

Determination of burnout, life satisfaction, and stress coping styles of parents with disabled children

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Abstract

Purpose: This study determined problems, fatigue, life satisfaction, family stress, and coping strategies of families who had a disabled child and the relationships between them.

Design and Methods: This descriptive and cross-sectional study conducted with 191 parents of children with disabilities.

Findings: As the life satisfaction of childcare providers increased, their emotional exhaustion decreased and sense of personal accomplishment increased ($p < 0.05$).

Practice Implications: It is necessary that nurses and health team members should provide regular and continuous education for burnout, life satisfaction, family stress and coping styles to parents of disabled children using interactive education techniques and group interactions.

KEYWORDS

burnout, coping with stress, disabled child, life satisfaction parent

1 | INTRODUCTION

Having a child with a disability is a crisis situation that can affect the quality of life of family members, the gender roles of parents, their economic expenses, their working status, their health, stress situations, their decision to maintain a marriage, and their decision to give birth to a new child.¹ The presence of a disabled person in the family generates ongoing problems in every period of life. Living with a disabled individual requires adaptation and causes some limitations in the lives of family members.^{2,3} The birth of the disabled child or the subsequent disability situation causes difficulties and changes as the family members adapt to the new conditions, family structure, and relationships with each other and their inner worlds.⁴ It is emphasized that this situation, which is difficult to get used to, affects parents' close environment economically, socially, and psychologically.^{2,3,5} In addition, disability in children affects

the emotional burden in the family, the social support for families is low,⁶ and the physical and mental health of mothers, especially, is negatively affected due to their higher responsibility for these children.⁷

Families need help and support in dealing with the stressful and long-term changes required to care for a child with disabilities. Therefore, it is important for nurses who care for children with disabilities and their families to know these families, to know their lives, and to plan family-centered nursing care. The nurse should make a holistic and family-centered care plan using many roles and independent functions such as educator, counselor, advocate, decision maker, and caregiver while carrying out her studies in this field.^{8,9} Research indicates that the gathering of families with similar problems has positive effects, professional support services for families reduces stress, family burdens,⁶ and burnouts, and increase their satisfaction.^{10,11} Nurses, who have a responsibility to provide

holistic care to families, should advise these families on coping with stress and take initiatives to increase their social support.^{10,12,31} Despite descriptive studies in the literature regarding the problems experienced by families with disabled children,^{1,13–18} we did not encounter any study emphasizing the relationship between burnout, life satisfaction, and coping styles of families with children with disabilities. Therefore, this study was needed.

2 | THE AIMS OF THE STUDY

This study determined problems, fatigue, life satisfaction, family stress, and coping strategies of families who had a disabled child and the relationships between them.

3 | METHODS

3.1 | Study design and population

This descriptive and cross-sectional study occurred in Turkey's centrally located province in Cappadocia, Family and Social Policies Provincial Directorate of Disability Services, located in the Department of Finance. Data was collected between April 2016 and June 2016. Parents of children with disabilities in the 0–18 age group were included.

The population of the study was composed of all parents who registered disabled children ($N: 278$) according to 2015 data. In the study, no sample calculations were made and all parents who voluntarily agreed to participate in the study were included. The research was completed with 191 parents.

4 | DATA COLLECTION TOOLS

4.1 | Information form

The researchers developed this based on the literature reviewed.^{6,19–21} The information form gathered the socio-demographic characteristics of the child with disabilities and their parents. Questions regarding the difficulties experienced by the parents in their individual and family life due to the disability in their children were included.

4.2 | Maslach Burnout Inventory

The scale, developed by Maslach and Jackson, consists of 22 items. The scale evaluates three subscales of burnout: “emotional exhaustion” (9 items), “personal accomplishment” (8 items), and “depersonalization” (5 items). From subscales of the Maslach Burnout Inventory, 0–36 points can be obtained for the emotional exhaustion (Cronbach $\alpha = 0.83$), 0–32 points can be obtained for the personal accomplishment (Cronbach $\alpha = 0.72$) and 0–20 points can be obtained for the depersonalization (Cronbach $\alpha = 0.65$)²² In this current study Cronbach α values of the

subscales were 0.84, 0.76, and 0.55, respectively. The scale does not give total points but gives the total score of each subscales. High burnout reflects a high score in the “emotional exhaustion” and “depersonalization” subscales and a low score in the “personal accomplishment” subscale. Moderate burnout reflects moderate scores for all three subscales. Low level burnout reflects low scores on the “emotional exhaustion” and “depersonalization” subscales and high scores on the “personal accomplishment” subscale. In scoring, three separate burnout points are calculated for each person.²²

