed psychiatric patients with the age range from 20 years to 60 years. The sample of the study was selected by using purposive convenient sampling method. The sample included mentally ill patients from outpatient department and inpatient department of different private and government hospitals (Benazir Bhutto Hospital, Rawalpindi, Capital Hospital, Islamabad, Al-Shifa Hospital, Islamabad, Bilal Hospital Rawalpindi, PIMS hospital Islamabad, Holy family hospital, Poly clinic Hospital Islamabad) in the vicinity of Rawalpindi and Islamabad.

2.5.1. Inclusion Criteria

primary caregivers (parents, spouses, children and siblings) of already diagnosed and referred case by the psychiatrists and psychologists were taken with the age range from 20 years to 60 years and with those patients who were with stable medical condition were included in the sample. Caregivers who were active and accompanied patients were the part of this study.

2.5.2. Exclusion Criteria

Primary caregivers of those patients who were in alarming condition, were not included. Those caregivers who were not willing to participate nor active and were in hurry, were not the part of this study. Care givers who were beyond the age range were not included.

2.6. Procedure

This research study was carried out in twin cities i.e. Islamabad and Rawalpindi. First of all, permissions were taken from the authors of the translated versions of scales for this study. Afterwards, permission was taken from the consultants of the hospitals. After taking permission, the study was conducted by approaching the caregivers of mentally ill patients in different government and private hospitals. The caregivers were briefed about the objectives of study and assured about the maintenance of confidentiality of their responses that would be used only for research purpose. By taking informed consent from the respondents. After that, they were requested to fill the questionnaires by giving response to each item of every questionnaire. All their queries were addressed at that time and they were encouraged to provide as accurate information as they can. Finally, questionnaires were collected and they were thanked for their cooperation. At the end scoring and analysis was done.

	OCD	14(5.6)
Hospital	Benazir Hospital	80(32)
	Capital Hospital	55(22)
	Holy Family Hospital	15(6)
	Al-Shifa Hospital	10(4)
	PIMS	40(16)
	Poly Clinic Hospital	30(12)
	Others	20(8)
Relation with patient	Parents	80(32.0)
	Spouse	36(14.4)
	Sibling	85(34.0)
	Children	49(19.6)
Time with patient	Full time (24 hrs.)	68(27.2)
	Most of the time(12>)	128(51.2)
	Less time(12<)	54(21.6)

Table 1 shows the frequency distribution of all the variables involved i.e., age, gender, marital status, social economic status, disorder, hospital, relation with patient and time with patient. There are 50% male and 50% female amongst the total of 250 respondents. Above mentioned table shows that the majority of respondents which is 44.8% lies in the age group of "21-30" whereas 30.0% of whole sample lies in the age group of "31-40", 20.4% of respondents lies in the age group of "41-50" and only 4.8% lies in the age group of "51-60". Furthermore majority of respondents i.e., 68.4% is married whereas 31.6% of respondents are unmarried.

According to the above tabulated frequencies there are 20.8% of respondents belongs to lower class families, and the large number of respondents which is 79.2% belongs to middle class families whereas 31.2% respondents suffered from depression, 21.4% suffered from anxiety, 11.2% from schizophrenia, 15.2 from bipolar disorder, 8.4% from conversion disorder, 6.8% from PTSD, and 5.6% from obsessive compulsive disorder (OCD). Respondents from Benazir hospital was 32%, while 22% from capital hospital, 16% from PIMS, 12% from poly clinic, 6% from holy family hospital, 4% from Al-shifa, and 8% from others.

The above provided table exhibits that the 32.0% of parents, 14.4% of spouse, 34% of siblings whereas 19.6% of respondents are in relation with patient. In addition to these facts there are 27.2% of respondents spent full time, 51.2% of them spent most of the time whereas only 21.6% of respondents spent less time with the patient.

Table 2

Psychometric properties of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview (N=250)

			Score Range			
Scales	*M*	*SD*	Potential	Actual	Skewness	Kurtosis
Resilience scale	47.6	22.4	8-96	0-100	.30	-.96
Perceived Public Stigma	42.0	8.1	26-57	12-72	.00	-1.22
Life Satisfaction	17.1	7.4	5-35	5-35	.59	-.65
Burden Interview	51.5	18.1	10-77	0-88	-.16	-1.02

Table 2 shows the psychometric properties of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview which shows that all the scales show the skewness of Resilience Scale, Perceived public stigma scale and Life satisfaction is within range of +1 to -1 which indicates that the data of all variables is normally distributed.

Table 3.

Reliability statistics of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview (N=250)

Scales	No. of items	Cronbach's α
Burden interview	22	0.93
Life Satisfaction	05	0.84
Perceived public Stigma	12	0.78
Resilience Scale	25	0.93

Table 3 exhibits the chronbach alpha reliability of scales Burden interview, Perceived Public Stigma, Resilience scale. The overall alpha reliabilities of all scales are satisfactory and appropriate to use on the sample of this study.

Table: 4

Pearson's correlation coefficient of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview (N=250)

Variables	1	2	3	4
1. Burden Interview	-	-0.65^{**}	0.38^{**}	-0.60^{**}
2. Life Satisfaction		-	-0.43^{**}	0.59^{**}
3. Perceived Public Stigma			-	-0.43^{**}
4. Resilience Scale				-

$^{**}p < .01$

Table 4 noted that BI is negatively correlated to LS with its correlation coefficient i.e., -0.65 a significant value with reference to the level 0.01. But BI is positively correlated to PPS with correlation coefficient at 0.38 which is also significant at the level 0.01. Here exists another negative correlation between BI and RS which is significant at level 0.01 with its coefficient of correlation at -0.60. In the case of LS, there exists negative correlation (-0.43) as well as positive correlation (0.59) with the variables PPS and RS respectively. Moreover PPS variable has a significant negative correlation with the variable RS.

Table 5.

Multiple regression analysis to test the effect of resilience on perceived public stigma among primary caregivers of psychiatric patient. (N=250)

	Perceived public stigma	
		Model 1
Variables	*B*	95 % CI
Constant	49.40***	[47.25, 51.55]
Resilience	-.15***	[-.19, -.11]
R^2	.18***	
F	56.11***	

Note. CI = confidence interval.

****p < .001*

In Table 5, multiple regression analysis is used to find out the effect of resilience on perceived public stigma. As shown, resilience ($\beta = -.430, p < .001$) negatively predict perceived public stigma. The value of R^2 indicated that resilience explained a total of 18% variance in perceived public stigma. The above stated prediction is significant as F (56.11) at $p < .001$.

Table 6.

Multiple regression analysis to test the effect of perceived public stigma on Bburden among primary caregivers of psychiatric patient. (N=250)

	Burden	
		Model 1
Variables	*B*	95 % CI
Constant	9.36	[-12.43, 32.16]
Perceived Public Stigma	.86***	[.82, 1.79]
R^2	.14***	
F	42.73***	

Note. CI = confidence interval.

****p < .001, p > .05*

In Table 6, multiple regression analysis is used to find out the effect of perceived public stigma on burden. As shown, perceived public stigma ($\beta = .383, p < .001$) positively predict burden. The value of R^2 indicated that perceived public stigma explained a total of 14% variance in burden. The above stated prediction is significant as F (42.73) at $p<.001$.

Table 7.

Moderation of Resilience among Burden and perceived public stigma among primary caregivers of psychiatric patient. (N=250)

				BI
				Model3
Variables	Model 1*B*	Model 2*B*	*B*	95 % CI
Constant	9.36	51.72***	9.86	[-12.43,32.16]
PPS	.86***	.34**	1.30***	[.82, 1.79]
RS		-.43***	.496*	[.06, .87]
PPS*RS			-.022***	[-.03, -.01]
R^2	.14***	.38***	.42***	
F	42.73***	75.71***	60.89***	

Note: BI= Burden interview, LS= Life Satisfaction, PPS= Perceived Public Stigma, RS= Resilience scale, *CI = confidence interval.*

****p < .001, **p < .01, *p < .05*

Multiple regression analysis is used to find out the moderating effect of resilience on burden and perceived public stigma. Results showed that resilience act as a moderator in the relationship between perceived stigma and burden. As presented in Table 7, resilience (β = -1.028, p< .001) indicated to moderate the effect of resilience on public stigma and burden. The value of R2 explained 42% of variance in the model. The above stated prediction is significant as F (60.89) and p< .001.

Table 8.

Mean, Standard Deviations, and t-values of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview (N=250)

	Males (n=150)		Females (n=150)				95% CI	
	M	*SD*	*M*	*SD*	*t (248)*	*Cohen's d*	*LL*	*UL*
Resilience Scale	52.57	22.72	42.67	21.11	3.56***	.45	4.43	15.36
Perceived public stigma	39.37	7.05	44.62	8.29	5.38***	.68	-7.16	-3.32
Life satisfaction	18.61	6.73	15.76	7.78	3.09**	.39	1.03	4.66
Burden interview	41.86	17.41	49.20	18.39	3.24**	.40	-11.80	-2.88

****p < .001, **p < .01*

Above table 8 shows the gender difference in Resilience, Perceived Public stigma, Burden and Life satisfaction. Table shows that there are significant gender differences in Resilience, Perceived Public stigma, Burden and Life satisfaction. Scores revealed that males (M=18.61, SD=6.73) have more life satisfaction than females (M=6.73, SD=7.78). Females (M=49.20, SD=18.39) are more burdened than males (M=41.86, SD=17.20).

Table 9.

Mean, Standard Deviations, and t-values of Resilience scale, Perceived public stigma scale, Life satisfaction and Burden interview (N=250)

	Lower Class (n=52)		Middle Class (n=198)				95% CI	
	M	*SD*	*M*	*SD*	*t (248)*	*Cohen's d*	*LL*	*UL*
Resilience Scale	51.43	21.61	46.22	22.33	1.49	.23	-1.66	12.06
Perceived public stigma	40.78	6.90	42.36	8.41	1.23	.20	-4.09	.93
Life satisfaction	17.19	7.78	17.05	7.22	.12	.01	-2.12	2.41
Burden interview	43.50	20.17	46.24	17.73	.95	.14	-8.38	2.90

$P > .05$

Above table 9 shows the socioeconomic differences in Resilience, Perceived Public stigma, and Burden. Table shows that there are nonsignificant socioeconomic differences in Resilience, Perceived Public stigma, and Burden.

