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Young carers, mental health and psychosocial wellbeing: A realist synthesis

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Abstract

Growing evidence demonstrates that the mental and psychosocial health impacts of caring vary significantly for individual children, depending on who they are, the person that they care for, their responsibilities and the wider family situation. Although individual studies have made progress in identifying the range of impacts, there is a lack of clarity around which impacts affect who and in what circumstances. This synthesis, based on RAMESES realist protocols, aims to increase clarity concerning how and why the mental and psychosocial health impacts of caring for a family member vary for different children. There were 12 391 unique search results screened at title, abstract and full-paper levels. Forty-four retained studies were analysed, resulting in the development of a model with 17 context-mechanism-outcome configurations. The model divides the configurations into three interlinking domains. The caregiving responsibilities domain considers how the impacts of caring vary with the circumstances of the individual young carer, the person they care for and their family. The identity domain details the development of a caring identity that potentially mitigates the negative effects of caring and enables positive benefits. The support domain concerns the support provided from family, community and services that, depending on quality, can mitigate or exacerbate the impacts of caring. Support also moderates the care identity by affecting self-perception of the caring role. The model has the potential to inform the development of interventions that target particular mechanisms to enable positive change for young carers. This potential can be enhanced by further research to test the model, with a focus on refining configurations where less evidence is available. There is a particular need to focus on identification which is under-represented in the model as both a mechanism and a contextual factor due to unidentified young carers being largely absent from past research.

KEYWORDS
mental health, realist, young carers

1 | INTRODUCTION

Early young carer research focused on the lives, experiences and needs of children undertaking primary care for adults in the home (Aldridge & Becker, 1993). Following that, research prioritized how to best identify those most in need of support, resulting in different approaches to measuring level of care including a focus on 'substantial' care (Department of Health, 1995), assessing the appropriateness of particular caring responsibilities (Aldridge, 2006; Andersen, 2012) and looking at impact irrespective of responsibilities (UK Government, 2014; Warren, 2007). There has been an increasing focus on caring for people with particular illnesses and disabilities, including substance misuse (Moore et al., 2011) and mental health issues (Aldridge, 2006), with an internationalization of research to include different countries and cultures. It has become increasingly clear that young carers are a non-homogenous group of children taking on a range of caring responsibilities for different family members, while receiving varying levels of support from individuals and services.

The 1990s research impacted UK policy and led to the development of young carers provision offering support and respite. Although there is evidence that these services are valued and beneficial (Aldridge, 2006), there has been little diversification of services to support the specific needs of different young carers. Consequently, there is a need to incorporate the research evidence into a structured understanding of why the positive and negative impacts vary for different young carers, to inform what young carers' differing support needs are.

1.1 | Objectives and focus of review

The primary research objective is to clarify how the experiences of caring impact individual children differently depending on their responsibilities but also their wider lives and family circumstances. This will be achieved by identifying and incorporating evidence from previous studies to develop a model relating to young carers and mental health. Additional objectives concern whether there is sufficient evidence underpinning the different components of the model to ensure reliability, and therefore have confidence in the model's potential to inform service development.

2 | METHODS

2.1 | Rationale for using realist synthesis

Realist syntheses utilize previous research to conceptualize a social programme through constructing a series of context-mechanism-outcome (CMO) configurations (Pawson & Tilley, 1997). Each configuration enables the witnessing of transformation in the service and participants. Within a configuration, a mechanism (M) can produce a change in the system, with contextual (C) factors having the potential to trigger the mechanism. Outcomes (O) are the product of the context and mechanism together. Modelling the programme in full provides a complex picture of its success in triggering desired mechanisms while also considering the reasons why other mechanisms remain unchanged.

Key messages

- Realist synthesis clarifying how and why the mental and psychosocial health impacts of caring vary for different children.
- Resulting model has three domains relating to the child's caregiving responsibilities, support received from different levels of society and the development of a carer identity.
- A positive carer identity mitigates the negative impacts of caring and enables benefits.
- Positive support mitigates the impacts of caring responsibilities and aids development of a positive carer identity.

A traditional realist synthesis of young carers support would need to incorporate research concerning both mainstream services (schools, health and social services) and specialist projects. Although young carer projects have been studied in the past (Coles et al., 2007; Cunningham et al., 2017; Fraser & Pakenham, 2009; Richardson et al., 2009; Schlarmann et al., 2011), neither intervention evaluations or wider research have considered provision by mainstream services in terms of what works and for whom in any detail.

There is however a growing focus not on interventions but on evaluations of the pre-existing social context (de Souza, 2013). Through developing a better understanding of this pre-existing social context, the accompanying mechanisms and the resulting outcomes, we can better understand the change that is needed and develop suitable interventions. Therefore, this synthesis will focus on the pre-existing context and mechanisms relevant to young carers, and the resulting negative impacts and benefits.

The procedure used to identify, screen and analyse papers to develop the model follows the RAMESES realist protocols (Wong et al., 2014).

2.2 | Scoping the literature

Prior to the realist synthesis, a concept analysis had been developed to define young carers as follows:

> Children and young persons under 18 who provide, or intend to provide, care, assistance or support to another family member (or members) due to an illness or disability, mental health or substance misuse issue. They assume a level of responsibility which may, depending on the support that is in place both within

and from outside the family, have an impact on their lives.

The concept analysis had also identified antecedents and consequences for young carers, with these used to initiate theory-building. The concept analysis and definition informed the development of inclusion criteria (Table 1) to support development of the search strategy and subsequent screening of search results.

2.3 | Search process

A search strategy was developed with two strands. The main search strand contained two fields relating to young carers and mental and psychosocial health impact.

It was also important to identify research from disability studies research where terminology is significantly different and includes 'children of disabled people' in place of 'young carers'. In using these terms, it was recognized that not all children of disabled people are young carers and that young carers may be carers for other family members as well as parents. This increased the potential for the inclusion of irrelevant studies and omission of key papers and led to a decision to develop a separate strand for 'children of disabled people'. The results of the two strands were combined in the final search stage. Surrogate terms were also identified for all fields.