4.3 | Life Satisfaction Scale

On the scale developed by Diener in 1985,²³ participants are presented with five situations they are asked to score using a 7-grade scale as follows: (1) “I certainly agree” to (7) “I certainly do not agree.” A minimum of 5 and a maximum of 35 total points can be obtained. According to the total score of the scale, high scores indicate higher life satisfaction.²⁴ In the Turkish validity and reliability study of the life satisfaction scale, the Cronbach α value is 0.88. In this study Cronbach α value of the Life satisfaction scale is 0.80.

4.4 | Stress Coping Styles Scale (SCSS)

This scale is a 30-item, 5-subscale scale developed by Folkman and Lazarus called Ways of Coping Inventory in 1980 to determine the ways individuals use to deal with general or pronounced stressful situations.²⁵ Siva carried out the first standardization study of the scale. The scale is a 4-point Likert type and self-assessing scale rated from “not suitable” to “very convenient.” In the evaluation of the scale, the total score is not obtained, and separate scores are calculated for the subscales. The scale has two dimensions: problem-focused or emotion-focused. Effective approaches to problems are described as “self-confident,” “optimistic,” and “seeking social support” whereas ineffective approaches are “helpless” and “submissive.” The range of scores that can be obtained from the subscales are 7–28 points for the self-confident (Cronbach $\alpha = 0.80$), 5–25 points for the optimistic (Cronbach $\alpha = 0.68$), 4–16 points for the seeking social support (Cronbach $\alpha = 0.47$), 8–32 points for the helpless (Cronbach $\alpha = 0.73$) and 6–24 points for the submissive (Cronbach $\alpha = 0.70$). The score increase in the subscales is interpreted as the individuals use that method of coping more.²⁶ In this study Cronbach α values of the subscales were 0.79, 0.68, 0.50, 0.66, and 0.48, respectively. When categorizing ways of coping as effective and ineffective, internal consistencies were found to be 0.76 for effective and 0.69 for ineffective ways of coping.

4.5 | Ethics

Ethics committee approval from the University Non-Interventional Ethics Committee (2016/11.01) and written permission from the Provincial Directorate of Family and Social Policies, where the study

was carried out, was obtained before starting the study. In addition, the participants were informed about the purpose of the study, were asked to participate in the study, and their verbal and written consent was obtained.

5 | DATA ANALYSIS

The data were evaluated using a statistics program. Number, percentage, arithmetic mean, and standard deviation distribution were used to evaluate descriptive statistics. In addition, the data were evaluated using the significance test of the difference between the two means (independent *t*, Mann-Whitney *U*) and Pearson Correlation tests. The homogeneity of the variances was checked using the Levene test. Statistical significance of the results was evaluated at $p < 0.05$ level.

6 | RESULTS

Looking at the sociodemographics of the parents, 60.7% of the mothers and 53.4% of the fathers were primary school graduates, the majority of the mothers (96.3%) did not work, and 79.1% of the fathers worked. Most families had a nuclear structure (77%), 39.8% had three children, and more than half of the parents (66.5%) stated their income status as “less income than expenses” (Table 1).

It was determined that 60.7% of the children were male, 46.6% were in the 13–18 age group, and 67% went to the rehabilitation center. Most (68.1%) children were born vaginally, 57.1% had disabilities that emerged after birth, and 33.5% had more than one type of disability. The problems experienced from their disability include speech problems (51.9%) and bed sores (3.8%) (Table 2).

The majority of the families (86.9%) had difficulties in caring for the disabled child in general and most of them had difficulties in meeting hygiene requirements (61.3%) as well as communicating, education, walking, dressing, and eating (60.3%, 59.7%, 57.1%, 52.4%, and 48.7%, respectively) (Table 3).