DISCUSSION

The main purpose of this study was to investigate the relationship between resilience, burden, perceived stigma and life satisfaction among primary caregivers of psychiatric patients (Table 1 & Table 2). Results of this study were significant with the hypothesized relationships. There were equal numbers of male and female respondents. Majority of the respondents lied in the first age group and most of them were married and belongs to middle class. whereas most of the respondents suffered from depression and anxiety, while other disorders were schizophrenia, bipolar disorder, conversion disorder, PTSD, and obsessive compulsive disorder (OCD) from different hospitals in the vicinity of Rawalpindi and Islamabad. Most of the caregivers were parents and siblings while others were spouses and children. In which most of them were taking care for full time of their patients.

The first hypothesis states the correlation of resilience and life satisfaction was supported by the results (Table 4). In this way, there was positive correlation between resilience and life satisfaction. Individual who have high level of resilience, cope with the life hardships and have a higher level of satisfaction with life. There was a positive correlation between resilience and life satisfaction. People who have resilience have higher level of life satisfaction then those of who are not resilient (Fredrickson, Tugade, Waugh, & Larkin, 2003).

Another study showed with the purpose of to find out among the students of failure and success. There were 120 students in research sample who were selected through simple random sampling method among the students of failure and success. For collection of data, three scales were used, perceived stress scale, resilience scale and satisfaction with life scale. The research findings revealed that they feel better as a results of increase in resilience and lowering of stress leads to more satisfaction with life and as a result they developed different means for living batter (Abolghasemia & Varaniyaba, 2010).

Another similar study indicated that the association between stress and life satisfaction was found to be partially mediated by resilience. People had lower resilience whose scores were high on perceived stress, as a result they had lower levels of satisfaction with their lives, whereas those who had low scores on perceived stress had higher scores on resilience, as a result they contributed to higher levels of satisfaction with their lives (Shi, Wang, Bian, & Wang, 2015). The relationships between resilience and positive emotions have been established by previous research (Tugade & Fredrickson, 2004). Psychological health is protected by these positive emotions by destruction or protecting the adverse sound effects of stress (Rutter et al., 2013). Furthermore, a host of psychological resources Including optimism and confidence, low neuroticism and high openness were found to be possessed by resilient people.

In any problem they have to face, are more likely to find positive meaning (Fredrickson, Tugade, Waugh, & Larkin, 2003). Developing resilience are of great value not only to ease the confrontation maladaptive stress, but also enhance the coping mechanisms (Wu et al., 2013), as a result in increasing levels of satisfaction with life. Another study showed that people are more flexible over a period of 12 weeks by participating in the resilience of self-directed training program (Sharma et al., 2014).

The second hypothesis relating to the correlation of resilience and burden was supported by the findings (Table 4). In this way, there was a negative relationship between resilience and burden. These results are consistent with the results of other research conducted on the burden of caregivers for individuals who suffer from various disorders. Similar to our findings, in a study by

Chou, LaMontagne, and Hepworth (1999), caregiving contribution and coping which was focused on emotions had directly positive impact on the burden of care of relatives with dementia. Another study (Zauszniewski, Bekhet, & Suresky, 2002) that the two resilience indicators (resourcefulness and sense of coherence) were considerably related with the burden of care in family members of individuals who suffer from serious mental illness. Moreover, Nunley (2002) proposed that in a sample of 44 caregivers who were elderly spouses, they were providing care to their partners diagnosed with Alzheimer's and dementia related illness, resilience predicted the burden of care.

Another study was found by Jain & Singh (2014), demonstrated that there is a positive relationship between resilience and quality of life among caregivers. Both the quality of life and resilience are multifaceted concepts that are affected by multiple dimensions in the care providers, including their burden, the level of stress, personal characteristics, family environment, social adjustment, and the accessibility of financial resources as concise by the subsequent studies on the two variables. The results of the study accompanied by Urizar, Maldonado, & Castillo (2009) revealed that QOL (quality of life) of care provider has been adversely affected as a result of psychological, physical and economic hardships as a result of a number of unsatisfied necessities, such as the lack of free time, re-functioning of the patient's family and social roles among other dynamics. The lack of QOL may be related with the burden on care providers, lack of social support, and duration of the disorder and problems in family relationships. As well as Scott (2010), w in his study, recognized that if there is increase in resilience then there will be decrease in burden of caregivers.

The third hypothesis regarding to the relationship between burden and life satisfaction was sustained by the results (Table 4). In this way, there was a negative relationship between the burdens and life satisfaction. These results are related to the findings of other researchers conducted on individuals who suffer from various disorders caregivers. The research conducted by Osa and Didiana (2013) is to expand our present understanding of the effects of the burden of care on life satisfaction by examining whether or not there are ethnic differences of how to manage caregiving by using different coping strategies. Several particular hypothesis on the relationship between the burden of care, managing caregiving with coping strategies, and life satisfaction were tested. The results indicate that certain coping strategies can affect the levels of satisfaction with life and burdens challenged of caregiving by caregivers. Results of this study highlighted on the organizing a different interventions on psychoeducation that must be effective, and facilitate adjustment to adapt and cope with difficulty, and to reduce the burden, and improve life satisfaction for caregivers of older adults.

In the literature, the terminology, burden, stress and strain are quite frequently used interchangeably (Thornton & Travis, 2003). Accordingly this study showed in order to determine the relationship between resilience, perceived stress and life satisfaction in the students. The results showed that increased resilience, decrease of perceived stress became more comfortable lead to more satisfaction with life resulted they feel better and batter resources developed to live well. (Abolghasemia & Varaniyaba, 2010).

Another study revealed that there is a negative relationship between perceived stress and life satisfaction. People who scored highest on the perceived stress as a result they have lower resilience, leading to lower levels of satisfaction with life, while those who scored low in burden were observed having higher resilience, contributing to the higher level satisfaction with life. (Shi, Wang, Bian, & Wang, 2015). The stress has not only a direct impact on the satisfaction with satisfaction, but also an indirect effect on it through resiliency. It has been found that resilience is mediated the relationship between stress and life satisfaction. The medical students with scores of higher level of stress, had lower resilience, resulting in lower levels of satisfaction with life, while those who scored low in burden was seen with higher resilience, contributing to higher of satisfaction with life.

A similar study proposed by higher levels of resilience is associated with lower depression rates and greater physical health. Lower burden, stress, neuroticism and perceived control were the main psychological factors associated with resilience. Social support was a moderating factor of resilience, and different types of support seemed to relieve the physical and mental overload caused by excess (Dias et al., 2015).

The forth hypothesis relating to the relationship between stigma and life satisfaction was supported by the research findings (Table 4). In this way, there was a positive relationship between stigma and life satisfaction. These research findings are related to the results in other research studies conducted on care providers of those individuals with different disorders. A study was conducted in a sample of HIV-infected American men of African deserts in urban areas, in the favour of this study to find out a link between the dominions of perceived stigma and life satisfaction. An indirect relationship was found between life satisfaction and domains of perceived stigmatization like personal stigma, negative self-image, and fears of disclosure, public attitudes. Multiple regression analysis pointed out that the areas of the personal stigma and public attitudes working through the negative image of self to impact on the life satisfaction. The results of this study proposed that the stigma associated with HIV is a multifaceted phenomenon experienced in the areas of personal and social development. Stigma can be reduced through targeted interventions may help individuals with HIV / AIDS to join the best treatment regimens and improve the satisfaction of their lives virus (Buseh, Kelber, Hewitt, Stevens, & Park, 2006).

Some research studies have used the term quality of life (QOL), well-being and functioning interchangeably with life satisfaction (Post, Witte, & Schrijvers, 1999). Life satisfaction is frequently denoted as the global quality of life (QOL) (Veenhoven, 2000 & Elawsky, et al., 2005). A study similar to this study aimed to define the level of quality of life among the care providers of those patients who suffer from mental illness and to find out the relationship of social stigma and perceptions of care burden with the quality of life of caregivers. The results indicated that patients had low to moderate quality of life (QOL), and they suffered moderate to high perceived public stigma and their family care providers also experienced low to moderate level on quality of life (QOL). There was a negative correlation between the quality of life (WHOQOL-BREF) and perceived stigma of patients and family caregivers as well as burden of family care providers was negatively associated with all areas of quality of life (WHOQOL-BREF), and total QOL-100, public health and self-reported (Dalky, Qandil, Natour, & Janet, 2016).

The fifth hypothesis relating to the relationship between resilience and perceived stigma was approved by the results (Table 5). In this way, there was a negative correlation between resilience and public stigma. A study revealed that low levels of resilience correlates to higher levels of public stigma in primary caregivers that resulted in greater psychological stress. The research also shed light that the intervention which are used to enhance the resilience, particularly in caregivers who have higher levels of public stigma, it may be helpful to lessen the psychological distress (Chen et al., 2016). Min, et al. (2013) suggested that there is a negative linkage between resilience and psychological distress among cancer patients, youth who are homeless (Perron, Cleverley, & Kidd, 2014), patients with chronic spinal injury (Shin et al., 2012) and professionals of health care for children (McGarry et al., 2013). According to these research findings, this study proved that family caregivers of schizophrenic patients who have less resilience would be higher on psychological stress. It is stated by American Psychological Association (APA) that resilience means "echo" of the difficult experiences (APA, 2011). It was found that the individuals with greater resilience to retain a set of psychological resources, including optimism and confidence, low neuroticism and high openness (Shi Wang, Bian, & Wang, 2015), which may encourage better adapt to the role of care provider and contribute to psychological distress at lesser rate.