The strategy guided the search, which was amended to suit each of the seven electronic databases (PsycINFO, MEDLINE, EMBASE, ASSIA, Sociological Abstracts, IBSS and JSTOR), and the Web of Science citation index. The search was carried out in June 2018. Search results are in Table 2 with the full details included in Data S1.

TABLE 1 Inclusion criteria developed for screening of papers

	Criteria for inclusion of paper
Child age	•All participants are children/young people between the ages of 4 and 18 years. Alternatively, a significant proportion should be aged 4–18 with clear analysis of the age group.
Young carer status	•Child is taking on extra responsibility due to caring for someone. This can include sibling care (caring for an able-bodied sibling due to this person's disability). •The caring relationship may be fully inverted where the child cares for the adult, or partially inverted meaning there is a two-way caring relationship. •In addition, papers concerning the physical abuse, emotional abuse, neglect or parentification of children, due to adult being unable to care or child having inappropriate caring tasks
Relationship	•Care receiver is a member of the family, and usually living in the same home
Care receiver illness	•The care receiver has a chronic illness or disability. This can include mental health issues or a substance misuse problem
Outcome	•The mental health of the young person. This can include both potential impacts (e.g., depressions, anxiety and conduct disorder) and benefits (improved relationships). •Their psychosocial health including impacts (e.g., sleep and eating disorders, risky behaviour and adjustment and personality disorders including ADHD) and benefits (life skills and resilience). •Outcomes should be a result of their environment (i.e., their family situation and caring role). •Inclusion of education due to clear links between education success and mental health.
Research design	•Empirical studies including qualitative, quantitative and mixed methods will be included. •Articles and book chapters
Article language	•All articles in the English language

2.4 | Selection and appraisal of documents

The different stages of the search and screening process are included in the realist flow diagram (Figure 1). Following deduplication, studies were screened against the inclusion criteria at title ($n = 12\ 391$), abstract ($n = 4351$) and full paper ($n = 208$) levels. Due to the large number of results, titles were single screened to remove studies that clearly did not concern young carers. Abstracts were double screened against the inclusion criteria by two independent researchers using Rayyan QCRI software. This was a blind procedure with the screeners unaware of each other's decisions and meeting periodically to discuss and resolve conflicts.

Of the 208 papers that were progressed to full-paper screening 10 could not be obtained. The first author screened the remaining 198 studies and identified studies to include in the synthesis. Snowballing enabled the checking of reference lists in included papers for any unidentified studies ($n = 3$). The full papers were double screened with conflicting decisions again resolved through discussion. Seventy-two papers were progressed for inclusion in the review.

TABLE 2 Breakdown of the complex literature search results from each database, prior to deduplication

Database	Results
PsycINFO	4262
Medline	4933
EMBASE	4616
ASSIA	714
Sociological Abstracts	424
IBSS	199
JSTOR	85
Web of Science	285
Total search results	15 518
Deduplicated results	14 391

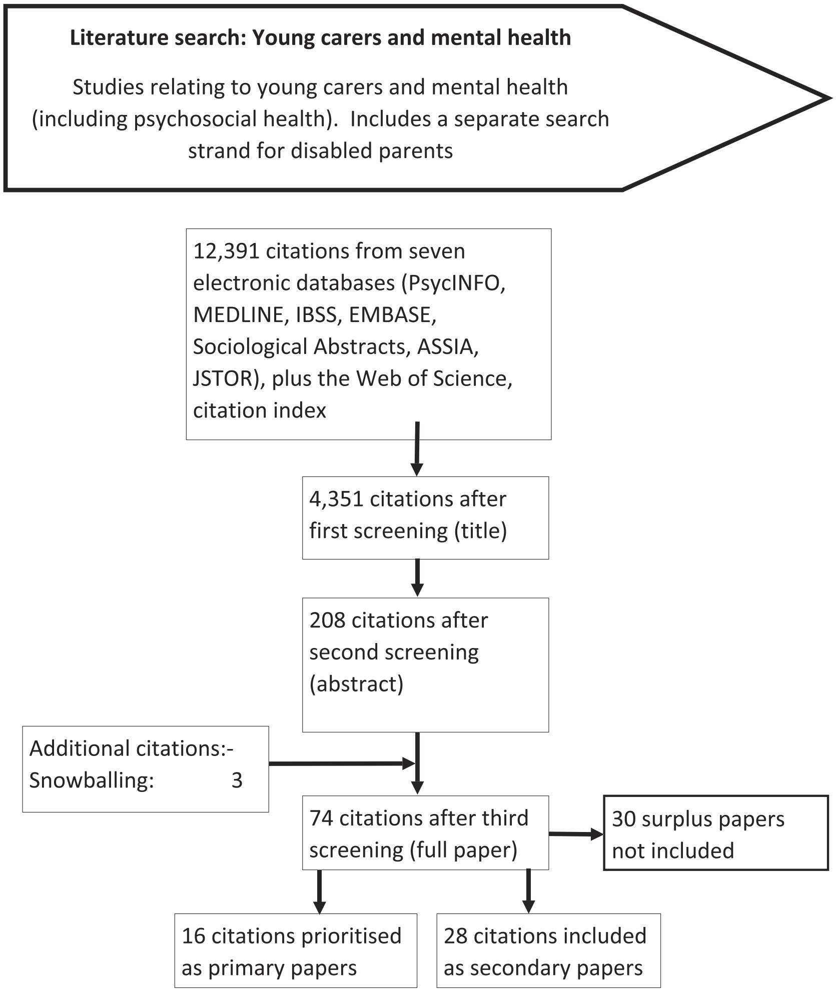

FIGURE 1 Realist flow diagram of the realist search and screening process

Due to the large number of studies included, the first author assessed and prioritized the studies on the basis of relevance and the potential to inform the model, and whether the methods that generated the data were rigorous. Studies were divided into primary ($n = 16$), secondary ($n = 28$) and surplus ($n = 30$) sets. Surplus papers with lower model-building potential were removed from the set, with the potential to utilize them to resolve uncertainties in the model.