Parents whose children were in the 0–5 age group used the submissive approach more ($p < 0.05$). There was no statistically significant difference between the gender of the child and the parents' SCSS subgroup scores (for all: $p > 0.05$). While 57% of the parents stated they thought they were not understood by the people around them, 61.1% stated that they felt “sadness, disappointment, anxiety” for their disabled children. When questioned about the impact of their child's disability diagnosis on their family and social relationships, the relationships of parents with healthy children, relatives, neighbors, and their spouses (53.9%, 48.7%, 48.2%, and 41.9%, respectively) were affected and the majority (89.5%) experienced financial difficulties.

Parents who received support in the care of the disabled child used the social support behavior and parents who do not receive support in the care of the child used the submissive approach (Table 4) ($p < 0.05$). Parents who stated that they had difficulty

TABLE 1 Socio-demographics of parents

Family characteristics	Count	%
Responding person		
Mother	169	88.4
Father	11	5.8
Other ^a	11	5.8
Mother's education status		
Not literate	29	15.2
Primary school graduate	116	60.7
Middle school graduate	15	7.9
High school graduate	31	13.1
University graduate	2	1.0
No answer	4	2.1
Father's education status		
Not literate	9	4.7
Primary school graduate	102	53.4
Middle school graduate	33	17.3
High school graduate	34	17.8
University graduate	6	3.1
No answer	7	3.7
Mother working status		
Working	4	2.1
Not working	184	96.3
No answer	3	1.6
Father working status		
Working	151	79.1
Not working	29	15.2
No answer	10	5.2
Family structure		
Nuclear family	147	77.0
Extended family	33	17.3
Broken family	11	5.7
Perceived income status		
Revenue is less than expenses	127	66.5
Revenue is more than expenses	11	5.8
Revenue is equal to expenses	53	27.7
Number of children in the family		
One	14	7.3
Two	61	31.9
Three	76	39.8
Four or more	40	21.0

^aOther: grandmother and Grandfather.

meeting the hygiene requirements of the child used the desperate and submissive approach ($p < 0.05$). Parents who stated they had difficulties in getting the child around, eating, and dressing also used the submissive approach ($p < 0.05$) (Table 4).

Those with no support, including from their spouse, had less life satisfaction ($p < 0.05$). In addition, those who stated that they had difficulty in all kinds of care (walking, communication, dressing,

TABLE 2 Characteristics of children with disabilities

Characteristics of children with disabilities	Count	%
Gender		
Female	75	39.3
Male	116	60.7
Age		
0–3	10	5.1
4–6	22	11.6
7–12	70	36.7
13–18	89	46.6
Going to the rehabilitation center		
Going	128	67.0
Not going	63	33.0
Form of delivery		
Normal vaginal delivery	130	68.1
Cesarean delivery	61	31.9
Time disability was identified		
At birth	82	42.9
After birth	109	57.1
Disability type		
Physically disabled	28	14.7
Mildly mentally disabled	8	4.2
Moderately mentally disabled	39	20.4
Severely mentally disabled	48	25.1
More than one type of disability	64	33.5
Other ^a	4	2.1
Problems faced due to the disability (n: 264)^b		
Hearing	21	7.9
Talking	137	51.9
Walking	96	36.4
Bedsore	10	3.8

^aOther: deaf, visually impaired.

^bMore than one answer was given. Percentages are calculated on “n” values.

education, and feeding) had less life satisfaction ($p < 0.05$) and more emotional exhaustion ($p < 0.05$) (Table 5).

There was a moderately negative relationship between life satisfaction and emotional exhaustion of the caregivers of the disabled child and a weakly positive relationship between life satisfaction and personal accomplishment ($p < 0.01$) (Table 6).

7 | DISCUSSION

The age of the disabled child can influence the difficulties experienced by the mothers and their coping strategies. According to the study of Oymak and Arslan,¹⁴ mothers of young children experience more problems than those of older children. One of the important findings in this study is that parents whose