A qualitative research examined the link between the perceived stigma, resilience, and seek help in the focus group design. The results specified two major themes related to the stigma and resilience which includes resilience helps to decrease stigma, and stigma reduces resilience. Three main axes related to the stigma, resilience, and help seeking were stigma leads to a reduction in seeking of assistance that caused low resilience, help seeking leads to lowering the stigma and reduced resilience, and help seeking leads to increased resilience and lower stigma (Crowe, Averett, & Glass, 2016).

A research was carried out on the care providers of children diagnosed with HIV. Resilience and perceived stigmatization were studied in that study. Results revealed that this research in such a way, that there is a negative relationship between resilience and perceived stigmatization, as high resilience leads to less perceived public stigma (Chi et al., 2015).

The sixth hypothesis relating to the relationship between the burden and perceived public stigma was proved by the results (Table 6). In this way, there was a positive relationship between the burden and stigma of public stigma. These results were linked to the results of other researches piloted on caregivers of those who suffer from various disorders caregivers. A research by Magaña, Ramírez, Hernández, and Cortez (2007) revealed that the burden with high scores due to higher stigma among caregivers of Latin families, caring of a relative with schizophrenia proposed that interferences should include the recovery of patient's mental health as well as consideration to psychological health and recovery of family care providers. Latino caregivers who were younger and have low levels of education are mostly having the possibility of depression. A similar research suggested that the perceived stigma was related the mental stress positively. The relationship gained in strength between stigma and psychological distress, while the relationship with the felt stigma was reduced (but still significant); peer support, family support, and pride in identity and all were related negatively with psychological stress, indorsing that these resources are defensive features (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013).

A research proposed that study that the communal rejection from perceived public stigma was directly proportional to the mental stress/strain of caregivers. Similar results (Magaña, Ramírez García, Hernández, & Cortez, 2007) have been found on the stigma that are connected to a large extent the symptoms of caregiver's depression.

Another research conducted by Mubarak, Baba, Heng Chin, and Soon Hoe (2003) that the stigma adjacent to schizophrenic patients also cause rejection from society and blame is unfair. The caregivers believes that most people will overlook it, and avoid to have friendship relations with them, or might be hesitant to have in contact with their families, that can prevent them from seeking some kind of help and social support when they needed the most (Corrigan, 2005). It has been reported that this caused negative outcomes in terms of relationship with community, work, and health status of the person who is stigmatized (Hanafiah & Van Bortel, 2015). In addition, there is a need to be able to deal with difficult issues and arrange for a quality care with the stigma which is perceived, can lead to more pressure on caregivers (Struening et al., 2001).

A research conducted on the caregivers of veterans with traumatic brain injury revealed that caregiver's personal care stress, depression, anxiety, and social seclusion were connected with the perceptions of being socially victimized against and stigma related with the caregiving. Stigma connected with care providing was also related with low self-esteem of caregiver. And there had been link between cover-up or need to explain the status of the recipient of care and greater depression and anxiety. In addition to that, it was linked to the perception of care providers about their recipient's experiencing discrimination with the personal strain, anxiety and social isolation (Phelan et al., 2011). The association between perceptions of discrimination of caregivers concerning themselves and the negative results indicate that it may be an important stressor or psychological distress for caregivers of individuals with traumatic brain injury. It is consistent with the study that reveals that the families of those people who are experiencing stigmatization, they feel stress and strain which is related to stigmatized by association (Treasure, et al., 2001 & Green, 2003). A different stress response presents by the caregivers towards their recipients associated with discrimination. In these cases, caregivers suffering from stress because of the need to protect by caring them the beneficiaries from damage or injury. This is consistent with former study by Green (2007), which found that care providers who are parents of children with disabilities, experienced a great deal of distress associated to fear that the care recipient might receive discrimination and unfair handling of treatment. It is proposed that the emotional and social consequences in these models are the result of injuries for care recipients, associated with the need to hide injuries or explain how it happened. It was not related to perceived requisite to hide / explain the case of the recipients of their care with social isolation, which is rational due to the caregivers who take these actions do so because they are likely in that social circumstances with their patients whose they are caregivers.

The seventh hypothesis relating to the relationship between burden and perceived stigma moderating by resilience was supported by the research findings (Table 7). These results are associated to the previous research findings conducted on caregivers of individuals with different psychological disorders. A research study suggested that the moderating influence of resilience in relationship between stigma and psychological distress about patients with schizophrenia among family caregivers was confirmed. It has been verified not only a direct relationship between resilience and psychological distress, but the moderating impact of resilience in the relationship between stigma and psychological distress was firstly established in our study. Negative impact of stigma on psychological stress was destabilized by the resilience. Be specific, and the worsening of the relationship between stigma and psychological distress when there was low resilience, and strengthened when the high resiliency. People showed greater ability to overcome adversity when they have high resilience (Ong, Bergeman, Bisconti, & Wallace, 2006), and to lessen the negative impact of a perceived public on mental health, so in traumatic circumstances, they experience less mental fatigue than those who have less resilience (Chen, et al., 2016).

Further hypotheses on demographic variables (gender and socioeconomic status) relating to life satisfaction and burden were supported by the research findings (Table 8 & Table 9). These research findings are related to the findings in previous research studies conducted on caregivers of individuals having different disorders.

The eight hypothesis relating to the male caregivers are more satisfied with their lives then female caregivers was supported by the research findings (Table 8). A study proposed the similar findings to this study that male caregivers have more life satisfaction then female caregivers. There is a significant gender difference on life satisfaction among caregivers (Isaac, Lawer, Stella, & Ocloo, 2016).

Another study supported with the findings of this study by indicating that female caregivers are more burdened then male caregivers (Table 8). There are significant gender differences among caregivers of psychiatric patients. (Chen, et al, 2016). Another study on burden experienced by primary caregivers of patients with mental illness proposed that females score higher on burden then males (Navidian & Bahari, 2008).

The tenth hypothesis relating to the socioeconomic status differences with burden was supported by the research findings (Table 9). There are nonsignificant results of socioeconomic status with burden among primary caregivers of psychiatric patients. A study revealed that there are nonsignificant socioeconomic differences in burden among primary caregivers of psychiatric patients. So these findings are supported by this study. (Chen, et al, 2016). As data was collected from government hospitals, this may cause the nonsignificant differences on socioeconomic status with burden among caregivers.

4.1. Conclusion

The present study reveals that resilience plays an important role for the mental health of primary caregivers of psychiatric patients. Resilience, burden, social stigma and life satisfaction were found to be associated in many ways. Stigma associated with psychiatric illness can reduce resilience and life satisfaction and having resilience can lower burden and stigma. Resilience also effects negatively the relationship between stigma and life burden among caregivers. Burden and social stigma hinder the resilience and satisfaction with life among primary caregivers in many ways which includes health of caregiver, psychological wellbeing, social life, and relationship between caregiver and patient when they negatively correlate with each other. Primary caregivers require interventions plans that enhance the function in all areas of life by increasing resilience and satisfaction with life and decreasing burden and stigma.

4.2. Limitations

1. The cross-sectional study method narrows the understanding of casual description.
2. The data was collected only from Islamabad and Rawalpindi due to limited resources.
3. Another limitation of this study is that data was collected only from caregivers on life satisfaction, resilience and stigma. Patient's views regarding all variables was not obtained due to the limitation of time and resources. There is a possibility of variations in results, if data is collected from the patients along with caregivers.

4.3. Suggestions

1. The sample size can be increased and data can be collected from different cities across Pakistan so that the results can be generalized.
2. Data can be collected from both caregivers and patients regarding all variable to get more accurate information.
3. Results suggest that there is a need of longitudinal study of how all these variable demographic, burden, stigma, resilience and life satisfaction interact with each other.
4. Information about the specific coping strategies which are related to betterment of psychological health outcomes can shape and plan different psychosocial interventions with the aim of providing training and facilitation to use these coping strategies to reduce stigma and burden and improving life satisfaction and resilience among the caregivers.
5. Psychoeducational interventions can focus on the importance of improving the resilience for batter outcome.

4.4. Implications

1. The finding of this study about the positive effect of resilience and life satisfaction on reducing the burden and public stigma can be useful in clinical settings.

2. It gives a new direction to clinicians, psychologists, psychiatrists and all those who are involved in the management of caregiver's betterment about to plan a psychoeducational interventions.

3. Assessing the public stigma and burden among clinical workers can early detect who have low level of higher level of burden and stigma so that resilience could be restructured, enhanced and give a new insight to reduce the level of burden and stigma among primary caregivers of psychiatric patients.

4. This study focus upon the importance of caregivers while giving appropriate care, support as useful resource, mental health clinicians who are interested in the care of psychiatric ill patients.

5. The similarities and differences between the main results of this study and previous researches do provide a clinical understanding to the practitioners in clinical setting and general population to adopt a careful attitude towards the betterment of caregivers.

REFERENCES

Abikoye, G. E. (2007). Subjective quality of life among caregivers of mentally ill persons in Southwestern Nigeria. *Life Psychology*, 15 (1), 213-226.

Abolghasemi, A., & Varaniyab, S. T. (2010). Resilience and perceived stress: predictors of life satisfaction in the students of success and failure. Procedia - *Social and Behavioral Sciences*, 5, 748-752.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica,*113(3),163–179.https://dx.doi.org/10.1111/j.1600-0447.2005.00699.x

Anjum, W., Chaudhry, H. R., & Irfan, M. (2010). Burden of care in caregivers of patients with Schizophrenia and Epilepsy, *Journal of Pakistan Psychiatric Society,* 7(2).

APA (2011). The Road to Resilience. Psychology Help Centre. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx

Arunima, G., & Ranjee, S. (2013). Burden and Coping of Caregivers of Mental and Physical Illnesses. *Delhi Psychiatry Journal*, 16(2).

Awad, A. G., & Voruganti, L. N. (2008). The Burden of Schizophrenia on Caregivers. *Pharmaco Economics*, *26*(2), 149-162.