2.5 | Analysis and synthesis processes

The first author was responsible for the analysis of data and the development of the model. Analysis and synthesis were completed in Nvivo 11. In line with the realist approach that all information has the potential to inform the model, all studies were assessed using line-by-line coding. The process was incremental with primary papers analysed in turn to identify key evidence and develop concepts. As the analysis continued, these concepts became increasingly detailed configuration components, resulting in the individual configurations. Analysis of the secondary paper analysis enabled further strengthening and modification of the configurations and consideration of how the different configurations linked together. This resulted in significant 'embedding' (Jagosh et al., 2014) where evidence used to inform the mechanism in one configuration was also the basis of context in a subsequent configuration.

3 | RESULTS

In total, 44 of the 15 518 unduplicated search results were included in the synthesis. The dataset had 40 different lead authors and spanned from 1993 (Aldridge and Becker) to 2018 (Kallander et al; Tseliou et al.). Seventeen of the studies were based in Europe including the UK ($n = 15$), with 11 American and 10 African studies. The method of recruiting young carers varied and included care receiver services ($n = 12$), mainstream (education, health and social care) services ($n = 12$) and carer projects ($n = 11$).

Eighteen studies were quantitative (Assaf et al., 2016; Bauman et al., 2007; Cassidy & Giles, 2013; Champion et al., 2009; Coles et al., 2007; de Roos et al., 2017; Early et al., 2006; Fraser & Pakenham, 2009; Joseph et al., 2009; Kallander et al., 2018; Kavanaugh, 2014; Khafi et al., 2014; Lloyd, 2013; McMahon & Luthar, 2007; Pakenham & Cox, 2012; Sharer, 2015; Stein et al., 1999; Tseliou et al., 2018). These diverse methods included cross-sectional studies ($n = 6$) comparing the lives of young carers with non-caring peers at a particular point in time, and longitudinal studies ($n = 2$), in addition to studies that developed measures for caregiving level or magnitude of impact ($n = 3$).

Nineteen studies were qualitative (Aldridge, 2006; Aldridge & Becker, 1993; Andersen, 2012; Bolas et al., 2007; Doutre et al., 2013; Gelman & Greer, 2011; Hwang & Charnley, 2010; Kain, 2009; Martin, 2006; Moore et al., 2011; Nichols et al., 2013; Olang'o et al., 2012; Sahoo & Suar, 2010; Skovdal, 2011; Skovdal et al., 2009; Skovdal & Ogutu, 2009; Thomas et al., 2003; Trondsen, 2012; Williams et al., 2009) with the majority utilizing either focus groups or interviews. The remaining seven studies used mixed methods (Bifulco et al., 2014; Cree, 2003; Kavanaugh, 2014; Lane et al., 2015; Nagl-Cupal et al., 2014; Olsen & Clarke, 2003; Robson et al., 2006). Tables 3 and 4 include full details of the primary and secondary studies, respectively.

3.1 | Main findings

The resultant model contains 17 CMO configurations in three domains concerning caregiving responsibilities, identity and support (Figure 2). The impacts of caring itself were captured in the caregiving responsibilities domain and varied significantly due to the circumstances of individual young carers, the person that they care for and their family. The development of a caring identity within the young person's wider identity was detailed in the Identity domain, and the support and recognition provided to young carers at different levels of society was encapsulated in the support domain. Data S2 contains a guide detailing every evidence component (contextual factors, mechanisms and outcomes), with excerpts demonstrating links between components.

The organizing construct demonstrates how the three domains interact with each other. The identity domain moderates the caregiving responsibilities domain through the potential development of a caregiving identity that mitigates the negative effects of caring and enables positive benefits. The support domain moderates the caregiving responsibilities domain through positive support. This mitigates the negative effects and enables the development of positive benefits, though a lack of support exacerbates the negative impacts of caregiving. The support domain moderates the identity domain as support improves self-perception of caring and aids the development of the caregiving identity, but a lack of support leads to young carers devaluing their role.

TABLE 3 Primary papers included in the realist review

	Authors	Year	Country	Recruitment	Methodology	Data collection/analysis
1	Kavanaugh, M.	2013	USA	Care receiver services	Mixed	Interviews/thematic analysis; structural equation modelling
2	Olang'o, C.O. et al.	2012	Kenya	Community services; h ealth services	Qualitative	Interviews; focus groups; observations/ content analysis
3	Moore, T. et al.	2011	Australia	Advertisements; services	Qualitative	Interviews/thematic analysis
4	Skovdal, M.	2011	Kenya	Community services	Qualitative	Photovoice; essay writing; Interviews; focus groups/thematic network analysis
5	Early, L. et al.	2006	UK	Carer projects	Quantitative	Questionnaire; measure development
6	Nagl-Cupal, M. et al.	2014	Austria	Schools	Mixed	Questionnaire/cross-sectional descriptive analysis
7	Aldridge, J. & Becker, S.	1993	UK	Community services; health services; social services	Qualitative	Interviews
8	Aldridge, J.	2006	UK	Care receiver services	Qualitative	Interviews
9	Pakenham, K. I. & Cox, S.	2012	Australia	Care receiver services	Quantitative	Questionnaire/longitudinal inferential analysis
10	Bolas, H. et al.	2007	UK	Carer projects	Qualitative	Interviews/interpretative phenomenological analysis
11	De Roos, S. A. et al.	2017	Netherlands	Survey participants	Quantitative	Secondary data/cross-sectional inferential analysis
12	Cree, V.E.	2003	UK	Carer projects	Mixed	Questionnaire; interviews/descriptive statistics; thematic analysis
13	Robson, E. et al.	2006	Lesotho, Tanzania, Zimbabwe	Schools; social services; survey participants	Mixed	Focus groups; interviews; questionnaire
14	Skovdal, M. et al.	2009	Kenya	Community	Qualitative	Photovoice; interviews; focus groups/ thematic analysis
15	Lane, T. et al.	2015	South Africa	Community; schools	Mixed	Interviews/descriptive analysis; thematic analysis
16	Andersen, L. B.	2012	Kenya	Health services	Qualitative	Ethnography

