



Study of Burnout Syndrome among Sample of Caregivers of Children with Disruptive Behavior Disorders

Prof. Reda Mohammad Ismail¹, Ass. Prof. Rania Hussein Mohammad², Dr. Shaymaa Mohammed Arafa³, Asmaa Mohammad Khamis Mohammad⁴

¹ Professor and Head of Psychiatric Department, Faculty of Medicine, Al-Azhar University; Egypt.

² Ass. Professor of Psychiatry, Faculty of Medicine, Al-Azhar University; Cairo, Egypt.

³ Lecturer of Psychiatry, Faculty of Medicine, Al-Azhar University; Cairo, Egypt.

⁴ M.B., B. Ch, Psychiatry Resident, Al-Azhar University, Egypt.

¹redaismail2004@yahoo.com; ²mohalarania99@yahoo.com; ³sheima_doctor@yahoo.com;

⁴layanashraf2018@gmail.com

Abstract: Background: Parental burnout is a syndrome related to parenthood and characterized by three dimensions: emotional and physical exhaustion, emotional distancing of parents from their children, and loss of parental accomplishment. Many factors can explain the inter individual differences in parental burnout. **Objectives:** Reviewing the available literature on burnout of the care giver of children with disruptive behavior disorders, and their coping strategies. Assess the frequency of burnout among caregivers of children and adolescents with disruptive behavior, assess psychological profile of caregivers of behaviorally disturbed children and adolescents, assess other factors associated with burnout, evaluate their coping strategies. **Subjects and Methods:** This study was a cross sectional comparative study that explores the frequency of burn out, sociodemographic factors, coping strategies among the care givers of children and adolescent with disruptive behavior disorders compared to care givers of apparently healthy matched group. The patients recruited from outpatient clinic of psychiatry department at Al-Zahraa hospital Al-Azhar University after diagnosis of their children to have disruptive behavior disorder by using of - Mini-International Neuropsychiatric Interview for Children and adolescents. This study was carried from February 2019- July 2019. **Results:** In relation to the socio-economic status of caregivers in the study, the present study results revealed that about 68% of the study sample were low socio-economic status compared to 64% in the control group. This may be due to the area covered by al zahraa university hospital is public area with low socioeconomic state. **Conclusion:** Caregivers of children with disruptive behavior disorders have high levels of burn out. More than 60% of the caregivers have burnout. The caregivers burnout was affected by their, age, sex, relation to the child, marital satisfaction, work, and socio-economic status to which they are belonging, and also affected by the sex of the child, type of disruptive behavior disorders, severity the disorder of a however, it had no relation with the caregivers' educational level residence, or marital status. The caregivers used many coping strategies. The most used coping strategy is concentration on the problem.

[Reda Mohammad Ismail, Rania Hussein Mohammad, Shaymaa Mohammed Arafa, Asmaa Mohammad Khamis Mohammad. **Study of Burnout Syndrome among Sample of Caregivers of Children with Disruptive Behavior Disorders.** *J Am Sci* 2019;15(11):1-10]. ISSN 1545-1003 (print); ISSN 2375-7264 (online). <http://www.jofamericanscience.org>. 1. doi:10.7537/marsjas151119.01.

Keywords: Burnout Syndrome, Caregivers, Disruptive Behavior Disorders

1. Introduction

Parental burnout is a syndrome related to parenthood and characterized by three dimensions: emotional and physical exhaustion, emotional distancing of parents from their children, and loss of parental accomplishment. Many factors can explain the interindividual differences in parental burnout (Roskam et al., 2017).

Although one of the most positive experiences reported by parents, parenting might also be hazardous. Recent research has shown that some factors might lead to a form of burnout among parents (Mikolajczak et al., 2017).

Parenting or child rearing is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood. Parenting refers to the intricacies of raising a child and not exclusively to the biological relationship (Brooks, 2017).