Bailey, T. C., & Snyder, C. R. (2007). Satisfaction with life and hope: A look at age and marital status. *The Psychological Record*, 57, 233-240.

Barnes, A. L., Murphy, M. E., Fowler, C. A., & Rempfer, M. V. (2012). Health-related quality of life and overall life satisfaction in people with serious mental illness. *Schizophrenia Research and Treatment.*

Baronet, A. (1999). Factors associated with caregiver burden in mental illness: A critical review of the research literature. *Clinical Psychology Review*, *19*(7), 819-841.

Basheer, S., Niazi, R. S., Minhas, F. A., Ali, W., Najam, N. (2005). Depression and anxiety in the caregivers of mentally ill patients. *Journal of Pakistan Psychiatric Society*, 2, 27-33.

Bastawrous, M. (2012). Caregiver burden—A critical discussion. *International Journal of Nursing Studies*, 50, 431–441.

Batowclough, C. & Parle, M. (1997). Appraisal, psychological adjustment and expressed emotion in relatives of patients suffering from schizophrenia. *British Journal of Psychiatry*, 171, 26-30.

Bauer, R., Koepke, F., Sterzinger, L., & Spiessl, H. (2012). Burden, rewards, and coping-the ups and downs of caregivers of people with mental illness. *Journal of Nervous and Mental Disease*, 200(11), 928–934.

Biegel, D. E., Shafran, R. D., & Johnsen, J. A. (2004). Facilitators and barriers to support group participation for family caregivers of adults with mental illness. *Community Mental Health Journal*, 40(2), 151–166.

Blaine, B. E. (2000). The psychology of diversity: Perceiving and experiencing social difference. *Mountain View, CA: Mayfield Publishing.*

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, 103(5), 943-951.

Boyer, L., Millier, A., Perthame, E., Aballea, S., Auquier, P., & Toumi, M. (2013). Quality of life is predictive of relapse in schizophrenia. *BMC Psychiatry*, 9, 13–15.

Broe, G. (1999). Carer distress in the general population: results from the Sydney Older Persons Study. *Age and Ageing, 28*(3), 307-311.

Brooks, N., Campsie, L., Symington, C., Beattie, A., & McKinlay, W. (1987). The effects of severe head injury on patient and relative within seven years of injury. *Journal of Head Trauma Rehabilitation, 2*(3), 1-13.

Brundtland, G.H. (2001). Mental health in our world: the challenges ahead. *Presented at the Council for Mental Health Seminar.*

Buseh, A., Kelber, S., Hewitt, J., Stevens, P., & Park, C. (2006). Perceived stigma and life satisfaction: Experiences of urban African American Men living with HIV/AIDS. *International Journal of Men's Health*, 5(1), 35-51.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, *6*(1), 65-72.

Canive, J. M., Sanz-Fuentenebro, J., Vazquez, C., Qualls, C., Fuentenebro, F., Perez, I. G., et al (1996). Family psychoeducational support groups in Spain: Parents' distress and burden at nine-month follow-up. *Annals of Clinical Psychiatry*, 8(2), 71–79.

Caqueo-Urizar, A., & Gutierrez-Maldonado, J. (2006). Burden of Care in Families of Patients with Schizophrenia. *Quality of Life Research, 15*(4), 719-724.

Chan, S. (2011). Global perspective of burden of family caregivers for persons with schizophrenia. *Archives of Psychiatric Nursing*, 25(5), 339–349.

Chan, S., & Yu, I. W. (2004). The quality of life of clients with schizophrenia. *Journal of Advanced Nursing*, 45(1), 72–83.

Chan, S., Mackenzie, A., Ng, T. F. D., & Leung, J. K. Y. (2000). An evaluation of the implementation of case management in community psychiatric nursing services. *Journal of Advanced Nursing*, 31(1), 144–156.

Chan, S., Yip, B., Tso, S., Cheng, B.S., & Tam, W. (2009). Evaluation of a psychoeducation program for Chinese clients with schizophrenia and their family caregivers. *Patient Education and Counselling*, 75, 67–76.

Chang, K. H., & Horrocks, S. (2006). Lived experience of family caregivers of mentally ill relatives. *Journal of Advanced Nursing*, 53(4), 435–443.

Chen, X., Mao, Y., Kong, L., Li, G., Xin, M., Lou, F., & Li, P. (2016). Resilience moderates the association between stigma and psychological distress among family caregivers of patients with schizophrenia. *Personality and Individual Differences*, 96, 78-82.

Chi, P., Slatcher, R. B., Li, X., Zhao, J., Zhao, G., Ren, X., … Stanton, B. (2015). Perceived stigmatization, resilience, and diurnal cortisol rhythm among children of parents living with HIV. *Psychological Science*, 26(6), 843-852.

Chien, W. T., & Chan, S. (2005). One-year follow-up of a multiple-family-group intervention for Chinese families of patients with schizophrenia. *Psychiatric Services*, 55, 1276–1284.

Chien, W. T., Chan, S., & Morrissey, J. (2007). The perceived burden among Chinese family caregivers of people with schizophrenia. *Journal of Clinical Nursing*, 16, 1151–1161.

Chou, K. R., LaMontagne, L. L., & Hepworth, J. T. (1999). Burden experienced by caregivers of relatives with dementia in Taiwan. *Nursing Research*, 48(20), 614.

Chou, K., LaMontagne, L. L., & Hepworth, J. T. (1999). Burden experienced by caregivers of relatives with dementia in Taiwan. *Nursing Research*, 48(4), 206-214.

Collings, S. C. D., & Seminiuk, D. H. (1998). *The caring role. In S. E. Romans, Folding Back the Shadows.* New Zealand: University of Otago Press, 115-130.

Corrigan, P. W. (2005). On the stigma of mental illness: Practical strategies for research and social change. *American Psychological Association.*

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatization of people with mental illness. *British Journal of Psychiatry*, 177, 4–7.

Crowe, A., Averett, P., & Glass, J. S. (2016). Mental illness stigma, psychological resilience, and help seeking: What are the relationships? *Mental Health & Prevention*, 4(2), 63-68.

Cuijpers, P., & Stam, H., (2000). Burnout among relatives of psychiatric patients attending psychoeducational support groups. *Psychiatric Services*, 51, 375–379.

Cuijpers, P. (2005). Depressive disorders in caregivers of dementia patients: A systematic review. *Aging & Mental Health*, *9*(4), 325-330.

Cummins, R. A. (200 I). The subjective well-being of people caring for a severely disabled family member at home: A review. *Journal of Intellectual and Developmental Disability*, 26, 83-100.

Dalky, H. F. (2012). Mental illness stigma reduction interventions: Review of intervention trials. *Western Journal of Nursing Research*, 34(4), 520–547.

Dalky, H. F., Qandil, A. M., Natour, A. S., & Janet, M. C. (2016). Quality of Life, Stigma and Burden Perception Among Family Caregivers and Patients with Psychiatric Illnesses in Jordan. *Community Mental Health Journal*, 53(3), 266-274.

Dias, R., Santos, R. L., Sousa, M. F., Nogueira, M. M., Torres, B., Belfort, T., & Dourado, M. C. (2015). Resilience of caregivers of people with dementia: a systematic review of biological and psychosocial determinants. *Trends in Psychiatry and Psychotherapy*, 37(1), 12-19.

Diener, E., & Biswas, Diener. R. (2002). Will money increase subjective well-being? A review and guide to needed literature. *Social Indicators Research*, 57, 119-169.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 71-75.

Elavsky, S., McAuley, E., Moti, R. W., & Et al. (2005). Physical activity enhances long term quality of life in older adults: efficacy, esteem, and affective influence. *Annals of behaviour Medicine: a publication of the society of behavioural medicine*, 30(2), 138-145.

Elliott, G. C., Ziegler, H. L., Altman, B. M., & Scott, D. R. (1982). Understanding stigma: Dimensions of deviance and coping. *Deviant Behavior*, *3*(3), 275-300.

Elmahdi, M., Kamel, F., Esmael, A., Lotfi, M., Kamel, A., & Elhosini, A. (2011). Burden of care on female caregivers and its relation to psychiatric morbidity. *Middle East Current Psychiatry*, *18*(2), 65-71.

Enkvist, A., Ekström, H., & Elmstahl, S. (2012). What factors affect life satisfaction (LS) among the oldest-old? *Archives of Gerontology and Geriatrics*, *54*(1), 140-145.

Fadden, G., Bebbington, P., & Kuipers, L. (1987). The burden of care: The impact of functional psychiatric illness on the patient's family. *British Journal of Psychiatry*, 150, 285-292.

Fadden, G., Bebbington, P., Kuipers, L. (1987). Caring and its burdens: a study of the spouses of depressed patients. *British Journal of Psychiatry*, 151, 660–667.

Farina, A. (1981). Are women nicer people than men? Sex and the stigma of mental disorders. *Clinical Psychology Review*, *1*(2), 223-243.

Fortune, D. G., Smith, J. V., & Garvey, K. (2005). Perceptions of psychosis, coping, appraisals, and psychological distress in the relatives of patients with schizophrenia: An exploration using self-regulation theory. *British Journal of Clinical Psychology*, *44*(3), 319-331.

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. R. (2003). What good are positive emotions in crisis? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology*, 84(2), 365-376.

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. R. (2003). What good are positive emotions in crisis? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality & Social Psychology*, 84(2), 365-376.

Garmezy, N. & Rutter, M. (1983). Stress, coping, and development in children. *New York: McGraw-Hill.*

Gillespie, B. M., Chaboyer, W., & Wallis, M. (2007). Development of a theoretically derived model of resilience through concept analysis. *Contemporary Nurse*, *25*(2), 124-135.

Goffman, E. (2009). *Stigma: notes on the management of spoiled identity. Simon and Schuster.* London: Penguin Books.

Green, S. E. (2007). “We’re tired, not sad”: Benefits and burdens of mothering a child with a disability. *Social Science & Medicine*, 64(1), 150-163.