TABLE 4 Secondary papers included in the realist review

	Authors	Year	Country	Recruitment	Methodology	Data collection/analysis
17	Assaf, R. R. et al.	2015	USA	Carer projects	Quantitative	Secondary data/descriptive analysis
18	Bauman, L. J. et al.	2007	USA, Zimbabwe	Previous research	Quantitative	Questionnaire/cross-sectional analysis
19	Bifulco, A. et al.	2014	UK	Care receiver services	Mixed	Interviews/inferential analysis
20	Cassidy, T. & Giles, M.	2013	UK	Carer projects	Quantitative	Questionnaire/measure development
21	Champion, J. E. et al.	2009	USA	Advertisements; previous research	Quantitative	Questionnaire/cross-sectional inferential analysis
22	Coles, A. R. et al.	2007	Australia	Care receiver services	Quantitative	Intervention evaluation; questionnaire/ inferential analysis
23	Doutre, G. et al.	2013	UK	Carer projects	Qualitative	Photovoice; interviews/interpretative phenomenological analysis
24	Fraser, E. & Pakenham, K. I.	2009	Australia	Parents; schools; youth services	Quantitative	Questionnaire/inferential analysis
25	Gelman, C. R. & Greer, C.	2011	USA	Carer projects	Qualitative	Case study
26	Hwang, S. K & Charnley, H.	2010	Korea	Care receiver services; carer projects	Qualitative	Ethnography/thematic analysis
27	Joseph, S. et al.	2009	UK	Carer projects	Quantitative	Questionnaire; measure development
28	Kain, C. A.	2009	USA	Carer projects	Qualitative	Interviews/grounded theory
29	Kallander E. K. et al.	2018	Norway/UK	Care receiver services	Quantitative	Questionnaire; cross-sectional inferential analysis
30	Kavanaugh, M.	2014	USA	Care receiver services	Quantitative	Interviews/inferential analysis
31	Khafi, T. Y. et al.	2014	USA	Previous research	Quantitative	Questionnaire/longitudinal and cross-sectional analysis
32	Lloyd, K.	2013	UK (Northern Ireland)	Survey participants	Quantitative	Secondary data/cross-sectional inferential analysis
33	McMahon, T. J. and Luthar, S. S.	2007	USA	Advertisements	Quantitative	Interviews/inferential analysis
34	Martin, R.	2006	Zimbabwe	Health services	Qualitative	Secondary data analysis
35	Nichols, K. et al.	2013	Canada	Previous research	Qualitative	Focus groups/thematic analysis
36	Olsen, R. & Clarke, H.	2003	UK	Care receiver services	Mixed	Questionnaires; interviews/descriptive statistics
37	Sahoo, R. & Suar, D.	2009	India	Care receiver services	Qualitative	Interviews/cross-sectional content analysis
38	Sharer, M.	2015	South Africa	Previous research	Quantitative	Secondary data/inferential analysis
39	Skovdal, M. & Ogutu, V. O.	2009	Kenya	Not disclosed	Qualitative	Case studies; photovoice/thematic analysis
40	Stein, J. A et al.	1999	USA	Care receiver services	Quantitative	Interviews/structural equation modelling
41	Thomas, N. et al.	2003	UK	Carer projects; community services; health services; schools; social services	Qualitative	Focus groups; interviews
42	Trondsen, M. V.	2012	Norway/UK	Health services	Qualitative	Observations/framework analysis
43	Tseliou, F. et al.	2018	UK (Northern Ireland)	Survey participants	Quantitative	Secondary data/cross-sectional inferential analysis
44	Williams, J. K. et al.	2009	USA, Canada	Care receiver services	Qualitative	Focus groups/content analysis

3.2 | Caregiving responsibilities domain

The caregiving responsibilities domain (Figure 3) contains six CMO configurations relating to the responsibilities of the young carer and the person that they care for.

The first configuration is informed by 9 of the 44 studies and concerns the appropriateness of responsibilities (CMO[1]), which can include domestic, emotional or personal tasks. Specific tasks identified as potentially inappropriate include toileting and bathing, dressing, administering medication, emotional care and physical support

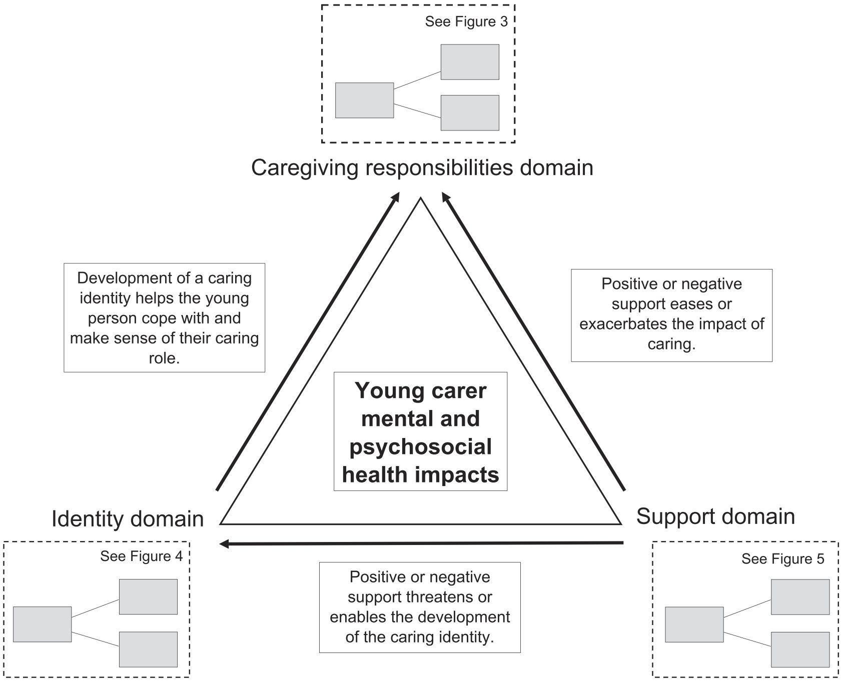

FIGURE 2 Organizing construct of the model and how the three domains relate to each other