The most common caretaker in parenting is the biological parent (s) of the child in question, although others may be an older sibling, a grandparent, a legal guardian, aunt, uncle or other family member, or a family friend. A caregiver helps another person with their medical and personal needs. Unlike a paid healthcare worker, a caregiver has a significant

personal relationship with the person. Caregivers are often family members, typically unpaid, providing care to someone with whom they have a personal relationship (**Schulz and Tompkins, 2010**).

Being a caregiver for someone you know and love can be very rewarding, but it can also be exhausting and frustrating. It's often emotionally, physically, and mentally draining. It tends to limit your social life and can cause financial problems. Caretaker burnout occurs when the stress and burden from these negative effects become overwhelming, negatively affecting your life and health (**Perkins et al., 2012**).

Recent research has attributed the triggering of this syndrome to an accumulation of demographic, situational and dispositional risk factors (**Roskam et al., 2017**).

Disruptive behavior disorders are a group of related psychiatric disorders of childhood and adolescence marked by behaviors such as temper tantrums, interpersonal aggression, defiance, and persistent impairment. Recent estimates indicate that 3.5% of children between the ages of 3 and 17 years had behavioral or conduct problems from 2005 to 2011 (**Epstein et al., 2015**).

Disruptive behavior disorders (DBDs) are among the most common forms of child psychopathology as oppositional defiant disorder (ODD) and conduct disorders (CD) have an estimated world-wide prevalence of 3.3% and 3.2% respectively (**Canino et al., 2010**).

The Disruptive Behavior Disorders (DBDs) especially oppositional defiant disorder (ODD) and conduct disorder (CD) are frequently cooccurring psychiatric disorders in approximately half of children and adolescents with attention deficit hyperactivity disorder (ADHD) (**Masi et al., 2015**).

Oppositional defiant disorder is characterized by recurring pattern of negative, defiant, disobedient and hostile behavior against authority figures (**Hamilton & Armando, 2008**).

ADHD is a developmental disorder of executive functioning that impairs the ability to focus, increases impulsivity, and increases motor activity. The condition is usually diagnosed between the ages of 6 to 12, but symptoms can persist into adulthood. Treatment of adults with persistent symptoms is becoming increasingly common (**Du Rietz et al., 2018**).

Conduct disorder is diagnosed based on a prolonged pattern of antisocial behavior such as serious violation of laws, aggression to peoples and animals, destruction of property and deceitfulness or theft (**Murray & Farrington, 2010**).

As children with disruptive behavior disorders require more supervision and attention than a normal

child would, parents tend to avoid public places such as cinemas, restaurant, shops, and public transport. Parents can also feel embarrassed and ashamed by their child's behavior when they visit relatives or friends. This results in reduced social contact. Adverse family interactions (parent-child, marital, and siblings) are also often linked to the child's behavior (**Myers, 2007**).

Parents and caregivers of children with behavioral disorders often experience significant burden associated with care of the child (**Liu and Lamber, 2007**).

These comprise financial burden, conflicts between family members, high irritability and overprotection in families, effect on family social life, interruption at work, fatigue, sadness and limitations on time, personal freedom, and privacy (**Myers, 2007**).

Regarding the consequences, positioning burnout on a continuum between parental stress and depression (**Hakanen and Rennert, 2008**) suggests that depression may be a frequent consequence at the micro-system level. Other likely consequences include the risk of addiction and deteriorating health, as previously demonstrated for job burnout (**Ahola et al., 2006**).

Consequences of these at the macro-system level would be a significant increase in health care costs. At the meso-level, parental disengagement and low accomplishment may lead to a reduction of responsiveness, which is known to be related to poor parent child relationships and insecure attachment harsh, neglecting parenting or maltreatment (**Wiggins et al., 2015**).

Because of the potentially dramatic and long-lasting consequences that parental burnout may have for children, parental burnout's prospective effect on child development as well as behavioral issues should be a top priority in the research agenda. As well as the child, parental burnout certainly impacts the partner, who has to compensate for his/her cooperant's withdrawal from family life and/or neglectful behavior toward offspring. A negative effect of parental burnout on conjugal conflict and co-parenting is also expected. Finally, our experience with children suffering from externalized disorders suggests that parental burnout may also increase the risk of separation and divorce (**Roskam et al., 2017**).