Gururaj, G. P., Math, S. B., Reddy, J., & Chandrashekar, C. R. (2008). Family burden, quality of life and disability in obsessive compulsive disorder: An Indian perspective. *Journal of Postgraduate Medicine*, 54, 91–97.

Hanafiah, A., & Van Bortel, T. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International Journal of Mental Health System*, 9(1), 10.

Hanzawa, S., Bae, J. K., Tanaka, H., Bae, Y. J., Tanaka, G., Inadomi, H., et al. (2010). Caregiver burden and coping strategies for patients with schizophrenia: Comparison between Japan and Korea. *Psychiatry and Clinical Neurosciences,* 64(4), 377–386.

Hjarthag, F., Helldin, L., Karilampi, U., & Norlander, T. (2010). Illness-related components for the family burden of relatives to patients with psychotic illness. *Social Psychiatric Epidemiol*, 45, 275–283.

Idstad, M., Ask, H., & Tambs, K. (2010). Mental disorder and caregiver burden in spouses: The Nord-Trondelag health study. *BMC Public Health, 10*(1).

Isaac, A. A., Lawer, P. K., Stella, O. A., & Ocloo, E. K. (2016). Stigmatization, self-esteem and life satisfaction of HIV/AIDS caregivers in Ghana. *International Journal of Research and Development (IJRD)*, 1(7).

Jain, A., & Singh, D. C. (2014). Resilience and quality of life in caregivers of schizophrenia and bipolar disorder patients. *Global Journal of Human-Social Science: Arts & Humanities - Psychology, 14*(5).

Jenkins, J. H., & Schumacher, J. G. (1999). Family burden of schizophrenia and depressive illness. Specifying the effects of ethnicity, gender and social ecology. *British Journal of Psychiatry*, 174, 31–38.

Kabir, M. ,Iliyasu.Z., Abubakar,I.S., & Aliyu, M. H. (2004). Perceptions and beliefs about mental illness among adults in Karfi Village, Northern Nigeria. *Bio Medical Central International Health and Human Rights*, 4 (3): 10-15.

Kamel, A. A., Bond, A. E., & Froelicher, E. S. (2012). Depression and caregiver burden experienced by caregivers of Jordanian patients with stroke. *International Journal of Nursing Practice*, 18(2), 147–154.

Kaufer, D. I., Borson, S., Kershaw, P., & Sadik, K. (2005). Reduction of caregiver burden in Alzheimer's disease by Treatment with glutamine. *CNS Spectrums, 10*(06), 481-488.

Kaushik, P. & Bhatia M. S. (2013). Burden and quality of life in spouses of patients with schizophrenia and bipolar disorder. *Delhi Psychiatry Journal,* 16(1), 83-89.

King, L. (2000). The role of resiliency, interpersonal relationship restoration, and quality of life for persons in the process of divorce (Doctoral dissertation, Northern Illinois University). *Dissertation Abstracts International*, 61(9-A), 3474.

Kuipers, E., & Bebbington, P. E. (2005). Research on Burden and Coping Strategies in Families of People with Mental Disorders: Problems and Perspectives. *Families and Mental Disorders*, 217-234.

Lauber, C., Eichenberger, A., Luginbuhl, P., Keller, C., & Rossler, W. (2003). Determinants of burden in caregivers of patients with exacerbating schizophrenia. *European Psychiatry*, 1(6), 285–289.

Link, B., Cullen, F., Frank, J., & Wozniak, J. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, 92, 1461–1500.

Link, B. G. (1987). Understanding labelling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, *52*(1), 96.

Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*(2), 177.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work. *Child Development*, *71*(3), 543-562.

Magaña, S. M., Ramirez Garcia, J. I., Hernandez, M. G., & Cortez, R. (2007). Psychological distress among Latino family caregivers of adults with schizophrenia: The roles of burden and stigma. *Psychiatric Services*, 58(3), 378–384.

Magliano, L., Fadden, G., Fiorillo, A., Malangone, C., Sorrentino, D., Robinson, A., et al (1999). Family burden and coping strategies in schizophrenia: Are key relatives really different to other relatives?. *Acta Psychiatrica Scandinavica*, 99(1), 10–15.

Magliano, L., Fiorillo, A., De Rosa, C., Malangone, C., & Maj, M. (2005). Family burden in long-term diseases: a comparative study in schizophrenia vs physical disorders. *Social Science & Medicine*, *61*(2), 313-322.

Marsh, N. V., Kersel, D. A., Havill, J. H., & Sleigh, J. W. (1998). Caregiver burden at six months following severe traumatic brain injury. *Brain Injury*, *12*(3), 225-238.

Martens, L., & Addington, J. (2001). The psychological well-being of family members of individuals with schizophrenia. *Social Psychiatry & Psychiatric Epidemiology*, 36, 128–133.

Masten, A. S., Burt, K. B., Roisman, G. I., Obradovic, J., Long, J. D., & Tellegen, A. (2004). Resources and resilience in the transition to adulthood: Continuity and change. *Development and Psychopathology*, *16*(04).

Math, S., Reddy, J., Chandrashekar, C., & Gururaj, G. (2008). Family burden, quality of life and disability in obsessive compulsive disorder: An Indian perspective. *Journal of Postgraduate Medicine*, *54*(2), 91.

McCubbin, M.A. & McCubbin, H.I. (1996). Resiliency in families: a conceptual model of family adjustment and adaptation in response to stress and crises. *Madison (WI): University of Wisconsin System.* 1–64.

McGarry, S., Girdler, S., McDonald, A., Valentine, J., Lee, S., Blair, E., … Elliott, C. (2013). Paediatric health-care professionals: Relationships between psychological distress, resilience and coping skills. *Journal of Paediatrics and Child Health*, 49(9), 725-732.

Min, J., Yoon, S., Lee, C., Chae, J., Lee, C., Song, K., & Kim, T. (2013). Psychological resilience contributes to low emotional distress in cancer patients. *Supportive Care in Cancer*, 21(9), 2469-2476.

Mubarak, A. R., Baba, I., Heng Chin, L., & Soon Hoe, Q. (2003). Quality of life of community-based chronic schizophrenia patients in Penang, Malaysia. *Australian and New Zealand Journal of Psychiatry*, 37(5), 577-585.

Murray-Swank, A. B., Lucksted, A., Medoff, D. R., Yang, Y., Wohlheiter, K., & Dixon, L. B. (2006). Religiosity, psychosocial adjustment, and subjective burden of persons who care for those with mental illness. *Psychiatric Services*, *57*(3), 361-365.

Navidian, A., & Bahari, F. (2008). Burden experienced by family caregivers of patients with mental disorders. *Pakistan journal of Psychological research*, 23(1).

Neugarten, B. L., Havighurst, R.J., & Tobin, S. S. (1961). The measurement of life satisfaction. *The Journals of Gerontology*, 16, 134–143.

Nunley, B.L. (2002). Stress, hardiness, and psychological distress of elderly spousal caregivers of persons with dementia. *Dissertation abstracts international.*

Ogilvie, A. D., Morant, N., & Goodwin, G. M. (2005). The burden on informal caregivers of people with bipolar disorder. *Bipolar Disorders*, *7*(1), 25-32.

Ohaeri, J. U. (2003). The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*, *16*(4), 457-465.

Omonzejele, F.P. (2004). Mental health care in African traditional medicine and society: A philosophical appraisal. *Journal of Asian and International Bioethics*, 14, 165-1 69.

Ong, A. D., Bergeman, C. S., Bisconti, T. L., & Wallace, K. A. (2006). Psychological resilience, positive emotions, and successful adaptation to stress in later life. *Journal of Personality and Social Psychology*, 91(4), 730-749.

Ong, H., Ibrahim, N., & Wahab, S. (2016). Psychological distress, perceived stigma, and coping among caregivers of patients with schizophrenia. *Psychology Research and Behaviour Management*, Volume 9, 211-218.

Osa, D. L., & Didiana. (2013). *Correlations among Coping Skills and Life Satisfaction in Ethnic Older Caregivers* (FIU Electronic Theses and Dissertation).

Ostman, M., Hansson, L., & Andersson, K. (2000). Family burden, participation in care and mental health—an 11 year comparison of the situation of relatives to compulsorily and voluntarily admitted patients. *International Journal of Social Psychiatry*, 46(3), 191–200.

Perlick, D. A., Rosenheck, R. A., Miklowitz, D. J., Kaczynski, R., Link, B., Ketter, T., … Sachs, G. (2008). Caregiver burden and health in bipolar disorder. *The Journal of Nervous and Mental Disease*, *196*(6), 484-491.

Perron, J. L., Cleverley, K., & Kidd, S. A. (2014). Resilience, loneliness, and psychological distress among homeless youth. *Archives of Psychiatric Nursing*, 28(4), 226-229.

Phelan, S. M., Griffin, J. M., Hellerstedt, W. L., Sayer, N. A., Jensen, A. C., Burgess, D. J., & Van Ryn, M. (2011). Perceived stigma, strain, and mental health among caregivers of veterans with traumatic brain injury. *Disability and Health Journal*, 4(3), 177-184.

Pickett-Schenk, S. A., Cook, J. A., & Laris, A. (2000). Journey of hope program outcomes. *Community Mental Health Journal*, *36*(4), 413-424.

Pickett-Schenk, S. A., Cook, J. A., Steigman, P., Lippincott, R., Bennett, C., & Grey, D. D. (2006). Psychological well-being and relationship outcomes in a randomized study of family-led education. *Archives of General Psychiatry*, *63*(9), 1043.

Pipatananond, P., Boontong, T., & Hanucharurnkul, S., et al. (2006). Caregiver burden predictive model: an empirical test among caregivers for the schizophrenic. *Thai Journal of Nursing Research*, 6(2), 24–40.

Platt, S. (1985). Measuring the burden of psychiatric illness on the family: an evaluation of some rating scales. *Psychological Medicine*, 15, 383–94.