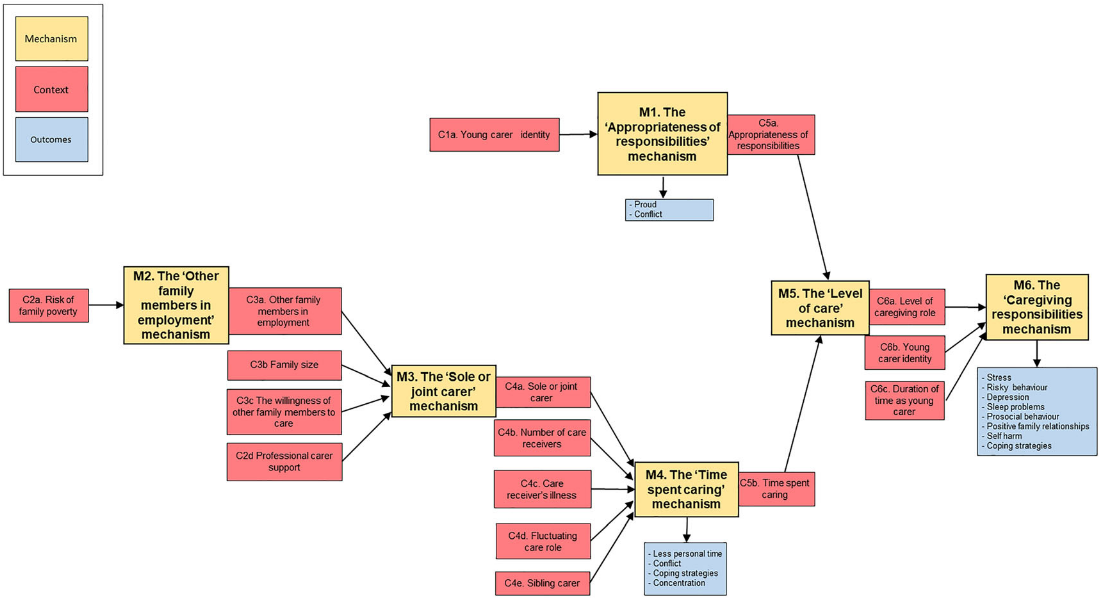

FIGURE 3 Caregiving responsibilities domain

(Aldridge, 2006; Aldridge & Becker, 1993; Kavanaugh, 2014; Lane et al., 2015; Martin, 2006; Pakenham & Cox, 2012) This mechanism can potentially be triggered by the single contextual factor of their *identity* (C^{1a}), specifically their age and development (Aldridge, 2006; Bifulco et al., 2014; Lane et al., 2015; Martin, 2006). The evidence suggests that intimate caring tasks can cause conflict (Andersen, 2012) but that they are proud of managing these difficult responsibilities (Nichols et al., 2013).

The other family members in employment configuration (CMO^2) is sourced from two studies (Gelman & Greer, 2011; Lane et al., 2015) and concerns the financial need for family members to work. The *risk of family poverty* is the single contextual factor (C^{2a}) that triggers the mechanism. This is an embedded mechanism as their employment is also a contextual factor (C^{3a}) for the subsequent sole or joint carer configuration.

The sole or joint carer configuration (CMO^3) concerns the presence of other carers alongside the young person and contains evidence from nine studies. In addition to *family members in employment* (C^{3a}), the configuration has three factors relating to *family size* (C^{3b}) with the young carer potentially the only person in the home other than the care receiver (McMahon & Luthar, 2007; Moore et al., 2011; Olang'o et al., 2012; Olsen & Clarke, 2003; Skovdal, 2011; Skovdal & Ogutu, 2009); *the unwillingness of other family members to care* (Aldridge & Becker, 1993; Lane et al., 2015; Olsen & Clarke, 2003; C^{3c}); and *professional carer support* (Aldridge & Becker, 1993; Kallander et al., 2018; Lane et al., 2015; Olang'o et al., 2012; Olsen & Clarke, 2003; C^{3d}).

Again, the *sole or joint carer* configuration is an embedded contextual factor (C^{4a}) in the subsequent time spent caring configuration (CMO^{4}) due to the presence of other carers reducing the responsibilities of the young carer (Aldridge & Becker, 1993; Kallander et al., 2018; Lane et al., 2015; Moore et al., 2011; Skovdal, 2011; Skovdal & Ogutu, 2009). The configuration is evidenced from 16 studies and has four additional contextual factors including the *number of care receivers* (Skovdal, 2011; Skovdal & Ogutu, 2009; C^{4b}), the nature and severity of the *care receiver's illness* (Andersen, 2012; Assaf et al., 2016; Bauman et al., 2007; Gelman & Greer, 2011; Joseph et al., 2009; Kallander et al., 2018; Kavanaugh, 2013; Moore et al., 2011; C^{4c}) and the *fluctuating care role* (Andersen, 2012; Champion et al., 2009; Moore et al., 2011; Skovdal, 2011; Skovdal & Ogutu, 2009; C^{4d}). Being a *sibling carer* in addition to caring for a family member is the final factor (Andersen, 2012; Lane et al., 2015; Moore et al., 2011; Sahoo & Suar, 2010; C^{4e}). Outcomes for the mechanism include having a lack of time for other activities (Kallander et al., 2018; Sahoo & Suar, 2010) and the development of both positive and negative coping strategies (Early et al., 2006). There was also evidence of conflict (Kavanaugh, 2013, 2014) and problems with concentration (Lane et al., 2015).

Level of caregiving (CMO^{5}) is the penultimate configuration in the domain. It is informed by six studies and is key to considering the different ways of assessing young carers. Both contextual factors are embedded mechanisms that have been already detailed in previous configurations; *appropriateness of responsibilities* (Lane et al., 2015; C^{5a}) and *time spent caring* (Aldridge & Becker, 1993; Champion et al., 2009; Joseph et al., 2009; Kallander et al., 2018; Lane et al., 2015; Moore et al., 2011; C^{5b}).