TABLE 3 Fields where families have difficulty in caring for a disabled child

Difficulties experienced	Count	%
General		
Having difficulties	166	86.9
Not having difficulties	25	13.1
Walking		
Having difficulties	109	57.1
Not having difficulties	80	41.9
No answer	2	1.0
Communication		
Having difficulties	115	60.3
Not having difficulties	74	38.7
No answer	2	1.0
Meeting the hygiene requirement		
Having difficulties	117	61.3
Not having difficulties	72	37.7
No answer	2	1.0
Dressing		
Having difficulties	100	52.4
Not having difficulties	89	46.6
No answer	2	1.0
Feeding		
Having difficulties	93	48.7
Not having difficulties	96	50.3
No answer	2	1.0
Education		
Having difficulties	114	59.7
Not having difficulties	75	39.3
No answer	2	1.0
Supporting person(s)		
Present	103	53.9
Absent	88	46.1
Supporting person(s)^a		
My family	73	38.2
My friends	5	2.6
My partner	28	14.7
My children	8	4.1
Reeve, municipality	1	0.5
Being understood by other people		
Yes	82	43.0
No	109	57.0
Feelings as a mother of a disabled child^a		
“I see him/her as a gift given to me, I am thankful”	15	7.8
“Sadness, astringency, anxiety”	118	61.1
“I got used to it”	15	7.8
“It is very difficult, you cannot know unless you live with it”	17	8.8
Other ^b	28	14.5

TABLE 3 (Continued)

Difficulties experienced	Count	%
Unanswered	7	3.1

Note: The bold values indicate the percentage of the most common responses given by parents.

^aMore than one answer was given.

^bOther (“I am hopeful, I think it is a test, I feel tired, I cannot get into the community, I am overwhelmed, I am hopeless...”).

children were in the 0–5 age group used more of the submissive approach to cope with stress ($p < 0.05$) (Table 4). If the disabled child is both in the young age group and has more than one disability, they have increased dependence on the parent caregiver. In this study, 86.9% of the participants stated that had difficulty caring for children with disabilities, primarily in communicating, educating, walking, dressing, and eating (60.3%, 59.7%, 57.1%, 52.4%, and 48.7%, respectively) (Table 3). Parents who had these difficulties used the submissive approach to cope with stress ($p < 0.05$) (Table 4). These results show it is difficult for mothers to care for their disabled child and they use ineffective methods for coping with these difficulties. Masulani-Mwale et al.¹⁹ stated it is tiring for the mothers when the children are dependent on them, but mothers feel compelled to fill this role. The mother often takes full responsibility for her child, does not have sufficient support,²⁷ especially in the nuclear family, and has difficulties performing other roles.²⁸ At this point, parents need professional and social support.²⁹ The reason mothers need support is that the rate of mothers' participation in childcare is higher than that of fathers.¹⁰ In the study, mothers who received support from their spouses in the care of the disabled child were low (14.7%). This is an important finding because it shows the mother plays the greatest role in the care of the disabled child, and sometimes is the only caregiver. Similar to the findings of this study, others have found the father's support in the care of the disabled child is low.³⁰ Because childcare and housework are considered the primary duty of women in a patriarchal society, this situation increases the burden of the mother in the care of the disabled child.

The disability often changes the daily routines of caregivers due to the workload it brings and can often lead to negative psychological and social effects.³¹ While 57% of the mothers stated that they thought that they were not understood by the people around them, 61.1% stated they felt “sadness, disappointment, anxiety” for their disabled children. In another study, parents felt sad after learning about the discomfort of their children, but most of these parents eventually accepted the situation due to their belief in fate. Some parents with sadness could not accept the seriousness of the situation and the negative perspective of society.²⁸ In the study, after their children were diagnosed as “disabled,” their family and social

relationships were negatively affected and most of them experienced financial problems. In the study conducted by Kahrman et al.,³² the relationships of individuals with disabled children with their spouses, friends, relatives, and neighbors were negatively affected. Having a child with a disability is a phenomenon that is difficult to accept for the family, restricting and complicating their individual and social lives.³¹

Mothers who have disabled children have difficulties in the care and treatment of their children and they experience burn-out, hopelessness, depression, and stress.^{13,15,17,18,30} The stress that families experience not only affects their ability to care for the child, but also affects their mental and physical health and the quality of their relationship with their children.²¹ Therefore, the coping styles used by the parents to handle this stress are important for well-being and psychological health.