Post, M. W., De Witte, L. P., & Schrijvers, A. J. (1999). Quality of Life and the ICIDH: towards an integrated conceptual model for rehabilitation outcomes research. *Clinical Rehabilitation*, 13, 5-15.

Reine, G., Lancon, C., Simeoni, M. C., Duplan, S., & Auquier, P. (2003). Caregiver burden in relatives of persons with schizophrenia: An overview of measure instruments, 29(2), 137–147.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*(3), 307-321.

Rose, L. E., Mallinson, R. K., & Gerson, L. D. (2006). Mastery, Burden, and areas of concern among family caregivers of mentally ill persons. *Archives of Psychiatric Nursing, 20*(1), 41-51. doi:10.1016/j.apnu.2005.08.009

Rutten, B. P., Hammels, C., Geschwind, N., Menne-Lothmann, C., Pishva, E., Schruers, K., … Wichers, M. (2013). Resilience in mental health: linking psychological and neurobiological perspectives. *Acta Psychiatrica Scandinavica*, 128(1), 3-20.

Rutter, M. (1999). Resilience concepts and findings: implications for family therapy. *Journal of Family Therapy, 21*(2), 119-144.

Saarni, S. I., Viertio, S., Perala, J., Koskinen, S., Suvisaari, J., & Lönnqvist, J. (2010). Health-related and subjective quality of life of people with schizophrenia, bipolar disorder and other psychotic disorders. *Schizophrenia Research, 117*(2), 519.

Santrock, J.W. (2003). *Psychology (7'h edition).* Boston: McGraw-Hill. Wiley

Sartorius, N. (2012). Guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry*, 11(1), 61–62.

Saunders, J. C. (2003). Families living with severe mental illness: A literature review. *Issues in Mental Health Nursing, 24*(2), 175-198.

Scott, C.B. (2010). *Alzheimer's disease caregiver burden: Does resilience matter* (Unpublished Master's thesis). University of Tennessee, Knoxville.

Sethabouppha, H., & Kane, C. (2005). Caring for the seriously mentally ill in Thailand: Buddhist family caregiving. *Archives of Psychiatric Nursing*, 19(2), 44–57.

Shah, A. J., Wadoo, O., & Latoo, J. (2010). Psychological Distress in Carers of People with Mental Disorders. *British Journal Medical Practitioners*, *3*(3), 18.

Sharma, V., Sood, A., Prasad, K., Loehrer, L., Schroeder, D., & Brent, B. (2014). Bibliotherapy to decrease stress and anxiety and increase resilience and mindfulness: A pilot trial explore: *The Journal of Science and Healing,* 10(4), 248-252.

Shi, M., Wang, X., Bian, Y., & Wang, L. (2015). The mediating role of resilience in the relationship between stress and life satisfaction among Chinese medical students: a cross-sectional study. *BMC Medical Education*, 15(1).

Sidlova, M., Prasko, J., Jelenova, D., Kovacsova, A., Latalova, K., Sigmundova, Z., et al. (2011). The quality of life of patients suffering from schizophrenia—A comparison with healthy controls. *Biomedical Paper, Medical Faculty of University of Palacky Olomouc Czech Republic*, 155(2), 173-180.

Smith-Osborne, A. (2007). Life span and resiliency theory. *A critical review. Advances in Social Work,* 18(1), 152–68.

Sousa, L. & Lyubomirsky, S. (2001). Life satisfaction. In J. Worell, Encyclopedia of women and gender: sex similarities and differences and the impact of society on gender, 667-676.

Struening, E. L., Perlick, D. A., Link, B. G., Hellman, F., Herman, D., & Sirey, J. A. (2001). Stigma as a Barrier to Recovery: The Extent to Which Caregivers Believe Most People Devalue Consumers and Their Families. *Psychiatric Services*, 52(12), 1633-1638.

Suresky, M. J., Zauszniewski, J. A., & Bekhet, A. K. (2008). Sense of coherence and quality of life in women family members of the seriously mentally ill. *Issues in Mental Health Nursing, 29*(3), 265-278.

Sveinbjarnardottir, E. & Dierckx de Casterle, B. (1997). Mental illness in the family: An emotional experience. *Issues in Mental Health Nursing*, 18, 45-56.

Talsma, A. N. (1995). Evaluation of theoretical model of resilience and select predictors of resilience in a sample of community based elderly. *Source: Dissertation Abstracts International*, 56(8), 42-46.

Tan, S. C., Yeoh, A. L., Choo, I. B., Huang, A. P., Ong, S. H., Ismail, H., et al. (2012). Burden and coping strategies experienced by caregivers of persons with schizophrenia in the community. *Journal of Clinical Nursing*, 21(17–18), 2410–2418.

Thornton, M., & Travis, S. (2003). Retrieved from http://caregivertoolkit.ca/?page_id=1427

Treasure, J., Murphy, T., Szmukler, T., Todd, G., Gavan, K., & Joyce, J. (2001). The experience of caregiving for severe mental illness: a comparison between anorexia nervosa and psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 36(7), 343-347.

Tsang, H. W. H., Tam, R. K. C., Chan, F., & Chang, W. M. (2003). Sources of burdens of families of individuals with mental illness. *International Journal of Rehabilitation Research*, 26(2), 123–130.

Tugade, M. M., & Fredrickson, B. L. (2004). Resilient Individuals Use Positive Emotions to Bounce Back From Negative Emotional Experiences. *Journal of Personality and Social Psychology*, 86(2), 320-333.

Ungar, M. (2004). A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & Society, 35*(3), 341-365.

Urizar, A. C., Maldonado, J. G. & Castillo, C. M. (2009). Quality of Life in Caregivers of patients with Schizophrenia: A review, Health and quality of Life Outcomes, 7, 84-89.

Vaddadi, K. S., Soosai, E., Gilleard, C. J., & Adlard, S. (1997). Mental illness, physical abuse and burden of care on relatives; a study of acute psychiatric admission patients. *Act of Psychiatry Scandinavia,* 95, 313-3 17.

Van Breda, A. D. (2001). Resilience theory: a literature review. Pretoria (South Africa): South African Military Health Service.

Veenhoven, R. (2000). The four qualities of life. *Journal of Happiness Studies*, 1(1), 1-39.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counselling Psychology*, 53, 325–337.

Wang S. H., Rong J. R., Chen C. C., Wei S. J., Lin K. C. (2007). A study of stress, learned resourcefulness and caregiver burden among primary caregivers of schizophrenic adolescents. *The Journal of Nursing*, 54(5), 37-47.

Werner, E.E. & Smith, R.S. (1992). *Overcoming the odds: high risk children from birth to adulthood.* Ithaca (NY), Cornell University Press.

Werner, P., Mittelman, M. S., Goldstein, D., & Heinik, J. (2011). Family stigma and caregiver burden in alzheimer's disease. *The Gerontologist, 52*(1), 89-97.

WHO (2001). The World Health Report 2001. *Mental Health: New Understanding, New Hope. Geneva: World Health Organization.*

WHO. (2010). *Mental health: Strengthening our response* (Fact Sheet).

WHO. (2012). *WHO Mental Health Gap Action Programme* (MHGAP) (Report)

WHO.(2001). *World health report.* Geneva, Switzerland.

WHO.(2008). *Mental Health Atlas.* Geneva, Switzerland.

Windi, A. A. (2005). The relations between symptoms, somatic and psychiatric conditions, life satisfaction and perceived health. *A primary care based study Health Qual Life Outcomes*, 3, 28.

Winefield, H. R., & Harvey, E. J. (1994). Needs of Family Caregivers in Chronic Schizophrenia. 20(3), 557-566.

World Federation of Mental Health (WFMH) (2010). Caring for the caregiver: Why your mental health matters when you are caring for others. *Woodbridge VA: WFMH.*

Wu, G., Feder, A., Cohen, H., Kim, J. J., Calderon, S., Charney, D. S., & Mathé, A. A. (2013). Understanding resilience. *Front. Behaviour. Neuroscience*, 7.

Wu, G., Feder, A., Cohen, H., Kim, J. J., Calderon, S., Charney, D. S., & Mathé, A. A. (2013). Understanding resilience. Front. *Behaviour Neuroscience*, 7.

Zahid, M., & Ohaeri, J. (2013). 2574 – Relationship of family caregiver burden with quality of care and psychopathology in a sample of arab subjects with schizophrenia. *European Psychiatry*, *28*, 1.

Zauszniewski, J. A., Bekhet, A. K., & Suresky, M. J. (2009). Effects on Resilience of women family caregivers of adults with serious mental illness: The role of positive cognitions. *Archives of Psychiatric Nursing*, *23*(6), 412-422.

Zauszniewski, J. A., Bekhet, A. K., & Suresky, M. J. (2009). Relationships among perceived burden, depressive cognitions, resourcefulness, and quality of life in female relatives of seriously mentally ill adults. *Issues in Mental Health Nursing*, *30*(3), 142-150.

asma khalid <asma.4902.iap@gmail.com> Thu, Mar 31, 2016 at 11:20 AM
To: farah saleem <farahsaleem66@gmail.com>, Rukhsana Saddul <rukhsana.saddul@gmail.com>

Dear Ms. Farah Saleem

Hope you are keeping well. You are more than welcome to use Perceived Devaluation Discrimination Scale translated by Farah Yaqoob & Rukhsana Kausar, PhD for your research project. Thank you for sending us your signed undertaking form. Please find enclosed files of your desired scale. You are required to use it only for research work and if you want to use it for further research work you are required to take formal permission again and should not provide it to others without permission.
Please do keep in touch and let us know how your research develops. I would be grateful for a summary of the results whenever it becomes available.

Regards:
Asma Khalid
Research Scholar
Institute of Applied Psychology,
University of the Punjab,
Quaid-e-Azam Campus
Lahore-54590-Pakistan

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6. Perceived Devaluation Discrimination (PDD) Scale Direction.docx
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farah saleem <farahsaleem66@gmail.com> Thu, Mar 31, 2016 at 2:54 PM
To: asma khalid <asma.4902.iap@gmail.com>

Respected Mam Asma khalid,
I am highly thankful to you for this favour.
I'll share the findings of my studies with you.