Aim of the work

Theoretical Part

- Reviewing the available literature on burnout of the care giver of children with disruptive behavior disorders, and their coping strategies.

Practical part

- Assess the frequency of burnout among caregivers of children and adolescents with disruptive behavior.
- Asses psychological profile of caregivers of behaviorally disturbed children and adolescents.
- Asses other factors associated with burnout.
- Evaluate their coping strategies.

2. Subjects and Methods

1. Design of the study:

This study was a cross sectional comparative study that explores the frequency of burn out, sociodemographic factors, coping strategies among the care givers of children and adolescent with disruptive behavior disorders compared to care givers of apparently healthy matched group.

2. Site of the study:

The patients recruited from outpatient clinic of psychiatry department at Al-Zahraa hospital Al-Azhar University.

3. Ethical considerations

The following approvals were obtained in order to conduct the study:

1. A written approval has been obtained for this study from Al-Azhar University Faculty of Medicine Ethical Committee.
2. The study steps were explained to all subjects in order to obtain oral consent. Only patients who agree to participate, included in the study.

Subjects:

Subject's recruitments:

A sample of 50 caregivers male and female above 18 years aged (20 -60) years who care children or adolescent with disruptive behavior disorders aged (7-16) years compared to care givers of an apparently healthy matched control group. Care givers were recruited from psychiatry outpatient clinic in Al-Zahra University hospital after diagnosis of their children to have disruptive behavior disorder by using of - Mini-International Neuropsychiatric Interview for Children And adolescents. This study was carried from February 2019- July 2019.

Aiming to detect the following:

- The frequency of burnout among caregivers.
- The psychological profile of caregivers.
- The other factors associated with burnout.
- Their coping strategies.

Inclusion criteria:

For the children:

- 1- Age range: 7-16 years.
- 2- Gender: males & females.
- 3- With disruptive behavior.

For the caregivers:

Apparently healthy caregiver of child with disruptive behavior.

Exclusion criteria:

For the children:

- 1- Children with chronic medical illness.
- 2- Children with intellectual disability.

For the caregivers:

- 1- Chronic medical or neurological Disease.
- 2- Past history of psychiatric disease.
- 3- Family history of psychiatric disease.

Control group

Control group of 50 caregivers of apparently healthy children were obtained from the relatives of the patients of our sample.

4. Methodology

The children were subjected to the following

- 1- IQ test was done to exclude intellectual disability.
- 2- Child behavior check list was done to pick up the symptoms.
- 3- Mini-International Neuropsychiatric Interview for Children and adolescents (MINI Kid) to diagnose disruptive behavior.
- 4- Conners Scale to asses severity of ADHD.

Both patients and control were subjected to the following:

1. Personal and socio demographic data including age, sex, marital status, residence, educational level, work, marital satisfaction, number of offspring's, relation to the child.
2. Complete medical and neurological history and examination.
3. Family history of psychiatric disease.
4. Complete psychiatric sheet used in psychiatry department of Al -Zahra university hospital and interview.
5. Maslach burnout inventory for assessment of burnout.
6. Coping strategies rating scale.

Statistical analysis

Data were analyzed using statistical program for social science (SPSS) version 20. Quantitative data were expressed as mean \pm standard deviation (SD), median and range (minimum – maximum). Qualitative data were expressed as frequency and percentage.

3. Results

Table (1) as regard Assessment of burnout among caregivers of children with disruptive behavior disorders compared to caregivers of children apparently healthy there was a highly significant difference between both groups regarding all dimensions of burn out.

Table (2) as regard the frequency of burn out among the among caregivers of children with disruptive behavior disorders compared to caregivers of children apparently healthy There were high

statistically significant results as regard to all dimensions of burn out.