In this study, the parents who received support in the care of the disabled child used the social support behavior, and the parents who did not receive child care support used the submissive approach ($p < 0.05$) (Table 4). Similarly in another study, it was found that disabled children's mothers who are received social support, use effective ways of coping with stress.¹⁴ The supportive attitudes of relatives, close friends, and spouses, which are described as social support, are an important factor in coping.^{10,21}

When tackling a problem-oriented coping strategy, there is a tendency to actively solve the problem or passive coping, such as avoidance, depersonalization, and ignoring. When using a problem-oriented coping strategy, the problem is actively solved by seeking social support and using an optimistic and self-confident approach. However, using emotional-oriented coping relies on avoiding, depersonalization, and submissive approaches. Although positive emotional coping tactics are necessary for the individual to maintain his psychological well-being, long-term passive tactics do not solve the problem.²⁵

In this study, the life satisfaction of those who received support and those who received support from their husbands in coping with the problems they experienced in caring for disabled children were higher ($p < 0.05$). Community relations and family relations affect the family's quality of life positively.³³

Parents may find it difficult to cope with the problems (physical, emotional, and social) that the child experiences. After addressing the physical problems and the increase in workload, care givers may experience a sense of exhaustion if professional support is not received.³¹ In this current study, emotional exhaustion scores of mothers who stated that they had difficulties in all kinds of care of children with disabilities were higher ($p < 0.05$). The burnout level increases as the severity of the child's disability increases.¹³ Families need support systems to deal with the problems faced by families with disabled children, especially the high level of stress and the burnout that occurs after the more intense difficulties.^{17,31} Since intense emotional burden causes serious psychosocial problems in mothers, it is

TABLE 4 Subgroup point averages of the families receiving support in the care of the disabled child, the areas where they had difficulties, and the SCSS

	SCSS subgroups				Searching for social support Median
	Confident approach Median (25th–75th percentile)	Optimistic approach Median (25th–75th percentile)	Desperate approach Median (25th–75th percentile)	Submissive approach Median (25th–75th percentile)	
Problems experienced					
<i>Age of child</i>					
0–5 years	14.50 (12.75–19.00)	10.00 (9.75–12.00)	13.00 ± 4.35 (5.00–22.00)	11.06 ± 1.89 (8.00–14.00)	6.50 (6.00–8.00)
6–12 years	15.00 (14.00–19.00)	11.00 (10.00–13.00)	11.67 ± 3.99 (3.00–21.00)	9.35 ± 2.92 (3.00–18.00)	7.00 (6.00–9.00)
13–18 years	16.00 (14.00–19.00)	11.00 (10.00–13.00)	11.61 ± 4.67 (2.00–24.00)	9.72 ± 2.58 (4.00–15.00)	7.00 (6.00–9.00)
	$\chi^2 = 2.268$ df = 2 p = 0.322	$\chi^2 = 0.639$ df = 2 p = 0.726	F = 0.873 p = 0.420	F = 3.093 p = 0.048	$\chi^2 = 2.388$ df = 2 p = 0.303
<i>Support in childcare</i>					
Present	16.00 (14.00–20.00)	11.00 (10.00–13.00)	12.00 (9.00–14.00)	9.31 ± 2.67 (3.00–15.00)	8.00 (6.00–9.00)
Absent	15.00 (14.00–18.00) U = 3723.00 p = 0.072	10.00 (10.00–12.00) U = 3840.00 p = 0.135	12.00 (9.00–14.00) U = 4332.00 p = 0.884	10.23 ± 2.69 (3.00–18.00) t = -2.342 p = 0.020	7.00 (5.00–8.00) U = 3286.00 p = 0.003
<i>Difficulty traveling with the child</i>					
Experiencing	16.00 (14.00–19.00)	11.00 (10.00–14.00)	12.59 ± 4.37 (2.00–22.00)	10.00 (8.00–12.00)	7.66 ± 2.08 (3.00–12.00)
Not experiencing	16.00 (14.00–20.00) U = 3660.00 p = 0.095	11.00 (10.00–12.00) U = 4129.00 p = 0.703	11.19 ± 4.11 (5.00–21.00) t = 1.863 p = 0.064	9.00 (7.00–10.00) U = 3195.00 p = 0.003	7.70 ± 2.24 (1.00–12.00) t = -0.827 p = 0.409
<i>Difficulty in meeting the hygiene requirement of the child</i>					
Experiencing	16.00 (14.00–18.00)	11.00 (10.00–13.00)	12.51 ± 4.26 (2.00–22.00)	9.69 ± 2.46 (4.00–15.00)	7.00 (6.00–9.00)
Not experiencing	17.50 (14.00–20.00) U = 3580.00 p = 0.148	11.00 (10.00–14.00) U = 3764.00 p = 0.347	11.20 ± 4.28 (3.00–21.00) t = 2.277 p = 0.024	8.83 ± 2.90 (3.00–15.00) t = 2.524 p = 0.012	8.00 (6.00–9.00) U = 3596.50 p = 0.159
<i>Difficulty in dressing the child</i>					
Experiencing	15.00 (14.00–19.00)	11.00 (10.00–13.00)	12.87 ± 4.36 (2.00–22.00)	9.98 ± 2.50 (3.00–15.00)	7.49 ± 2.40 (1.00–12.00)
Not Experiencing	17.00 (14.00–20.00) U = 3711.50 p = 0.081	11.50 (10.00–13.75) U = 3899.00 p = 0.214	11.02 ± 4.04 (2.00–21.00) t = 1.206 p = 0.229	8.65 ± 2.69 (4.00–15.00) t = 2.847 p = 0.005	7.88 ± 1.82 (3.00–12.00) t = -1.042 p = 0.299
<i>Difficulty in feeding the child</i>					
Experiencing	15.00 (14.00–18.00)	10.50 (9.00–13.00)	12.87 ± 4.22 (2.00–22.00)	10.09 ± 2.38 (4.00–15.00)	7.41 ± 2.28 (1.00–12.00)
Not Experiencing	17.00 (14.00–20.00) U = 3606.50 p = 0.038	12.00 (10.00–14.00) U = 3538.00 p = 0.022	11.25 ± 4.25 (2.00–21.00) t = 1.284 p = 0.201	8.73 ± 2.75 (3.00–15.00) t = 2.675 p = 0.008	7.89 ± 2.02 (3.00–12.00) t = -1.793 p = 0.076