Respected mam can you please send me the psychometric properties of urdu version too or a manual of Urdu version that you sent me ???

With best regards

Farah saleem

[Quoted text hidden]

Gmail **farah saleem <farahsaleem66@gmail.com>**

Permission for Scale

2 messages

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farah saleem <farahsaleem66@gmail.com> Thu, Jan 21, 2016 at 7:59 AM

To: ediener@illinois.edu

respected Sir
how are you? Hope you are doing well.

I am student of MS Psychology in International Islamic University Islambad (IIUI) Pakistan. I am doing my thesis in partial full fulfillment of my MS Degree.

As i go through from different researches while studying for my thesis your scale "

Satisfaction With Life Scale (SWLS)

" attracted to me.

I want you to please send me scale in urdu version with all psychometric properties like cut off point, realibility, validity, instructions for use, scoring procedure, manual and permission to use scale for research purpose.

Please let me know as soon as possible so i can work further.

Stay blessed

Farah Saleem

Diener, Edward F <ediener@illinois.edu> Thu, Jan 21, 2016 at 7:17 PM

To: farah saleem <farahsaleem66@gmail.com>

all our scales are free and open for use--see my website

From: farah saleem [farahsaleem66@gmail.com]
Sent: Wednesday, January 20, 2016 8:59 PM
To: Diener, Edward F
Subject: Permission for Scale

[Quoted text hidden]

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Muhammad Mussaffa Butt
Lecturer, Department of Psychology,
GC University, Lahore, Pakistan.
Ph# +92-321-9443132

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farah saleem <farahsaleem66@gmail.com> Thu, Mar 10, 2016 at 9:33 PM
To: mussaffa butt <mussaffa@gcu.edu.pk>

Respected sir,
I have taken permission from Mapi organization.
Can you please send me the psychometric properties of urdu version of ZBI ?
They just send me the scale.

[Quoted text hidden]

---

mussaffa butt <mussaffa@gcu.edu.pk> Thu, Mar 10, 2016 at 9:44 PM
To: farah saleem <farahsaleem66@gmail.com>

good to hear that. we just analyzed the reliability and it was about .80. you can cite this and also the international studies
Best
Mussaffa
[Quoted text hidden]

---

farah saleem <farahsaleem66@gmail.com> Fri, Mar 11, 2016 at 9:02 AM
To: mussaffa butt <mussaffa@gcu.edu.pk>

Respected sir,
Can you please send me some studies in which your translated scale has used ?
And please let me know about the validity of your translated scale ?

[Quoted text hidden]

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mussaffa butt <mussaffa@gcu.edu.pk> Fri, Mar 11, 2016 at 1:03 PM
To: farah saleem <farahsaleem66@gmail.com>

Burden of Care, Emotional Regulation and Psychological Adjustment in Primary Caregivers of Cancer Patients

Its a B.Sc (Hons.) Thesis of Sidra Bashir, Unpublished
You can use the reference in APA style.

On Fri, Mar 11, 2016 at 12:09 PM, farah saleem <farahsaleem66@gmail.com> wrote:

> Can you please send me the abstract or article of that thesis ?
> Actually I've to add as a reference in my research.

Cc: ayesha_yaqoob2000@hotmail.com, universitycounselingcenter@fjwu.edu.pk, ms aneela maqsood <aneelamaq@yahoo.co.uk>

Dear Farah Saleem

Thank you for contacting me. My student Ms. Ayesha Yaqoob (email copied) has used this scale with permission from the authors. Her translated version can be given to you, but you will have to fill up a form and pay a minimal amount to the center where it can be issued to you formally. Also note that contact original authors for permission purpose.

I am copying Ms Ayesha Yaqoob who will help you in explaining the scale etc. Ayesha please assist her with understanding how to score and interpret.

Uzma please help Farah understand and fill up the form which we use for students contacting from outside (within this week)

I wish you very best for your research!!

Sajida

With Regards,

Dr. Sajida Naz (MBPsS)
Assistant Professor
Department of Behavioural Sciences
Fatima Jinnah Women University
The Mall, Rawalpindi
Pakistan
051-9270050-55 Ext 192

~~~~~~

Happiness is always attained by giving it away without expectation. Those who help others are eventually helped. You have two hands, one to help yourself and the other to help those around you. If you can lie down at night knowing in your heart that you made someone's day just a little brighter, you have something to smile about.

[Quoted text hidden]

Sajida Naz <sajida.naz@gmail.com> Wed, Mar 9, 2016 at 1:00 PM
To: farah saleem <farahsaleem66@gmail.com>

Yes you can have the permission to use Urdu version of the scale but you are requested to cite the authors properly. The scale has sound psychometric properties, It has acceptable alpha reliability and it got good evaluations on face validity. We did some modifications for URDU transliterations. Further work is required to supplement its validity, therefore you are requested to share your findings regarding psychometric properties which we can supplement in a working article.

Further ayesha will elaborate

Sajida

With Regards,
~~~~~~

اجازت برائے تحقیق

میں شعبہ نفسیات انٹر نیشنل اسلامک یونیورسٹی اسلام آباد کی ایم ایس کی طالبہ ہوں۔ ہمارا ادارہ تعلیم و تدریس کے ساتھ تحقیق بھی کرتا ہے۔ یہ اس سلسلے کی ایک کڑی ہے جس کے لئے آپ کا تعاون درکار ہے۔ میں نفسیاتی مریضوں کی بنیادی دیکھ بھال کرنے والوں پر تحقیق کر رہی ہوں۔ آپ کی خدمت میں کچھ سوالنامے پیش کیے جا رہے ہیں۔ آپ سے درخواست ہے کہ سوالات کو غور سے پڑھنے کے بعد ساتھ دی گئی ہدایات کے مطابق جواب دیں۔ برائے مہربانی اس ریسرچ میں شرکت کے لئے نیچے دی گئی جگہ پر دستخط کریں۔ آپ کو یقین دلاتا جاتا ہے کہ آپ کی فراہم کردہ معلومات راز میں رکھی جائیں گی

آپکے تعاون کا شکریہ۔

دستخط۔ ____________________

فرح سلیم

(ایم ایس سکالر)

مریض کے کوائف

عمر__________ جنس__________ تعلیم__________

ازدواجی حیثیت__________

بیماری کی مدت__________ تشخیص بیماری__________

کوئی طبی بیماری__________

دیکھ بھال کرنے والے کوائف

نام__________ عمر__________ جنس__________

تعلیم__________ ازدواجی حیثیت__________

خاندان کے افراد__________ سماجی ومعاشی حیثیت__________

مریض کے ساتھ تعلق__________

دیکھ بھال کرنے والے کی صحت کا مسئلہ__________

دیکھ بھال کرنے والے کے ساتھ نفسیاتی مسئلہ__________

مریض کے ساتھ کتنا وقت گزارا__________

ہسپتال کا نام__________

Connor-Davidson Resilience Scale

ہدایات :

پچھلے ایک ماہ میں آپ نے جیسا محسوس کیا ہے اس کے مطابق ہر سوال کے سامنے درست جواب کے سامنے ✓ لکھیے اور اگر آپ کے ساتھ ایسی کوئی بات نہیں ہوئی تو بھی اپنی سمجھ کے مطابق ایسی صورت میں آپ کا جو جواب ہو تا وہ لکھیے

نمبر شمار	سوال	بالکل غلط	شاذو نادر ہی درست	کسی حد تک درست	اکثر درست	تقریبا مکمل درست
1	میں تبدیلیوں کے ساتھ ڈھلنے کی صلاحیت رکھتا / رکھتی ہوں					
2	میرے پاس کم از کام ایک ایسا قریب اور محفوظ رشتہ ہے جو ذہنی دباؤ کی صورت میں میری مدد کرتا / کرتی ہے					
3	بعض اوقات میرے مسائل کا کوئی اور حل نہیں ہوتا تو خدا اور قسمت میری مدد کر سکتے ہیں					
4	میں اپنے سامنے آنے والی کسی بھی مشکل سے نمٹ سکتا / سکتی ہوں					
5	پچھلی کامیابیاں مجھے آگے آنے والی مشکلات اور آزمائشوں میں حوصلہ فراہم کرتی ہیں					
6	جب میرا سامنا مشکلات سے ہوتا ہے تو میں ان کے دلچسپی کے پہلوؤں کو دیکھنے کی کوشش کرتا / کرتی ہوں					
7	ذہنی دباؤ سے چھٹکارا پالینے پر میں مضبوط تر محسوس کر سکتا / سکتی ہوں					

8	کسی بیماری، زخمی حالت یا مشکلات کے بعد جلد ہی بہتری کی طرف راغب ہو جاتا / جاتی ہوں					
9	میرا یقین ہے کہ چاہے اچھا ہو یا برا، کچھ بھی بلاوجہ نہیں ہوتا					
10	نتیجہ کچھ بھی ہو لیکن میں اپنی طرف سے بھرپور کوشش کرتا / کرتی ہوں					
11	مجھے اعتماد ہے کہ میں مشکلات کے باوجود اپنے مقاصد حاصل کر سکتا / سکتی ہوں					
12	ناممکن نظر آنے والے معاملات میں بھی میں امید کا دامن ہاتھ سے نہیں چھوڑتا / چھوڑتی					
13	ذہنی دباؤ یا کسی مشکل کی صورت میں مجھے معلوم ہوتا ہے کہ میں کہاں سے مدد حاصل کر سکتا / سکتی ہوں					
14	دباؤ کی صورت میں میری توجہ مقصد پر قائم رہتی ہے اور درست سمت میں سوچتا / سوچتی ہوں					
15	میں دوسروں کی طرف سے فیصلہ کرنے کی بجائے مسائل کے حل خود تلاش کرنے کو زیادہ مناسب سمجھتا / سمجھتی ہوں					
16	میں آسانی سے ناکامیوں کی وجہ سے ہار ماننے والا / والی نہیں					
17	میں زندگی کی مشکلات اور آزمائشوں کے سامنا کرتے وقت خود کو مظبوط تصور کرتا / کرتی ہوں					