'Caregiving responsibilities' is the final configuration (CMO^{6}) and considers why caregiving responsibilities impact on children differently. The configuration is sourced from 11 studies and includes the previous mechanism, *level of caregiving role* (Lane et al., 2015; C^{6a}) as one of three contextual factors. *Young carer identity* (C^{6b}) is key with evidence that female young carers are more likely to have emotional health impacts including depression (Sharer, 2015), risky behaviour, stress and self-harm (Cree, 2003) and to develop negative coping strategies (Fraser & Pakenham, 2009). In comparison, males develop more positive family relationships but have higher emotional stress (McMahon & Luthar, 2007) though this opposes findings by (Stein et al., 1999). Considering age, there is evidence that older young carers have increased problems with sleep, self-harm, stress (Cree, 2003) and risky behaviour (Stein et al., 1999). Minority ethnic young carers experience greater stress (Cree, 2003), but also improved family relationships compared to other young carers (Khafi et al., 2014). The final contextual factor, *duration of time as a young carer* (C^{6c}), can result in negative impacts (Doutre et al., 2013), but there was conflicting evidence over whether impacts grow with duration (Aldridge, 2006) or if some peak for middle range young carers (Cree, 2003). Young carers have poor mental health in comparison with peers (Lloyd, 2013; Tseliou et al., 2018) and are more likely involved in risky behaviour (Cree, 2003).

3.3 | Identity domain

The identity domain is a series of four configurations with each mechanism embedded in the next configuration as a contextual factor (Figure 4). The first, assignment configuration ($\text{CMO}^{7.}$) concerns how children can potentially be selected to be a carer by their family, and is evidenced by nine studies. A single contextual factor, *duty* (C^{7a}), reflects the cultures of African countries (Andersen, 2012; Lane et al., 2015; Olang'o et al., 2012; Robson et al., 2006; Skovdal, 2011; Skovdal et al., 2009; Skovdal & Ogutu, 2009) and South Korea (Hwang & Charnley, 2010) where children are raised to have a duty (C^{7a}) towards elderly or unwell relatives. In place of cultural duty, Aldridge and Becker (1993) evidenced familial duty as a reason for caring in the UK. There is significant evidence that gender is an important part of this duty, with females more likely selected to be young carers (Olang'o et al., 2012; Robson et al., 2006; Skovdal, 2011; Skovdal et al., 2009), though Hwang and Charnley (2010) found that

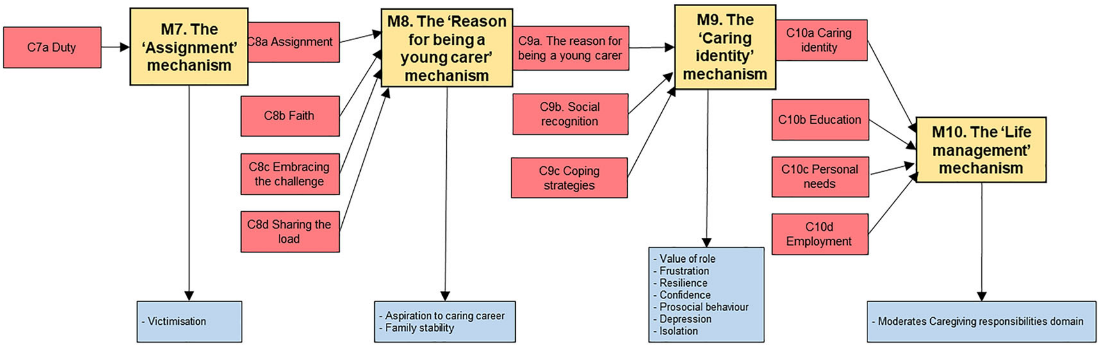

FIGURE 4 Identify domain

male young carers in Korea are common due to the honour attached to the role. Evidence was also found of age as important with older children becoming carers (Andersen, 2012; Hwang & Charnley, 2010; Skovdal et al., 2009). Evidence in the synthesis indicated that assigned young carers can feel victimized in the role (Skovdal et al., 2009; Skovdal & Ogutu, 2009).

Assignment (Skovdal, 2011; Skovdal et al., 2009; Skovdal & Ogutu, 2009; C^{8a}) is one of four factors for the next configuration on the reason for being a young carer (CMO^{8}). Ten studies inform this configuration with the remaining contextual factors including religious *faith* or love for the care receiver (Andersen, 2012; Skovdal, 2011; Skovdal & Ogutu, 2009; C^{8b}), *embracing the challenge* for children who are interested in caring (C8^{c}) and potentially aspire to enter a caring career (Kain, 2009; Robson et al., 2006), and *sharing the load* (C8^{d}), which can help to increase family stability (Bolas et al., 2007; Kain, 2009; Nagl-Cupal et al., 2014; Olsen & Clarke, 2003; Skovdal, 2011; Trondsen, 2012).

The caring identity configuration (CMO^{9}) concerns whether the young person perceives their caring as a positive part of who they are, and is based on 10 studies. Again the previous mechanism, the *reason for becoming a young carer* is a contextual factor (Andersen, 2012; Bolas et al., 2007; Skovdal, 2011; Skovdal & Ogutu, 2009; C^{9a}) as choice can impact whether young carers value the role. *Social recognition of their caring* (Andersen, 2012; Bolas et al., 2007; Cassidy & Giles, 2013; Skovdal, 2011; Skovdal et al., 2009; Skovdal & Ogutu, 2009; C^{9b}) is also key, as are coping strategies (C^{9c}). When positive these strategies lead to positive adjustment, role acceptance (Skovdal, 2011; Skovdal et al., 2009), resilience (Cassidy & Giles, 2013), confidence and prosocial behaviour (de Roos et al., 2017; Fraser & Pakenham, 2009). In contrast, avoidance coping strategies causes the young carer's focus to be redirected away from caregiving, leading to poor adjustment to the role, depression (Early et al., 2006; Fraser & Pakenham, 2009) and frustration (Bolas et al., 2007).