Abbreviations: F, one way ANOVA test; SCSS, Stress Coping Styles Scale; t, independent T test; U, Mann-Whitney U test.

TABLE 5 Subgroup averages of the parents, the areas where they have difficulties in the care of the child, and the Life Satisfaction and Maslach Burnout Inventory

Variables	Life satisfaction Median (25–75 percentile)	Personal accomplishment Median (25–75 percentile)	Emotional exhaustion Median (25–75 percentile)	Desensitization Median (25–75 percentile)
<i>Support person for parents</i>				
Present	19.0 (15.0–25.0)	27.0 (25.0–30.0)	10.0 (6.0–15.0)	3.0 (0.0–5.0)
Absent	15.0 (11.75–20.25)	26.0 (21.0–29.0)	12.5 (6.0–18.0)	3.5 (2.0–5.0)
	<i>U</i> = 3249.000 <i>p</i> = 0.002	<i>U</i> = 37.71.500 <i>p</i> = 0.078	<i>U</i> = 38.24.000 <i>p</i> = 0.106	<i>U</i> = 4186.000 <i>p</i> = 0.511
<i>Spouse support in the care of the child</i>				
Present	18.0 (13.0–24.25)	27.0 (23.75–30.0)	11.0 (6.0–16.0)	3.0 (1.0–5.0)
Absent	15.0 (10.25–20.0)	26.0 (21.5–28.0)	10.5 (7.0–19.0)	3.0 (0.0–7.0)
	<i>U</i> = 2577.500 <i>p</i> = 0.012	<i>U</i> = 3153.000 <i>p</i> = 0.437	<i>U</i> = 3060.000 <i>p</i> = 0.293	<i>U</i> = 3390.500 <i>p</i> = 0.957
<i>Difficulty in the general care of the child</i>				
Experiencing	17.0 (12.0–22.0)	26.0 (22.75–29.0)	12.0 (7.0–17.0)	3.0 (0.0–5.0)
Not experiencing	25.0 (17.5–29.0)	28.0 (25.5–31.0)	6.0 (2.0–10.5)	3.0 (0.5–5.0)
	<i>U</i> = 1225.000 <i>p</i> = 0.001	<i>U</i> = 1646.500 <i>p</i> = 0.121	<i>U</i> = 1106.500 <i>p</i> < 0.001	<i>U</i> = 1994.000 <i>p</i> = 0.750
<i>Difficulty traveling with the child</i>				
Experiencing	17.0 (11.0–22.0)	26.0 (22.0–29.0)	13.0 (8.08–18.0)	3.0 (0.25–5.75)
Not experiencing	19.5 (14.0–25.75)	27.0 (25.0–30.0)	8.5 (4.5–14.75)	3.0 (0.0–5.0)
	<i>U</i> = 3255.000 <i>p</i> = 0.004	<i>U</i> = 3758.500 <i>p</i> = 0.127	<i>U</i> = 2912.000 <i>p</i> < 0.001	<i>U</i> = 4246.500 <i>p</i> = 0.840
<i>Difficulty in communicating with the child</i>				
Experiencing	17.0 (12.0–22.0)	26.0 (22.0–28.0)	13.0 (7.0–17.0)	4.0 (1.0–6.0)
Not experiencing	19.0 (13.75–26.0)	27.5 (24.0–30.0)	9.5 (5.0–14.0)	2.5 (0.0–5.0)