18	ضرورت پڑنے پر میں ایسے مشکل اور غیر مقبول فیصلے کر سکتا/ سکتی ہوں جو دوسروں پر اثر انداز ہوں					
19	میں ناخوشگوار اور تکلیف دہ احساسات مثلاً اداسی، خوف، اور غصہ پر قابو پا سکتا/ سکتی ہوں					
20	زندگی کے مسائل حل کرتے وقت بعض اوقات اندازے کا سہارا لینا پڑتا ہے					
21	میں یہ سمجھتا/ سمجھتی ہوں کہ زندگی کا ایک خاص مقصد ہے					
22	مجھے اپنی زندگی کے معاملات پر قابو حاصل ہے					
23	مجھے چیلنجز پسند ہیں					
24	چاہے جتنی مشکلات ہوں میں اپنا مقصد حاصل کرنے کی جستجو کرتا /کرتی ہوں					
25	مجھے اپنی کامیابیوں پر فخر ہے					

Perceived Devaluation-Discrimination (PDD) Scale

پیمانہ کی ہدایات:

برائے مہربانی ذیل میں دیے گئے ہر سوال کو غور سے پڑھیں اور دیکھیں کہ کون سا سوال آپ کے مطابق کس درجے تک درست ہے۔ یہ درجے "بہت زیادہ متفق، متفق، نہ متفق نہ غیر متفق، غیر متفق، بہت زیادہ غیر متفق" پر مشتمل ہیں۔ آپ ہر سوال کو پڑھنے کے بعد اس درجہ بندی میں سے کسی ایک پر (✓) کا نشان لگائیں

نمبر شمار	بیانات	بہت زیادہ متفق	متفق	نہ متفق نہ غیر متفق	غیر متفق	بہت زیادہ غیر متفق
1	زیادہ تر لوگ ایسے شخص کو جو کہ ذہنی مریض رہ چکا ہو کو ایک قریبی دوست کے طور پر قبول کر لیں گے۔					
2	زیادہ تر لوگوں کا خیال ہے کہ ایک شخص جو ذہنی مرض کا علاج کروا کر آیا ہو وہ ایک عام آدمی کی طرح ہی ذہین ہے۔					
3	زیادہ تر لوگوں کا خیال ہے کہ اس شخص پر عام آدمی کی طرح یقین کیا جا سکتا ہے جو ذہنی مریض رہ چکا ہو۔					
4	زیادہ تر لوگوں کا خیال ہے کہ ایک ذہنی مریض جو کہ اب صحت مند ہو چکا ہو وہ کسی سکول میں ایک اچھا استاد بن سکتا ہے۔					
5	زیادہ تر لوگوں کو ایسا لگتا ہے کہ کسی شخص کا ذہنی ہسپتال میں داخل ہونا ذاتی ناکامی کی وجہ سے ہے۔					
6	زیادہ تر لوگ کسی ایسے شخص سے اپنے بچوں کی دیکھ بھال نہیں کروائیں گے جو کہ ایک ذہنی مریض رہ چکا ہو۔					

7	زیادہ تر لوگ کسی ذہنی مریض کے بارے میں اچھی رائے نہیں رکھیں گے۔					
8	کوئی بھی کاروباری شخص کسی آدمی کو جو کہ ذہنی مریض رہ چکا ہو کو ملازمت کے قابل نہیں سمجھے گا۔					
9	زیادہ تر کاروباری لوگ اپنی ملازمت کے لئے ایک ایسا شخص جو کہ ذہنی مریض تھا لیکن اب صحت یافتہ ہے کے مقابلے میں عام آدمی کو ترجیح دیں گے۔					
10	زیادہ تر لوگوں کا خیال ہے کہ عام ڈاکٹرز جو کہ کسی کا بھی علاج کر سکتے ہوں وہ ذہنی مرض کا علاج بھی کر سکتے ہیں۔					
11	زیادہ تر نوجوان کسی ایسے شخص کے ساتھ گھومنے پھرنے سے انکار کریں گی جو کسی ذہنی مرض کی وجہ سے ہسپتال میں داخل رہ چکا ہو۔					
12	کوئی شخص جو کہ ذہنی ہسپتال میں رہ کر آیا ہو لوگ اس کی بات کم ہی سنیں گے۔					

Satisfaction With Life Scale

مندرجہ ذیل جملوں کو پڑھیں، ان کی مناسبت سے موزوں عبارت کا انتخاب کریں۔ منتخب عبارت کے عدد پر نشان لگا کر اپنی رائے کا اظہار کریں۔

1. بہت اختلاف کرتا ہوں
2. اختلاف کرتا ہوں
3. تھوڑا اختلاف کرتا ہوں
4. نہ اتفاق نہ اختلاف کرتا ہوں
5. تھوڑا اتفاق کرتا ہوں
6. اتفاق کرتا ہوں
7. بہت سے اتفاق کرتا ہوں

نمبر شمار	بیانات	1	2	3	4	5	6	7
1	بہت سے طریقوں / راستوں میں میری زندگی، مثالی زندگی کے قریب ہے							
2	میری زندگی کے حالات بہترین ہیں							
3	میں اپنی زندگی سے مطمعن ہوں							
4	ابھی تک میں نے زندگی میں ہر ضروری یا اہم چیز حاصل کی ہے.							
5	اگر میں اپنی زندگی اور جی سکا، تو میں اسے بالکل بدلنا نہیں چاہوں گا.							

Zarit Burden Interview

ہدایات: مندرجہ ذیل بیانات کی فہرست اس بات کی عکاسی کرتی ہے کہ لوگ کسی عزیز کی دیکھ بھال کرتے ہوئے کیسا محسوس کرتے ہیں۔ ہر بیان

پڑھنے کے بعد نشاندھی کریں کہ دیکھ بھال کے دوران آپ نے کتنی بار ایسا محسوس کیا؟ کوئی بھی جواب غلط یا صحیح نہیں ہے

نمبر شمار	سوال	کبھی نہیں	بہت ہی کم	کبھی کبھی	اکثر	ہمیشہ
1	کیا آپ کو لگتا ہے آپ کا عزیز اس سے زیادہ مدد مانگتا ہے جتنی اسے ضرورت ہے؟					
2	کیا آپ کو لگتا ہے اپنے عزیز کو وقت کی وجہ سے آپ کے پاس اپنے لئے حسب ضرورت وقت نہیں بچتا؟					
3	کیا آپ اپنے عزیز کی دیکھ بھال کرنے کے ساتھ ساتھ اپنے خاندان اور گھر کی ذمہ داریاں نبھاتے ہوئے ذہنی وجسمانی تھکن محسوس کرتے ہیں؟					
4	کیا آپ اپنے عزیز کے رویہ پر شرمندگی محسوس کرتے ہیں؟					
5	جب آُپ اپنے عزیز کے پاس ہوتے ہیں تو آپ کو غصہ محسوس کرتے ہیں؟					
6	کیا آپ محسوس کرتے ہیں کہ اس عزیز کی دیکھ بھال کی وجہ سے آپ کے باقی خاندان اور دوستوں سے تعلقات متاثر ہو رہے ہیں؟					

7	کیا آپ اس عزیز کے مستقبل سے خوفزدہ ہیں؟					
8	کیا آپ کو لگتا ہے کہ آپ کے عزیز کا سارا انحصار آپ پر ہی ہے؟					
9	جب آپ اپنے عزیز کے پاس ہوتے تو کیا ذہنی تناؤ سا محسوس کرتے ہیں؟					
10	کیا آپ کو لگتا ہے کہ اپنے عزیز کی دیکھ بھال کی وجہ سے آپ کی صحت متاثر ہوئی ہے؟					
11	کیا آپ کو لگتا ہے کہ اپنے عزیز کی وجہ سے آپ کی اتنی فرصت نہیں ملتی جتنی آپ چاہتے ہیں؟					
12	کیا آپ کو لگتا ہے کہ اپنے عزیز کی دیکھ بھال کی وجہ سے آپ کی سماجی زندگی متاثر ہوئی ہے؟					
13	کیا اپنے عزیز کی وجہ سے دوستوں کو گھر بلاتے ہوئے آپ جھجک محسوس کرتے ہیں؟					
14	کیا آپکو لگتا ہے کہ آپ کا عزیز آپ سے اس طرح آس لگاتا ہے جیسے وہ صرف آپ پر انحصار کرتا ہے؟					
15	کیا آپ کو لگتا ہے کہ اپنے دیگر اخراجات کی وجہ سے آپ کے پاس اپنے عزیز کی دیکھ بھال کے لئے کافی پیسے نہیں ہیں؟					
16	کیا آپ کو لگتا ہے آپ اپنے عزیز کی زیادہ دیر تک دیکھ بھال ہیں کرسکتے؟					
17	کیا آپ کو لگتا ہے جب سے آپ کا عزیز بیمار ہوا ہے آپ کی زندگی آپ کے اختیار میں نہیں رہی؟					

18	کیا آُپ کا دل کرتا ہے کہ آپ اپنے عزیز کی دیکھ بھال کی ذمہ داری کسی اور کو سونپ دیں؟					
19	کیا آپ اپنے عزیز کو لے کر غیر یقینی کیفیت کا شکار ہیں؟					
20	کیا آپ کو لگتا ہے کہ آپ کو اپنے عزیز کے لئے اس سے زیادہ بھی کچھ کرنا چاہیے؟					
21	کیا آُپ کو لگتا ہے کہ آُپ اپنے عزیز کی دیکھ بھال اس سے زیادہ بہتر طریقے سے کر سکتے تھے؟					
22	مجموعی طور پر آپ اپنے عزیز کی دیکھ بھال کی وجہ سے کتنا دباو محسوس کرتے ہیں؟					