The life management configuration (CMO^{10}) is sourced from nine studies and has four contextual factors including the previous mechanism, *caring identity* (Andersen, 2012; Cassidy & Giles, 2013; Skovdal et al., 2009; C^{10a}). Together with *education* (C^{10b}), *personal needs* (C^{10c}) and *employment* (C^{10d}), their caring completes a complex and fluctuating life balance that young carers attempt to manage (Cassidy & Giles, 2013). Their top priority is usually their caring role, ahead of school (Andersen, 2012; Bauman et al., 2007; Kain, 2009; Kavanaugh, 2013; Olsen & Clarke, 2003; Robson et al., 2006; Skovdal et al., 2009; Thomas et al., 2003) and their personal needs that includes health and social components (Kain, 2009; Kavanaugh, 2013; Olsen & Clarke, 2003; Skovdal et al., 2009). There is also evidence of young carers working to raise income for their family (Andersen, 2012; 2007; Olsen & Clarke, 2003; Skovdal et al., 2009).

3.4 | Support domain

The support domain includes seven configurations (Figure 5). The first, supportive community configuration, refers to the support made available to young carers and their families in the local area and

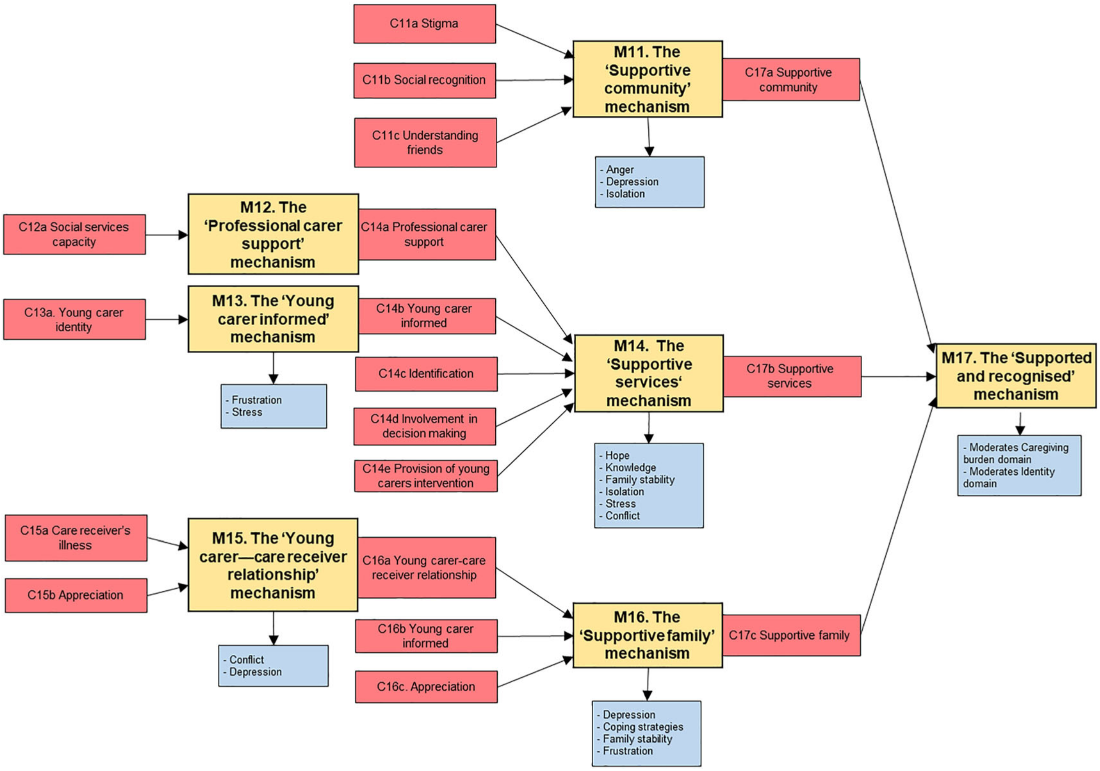

FIGURE 5 Support domain

contains data from 12 studies. The first of three contextual factors, *stigma* (C^{11a}) is due to particular illnesses being viewed as undesirable, for example AIDS (Bolas et al., 2007; Martin, 2006; Olang'o et al., 2012; Skovdal & Ogutu, 2009) or substance misuse issues (Moore et al., 2011). This can result in significant isolation from the community. In contrast *social recognition* (C^{11b}) of the young carer can increase community support and reduce this isolation (Andersen, 2012; Skovdal et al., 2009; Skovdal & Ogutu, 2009). The presence of *understanding friends* (C^{11c}) is the final factor with positive friendships potentially reducing the stress, anxiety and depression caused by the caregiving itself (Kain, 2009; Kavanaugh, 2013; Nichols et al., 2013; Sharer, 2015; Skovdal et al., 2009; Williams et al., 2009).

The professional carer support configuration (CMO^{12}) concerns the provision of formal support for the care receiver from outside the family. It is informed by four studies and has one contextual factor with *social services capacity* (C^{12a}) limiting the number of families who receive professional support (Aldridge, 2006; Aldridge & Becker, 1993; Andersen, 2012; Olang'o et al., 2012).

The young carer informed configuration (CMO^{13}) relates to the provision of information about the care receiver's illness from social care and health professionals. The configuration is evidenced by four sources and has a single contextual factor relating to *young carer identity* (CMO^{13a}) and the appropriate age to receive particular information to support them as a carer (Aldridge & Becker, 1993; Martin, 2006; Nichols et al., 2013; Trondsen, 2012). Trondsen (2012) found that a lack of information or training can cause stress and increase frustration.