	<i>U</i> = 3414.500 <i>p</i> = 0.022	<i>U</i> = 3465.500 <i>p</i> = 0.031	<i>U</i> = 3356.500 <i>p</i> = 0.014	<i>U</i> = 3739.500 <i>p</i> = 0.154
<i>Difficulty in meeting the hygiene requirement of the child</i>				
Experiencing	17.0 (12.5–22.0)	26.0 (23.0–29.0)	12.0 (7.0–17.0)	3.0 (0.0–5.0)
Not experiencing	19.0 (12.25–26.0)	27.0 (22.5–30.0)	9.5 (5.25–15.0)	3.0 (1.0–5.0)
	<i>U</i> = 3489.000 <i>p</i> = 0.048	<i>U</i> = 3717.500 <i>p</i> = 0.174	<i>U</i> = 3416.000 <i>p</i> = 0.029	<i>U</i> = 4160.500 <i>p</i> = 0.886
<i>Difficulty in dressing the child</i>				
Experiencing	16.0 (11.0–21.75)	26.0 (22.25–29.0)	14.0 (9.0–17.75)	4.0 (1.0–6.0)
Not experiencing	19.0 (15.0–24.5)	27.0 (24.0–30.0)	8.0 (4.5–14.0)	2.0 (0.0–4.5)
	<i>U</i> = 3387.000 <i>p</i> = 0.005	<i>U</i> = 4003.500 <i>p</i> = 0.233	<i>U</i> = 2972.500 <i>p</i> < 0.001	<i>U</i> = 3694.000 <i>p</i> = 0.041
<i>Difficulty in the education of the child</i>				
Experiencing	17.0 (12.0–22.0)	26.0 (22.0–29.0)	13.0 (8.0–18.0)	4.0 (1.0–6.0)
Not experiencing	19.0 (14.0–25.0)	27.0 (24.0–30.0)	8.0 (4.0–15.0)	2.0 (0.0–4.0)
	<i>U</i> = 3472.000 <i>p</i> = 0.029	<i>U</i> = 3906.500 <i>p</i> = 0.315	<i>U</i> = 3030.000 <i>p</i> = 0.001	<i>U</i> = 3629.500 <i>p</i> = 0.075
<i>Difficulty in feeding the child</i>				
Experiencing	17.0 (12.0–22.0)	26.0 (21.0–28.0)	14.0 (0–18.5)	4.0 (1.0–5.5)
Not experiencing	19.0 (13.0–25.0)	27.5 (24.25–30.0)	9.0 (4.0–14.0)	2.0 (0.0–5.0)
	<i>U</i> = 3519.000 <i>p</i> = 0.012	<i>U</i> = 3555.000 <i>p</i> = 0.015	<i>U</i> = 2995.000 <i>p</i> < .001	<i>U</i> = 4074.500 <i>p</i> = .294

TABLE 6 Correlation between parents' life satisfaction and Maslach Burnout Inventory Subgroup Mean Scores

	Life satisfaction <i>r</i>	Personal accomplishment <i>r</i>	Emotional exhaustion <i>r</i>	Desensitization <i>r</i>
Life satisfaction	1.000			
Personal accomplishment	0.328*	1.000		
Emotional exhaustion	-0.465*	-0.420*	1.000	
Desensitization	-0.277*	-0.315	0.493*	1.000

Abbreviations: *r*, Pearson correlation coefficient.