Both the *professional carer support* (Aldridge, 2006; Aldridge & Becker, 1993; C^{14a}) and *informed young carer* (Aldridge & Becker, 1993; Martin, 2006; Nichols et al., 2013; C^{14b}) configurations are embedded as contextual factors in the supportive services configuration (CMO^{14}). The configuration concerns whether education, health and social services meet the needs of young carers and is informed by 11 sources. The configuration includes three further contextual factors. There is evidence that a lack of *identification* (C^{14c}) by services can cause isolation (Aldridge, 2006; Aldridge & Becker, 1993; Thomas et al., 2003), with negative experience of school increasing conflict. In contrast positive experiences increase hope (Andersen, 2012; Skovdal et al., 2009). There was also evidence that young carers are not involved in *decision making* (Andersen, 2012; Martin, 2006; Robson et al., 2006; Thomas et al., 2003). The *provision of young carers projects* (C^{14e}) are valued by as a place to meet other young carers and receive support (Aldridge, 2006; Kavanaugh, 2013; Moore et al., 2011; Thomas et al., 2003), with benefits including isolation and stress reduction, increased knowledge of the illness and family cohesion (Coles et al., 2007).

The young carer—care receiver relationship configuration (CMO^{15}) is informed by eight studies. Symptoms relating to the *care receiver's illness* (C^{15a}) have the potential to affect their behaviour and the relationship with the young carer (Aldridge & Becker, 1993; Bolas et al., 2007; Martin, 2006; Nichols et al., 2013), potentially resulting in conflict (Kavanaugh, 2014). The relationship is also affected by *the appreciation* of the young carer (Kain, 2009; Martin, 2006; C^{15b}), with the potential for depression (Bauman et al., 2007) if the young carer does not feel fully appreciated (Kavanaugh, 2013, 2014).

The supportive family configuration (CMO^{16}) is based on nine studies and has three contextual factors including the previous *young carer—care receiver relationship* configuration as an embedded mechanism (Kavanaugh, 2013; Martin, 2006; Nichols et al., 2013; Trondsen, 2012; C^{16a}). Being *informed about the illness* (C^{16b}) by family is important (Kain, 2009; Nichols et al., 2013; Robson et al., 2006; Trondsen, 2012), but evidence suggests that families are reluctant to tell the young person (Martin, 2006) despite evidence that this reduces frustration and enables the development of coping strategies. *Appreciation* within the family (C^{16c}) was also important (Kain, 2009) with evidence of greater stability (Nichols et al., 2013). Previous research also linked appreciation with decreased depression (Bauman et al., 2007; Kavanaugh, 2013, 2014; Sharer, 2015).

The final supported and recognized configuration (CMO^{17}) has three contextual factors and is based on eight sources (Aldridge, 2006; Kain, 2009; Kavanaugh, 2013; Martin, 2006; Nichols et al., 2013; Robson et al., 2006; Sharer, 2015; Skovdal et al., 2009). Each factor is an embedded configuration concerning support from different levels of society, namely, *community* (C^{17a}), *services* (C^{17b}) and *family* (C^{17c}).

4 | DISCUSSION

4.1 | Summary of findings

This realist synthesis of previous research has resulted in a model of the relationship between young carer status and mental and psychosocial health, with three domains concerning caregiving responsibilities, identity and support. The realist approach of utilizing CMO configurations provides a framework by which to structure previous findings and gives clarity to the question of the ways in which young carer status impacts children differently depending on their lives. Despite the synthesis focusing on the outcomes of caring as a result of the social system rather than interventions, CMO configurations are still central. They are however framed differently with the mechanisms not targeted by a social programme but mapped in situ, based on pre-existing societal contextual factors.

The next stage for a traditional realist synthesis would be to utilize the model to evaluate a type of intervention by assessing whether it is able to trigger mechanisms and enable positive change. The results would then inform recommendations for the future of the interventions. As this is a realist synthesis of pre-existing social context the model can instead be used to inform intervention development rather than evaluation.

4.2 | Limitations

Despite including 44 studies, there is a need to refine and test the resultant model further with the reliability of the individual configurations, and therefore the wider model, dependent on the diversity of the dataset evidence. The most reliable configurations concern topics regularly researched in the past with the time spent caring configuration (CMO^4) and the caregiving responsibilities configuration (CMO^6) informed by 16 and 11 studies, respectively. In contrast the other family members in employment configuration (CMO^2) and the professional carer support configuration (CMO^{12}) are informed by two and four sources. When evidence is sparse, there is an increased risk that additional contextual factors or outcomes have not been identified or that those identified are incorrect. In addition, evidence from a larger number of sources could help resolve uncertainties that could indicate potential reliability issues. For example, it is unclear whether the impacts of caregiving responsibilities (CMO^6) grow over time (Aldridge, 2006) or peak for middle range carers (Cree, 2003), and further research would resolve this conflict.

There is a larger limitation to the realist synthesis in terms of young carers who are unidentified, and therefore unsupported, by key services including social services and schools. Although past research has highlighted the importance of identifying these young carers, little progress has been made as to how this should happen with the majority of research recruiting participants through young carer services where they are already receiving support. With the exception of the population-wide quantitative studies, unidentified young carers are not represented in the evidence. As a result of this they are also under-represented in the model, with *identification* a contextual factor for the supportive services configuration (CMO^{14}) but otherwise absent. This implies that, with the exception of identification by services, the lives and experiences of unidentified young carers are largely similar to as identified young carers when their unidentified status will potentially be a contextual factor for multiple configurations, and disclosure a key mechanism. Research with this population in particular will help strengthen the model.

5 | CONCLUSION

This study adapted the traditional realist synthesis methodology to focus on the pre-existing social context of young carers with a focus on caring responsibilities but also support and the development of a caring identity. The study clarifies why the mental and psychosocial health benefits and impacts vary for different young carers and identifies a number of possible mechanisms, which could be targeted by future interventions. It also reinforces the need to involve all young carers in research, including those not currently known to services.

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AUTHOR CONTRIBUTIONS

Conceptualization was performed by E. J., D. F. and G. J. M. T. Methodology was developed by E. J. and G. J. M. T. Validation was performed by E. J., G. J. M. T. and H. R. Formal analysis was carried out by E. J. Interpretation of results was performed by E. J., D. F. and G. J. M. T. Writing was made by E. J. Review and editing was carried out by D. F., G. J. M. T. and H. R. Approval of final manuscript was made by E. J., D. F. and G. J. M. T.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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