* $p < 0.01$.

Pearson *r*

$0 < r < 0.20$: very weak correlation.

$0.20 \leq r < 0.40$: Weak correlation.

$0.40 \leq r < 0.60$: Moderate correlation.

$0.60 \leq r < 0.80$: Good correlation.

$0.80 \leq r \leq 1$: Strong correlation.

important to address the difficulties experienced by mothers professionally. Education and counseling for the family can reduce the high level of stress and burnout experienced, especially for the mother.

The most important result of the study is that as the life satisfaction of those who care for the disabled child increases, their personal accomplishment increases ($p < 0.05$) and their emotional exhaustion decreases ($p < 0.01$). Similar to this study, a negative correlation was found between the burnout level of the mothers who have disabled children and their perceptions of quality of life and life satisfaction.¹³ Social and educational support for families with children with disabilities can contribute to increasing life satisfaction and personal achievement levels and reducing burnout levels. Nurses can try to reduce the burden and stress of the family and help them cope with it through efforts intended to meet the needs of families with children with disabilities.^{8,9} In addition to these activities, nurses should take a more active role in the education and support provided to the families of children with mental disabilities.¹⁰

8 | CONCLUSION

Having a disabled child can affect parents' gender roles, economic expenses, health, quality of life and satisfaction, stress levels and coping with stress abilities. Parents' getting adequate social support and getting professional help both increase their life satisfaction and enable them to use effective methods of coping with stress. The most important result of the study was that as the life satisfaction of those who care for the disabled child increases, their personal accomplishment increases and their emotional exhaustion decreases. According to the results obtained, it is recommended that:

- Regular monitoring of families with children with disabilities between the ages of 0–5, which is a high risk group for stress mismanagement, and establishing social support groups,

- In the Provincial Directorates of Family and Social Policies, regular and continuous training is provided to the mothers of children with disabilities, using interactive teaching techniques and providing effective group interactions, by a professional team, including nurses,
- Planning the interventions according to the levels of families' burnout, life satisfaction, and ways of dealing with stress at regular intervals after the children are diagnosed with a disability,
- Community trainings to change the negative views of the society towards children with disabilities and to accept these children.

9 | IMPLICATIONS FOR PSYCHIATRIC NURSING PRACTICE

Having a disabled child can affect parents' gender roles, economic expenses, health, quality of life and satisfaction, stress and coping with stress, and burnout levels, depending on the difficulties experienced in the care of the child. Parents' having adequate social support and professional help both increase their life satisfaction and enable them to use effective methods of coping with stress. The most important result of the study: as the life satisfaction increases, their personal success increases and their emotional exhaustion decreases of caregivers of disabled children. It is important for nurses who care for disabled children and their families in clinics, rehabilitation centers and the society in terms of getting to know these families, knowing their lives, and planning nursing care.

10 | LIMITATIONS OF THE STUDY

The collection of data mostly from mothers is a limitation of the research. More fathers' answers to questions may lead to differences in results. For this reason, it is recommended that both mothers' and

fathers' satisfaction with life, coping with stress, and burnout levels should be examined and compared in future research. In addition, how the siblings of mentally handicapped children are affected should be examined.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

AUTHOR CONTRIBUTIONS

Concept: Zehra Çalışkan. **Design:** Zehra Çalışkan and Derya Evgin. **Supervision:** Zehra Çalışkan and Derya Evgin. **Financing:** Zehra Çalışkan, Derya Evgin, Nuray Caner, and Bahriye Kaplan. **Material:** Zehra Çalışkan. **Data collection or processing:** Zehra Çalışkan, Bahriye Kaplan, Nuray Caner, and Gonca Özyurt. **Analysis and interpretation:** Zehra Çalışkan, Derya Evgin, Nuray Caner, Bahriye Kaplan, and Gonca Özyurt. **Literature search:** Zehra Çalışkan and Derya Evgin. **Posted by:** Derya Evgin and Zehra Çalışkan. **Critical revision:** Zehra Çalışkan.

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