Table (4) shows highly statistically significant of sex of the caregivers, type of caregivers, marital satisfaction and statistically significant of socio-economic status.

Table (5) shows highly statistically significant of age of the caregivers, type of caregivers and statistically significant of sex, marital satisfaction and socio-economic status

Table (1): MBI among total sample

		Control group	Patients group	Test value	P-value	Sig.
		No. = 50	No. = 50			
Emotional exhaustion	Low	36 (72.0%)	6 (12.0%)	45.113*	0.000	HS
	Moderate	10 (20.0%)	10 (20.0%)			
	High	4 (8.0%)	34 (68.0%)			
Emotional (score)	Mean ± SD	19.92 ± 8.10	35.16 ± 11.62	-7.608•	0.000	HS
	Range	13 – 45	15 – 51			
Depersonalization	Low	42 (84.0%)	10 (20.0%)	43.464*	0.000	HS
	Moderate	6 (12.0%)	14 (28.0%)			
	High	2 (4.0%)	26 (52.0%)			
Depersonalization score	Mean ± SD	6.04 ± 3.50	12.76 ± 5.62	-7.178•	0.000	HS
	Range	4 – 20	5 – 23			
personal accomplishment	Low	40 (80.0%)	10 (20.0%)	46.182*	0.000	HS
	Moderate	10 (20.0%)	12 (24.0%)			
	High	0 (0.0%)	28 (56.0%)			
personal accomplishment score	Mean ± SD	38.96 ± 5.22	32.00 ± 6.49	5.910•	0.000	HS
	Range	20 – 46	18 – 44			

P-value > 0.05: Non significant; P-value < 0.05: Significant; P-value < 0.01: Highly significant

*: Chi-square test; •: Independent t-test

Table (2): The frequency of burn out among both groups

		Control group	Patients group	Test value	P-value	Sig.
		No. = 50	No. = 50			
Emotional exhaustion (score)	Positive	4 (8.0%)	34 (68.0%)	38.200	0.000	HS
	Negative	46 (92.0%)	16 (32.0%)			
Depersonalization (score)	Positive	8 (16.0%)	40 (80.0%)	41.026	0.000	HS
	Negative	42 (84.0%)	10 (20.0%)			
personal accomplishment (score)	Positive	17 (34.0%)	31 (62.0%)	7.853	0.005	HS
	Negative	33 (66.0%)	19 (38.0%)			

Table (3): The coping strategies used by the care givers

		Patients group
		No. = 50
Concentration on the problem	Mean ± SD	21.80 ± 4.22
	Range	11 – 29
Optimistic thinking	Mean ± SD	11.08 ± 2.32
	Range	6 – 14
Searching for support	Mean ± SD	10.16 ± 2.55
	Range	2 – 13
Escape from the problem	Median (IQR)	8 (5 – 11)
	Range	1 – 21
Self-blame	Median (IQR)	0 (0 – 4)
	Range	0 – 6

Table (4): Relation between sociodemographic data of the care givers and the first dimension of burnout (emotional exhaustion)

		Emotional exhaustion			Test value	P-value	Sig.
		Low	Moderate	High			
Sex	Female	4 (66.7%)	10 (100.0%)	34 (100.0%)	15.278*	0.000	HS
	Male	2 (33.3%)	0 (0.0%)	0 (0.0%)			
Age	Mean \pm SD	35.33 \pm 3.61	41.20 \pm 10.65	35.47 \pm 7.94	1.964•	0.152	NS
	Range	33 – 40	30 – 57	28 – 59			
Residence	Rural	0 (0.0%)	2 (20.0%)	10 (29.4%)	2.528*	0.282	NS
	Urban	6 (100.0%)	8 (80.0%)	24 (70.6%)			
Marital status	Divorced	0 (0.0%)	0 (0.0%)	4 (11.8%)	4.482*	0.345	NS
	Married	6 (100.0%)	10 (100.0%)	26 (76.5%)			
	Widow	0 (0.0%)	0 (0.0%)	4 (11.8%)			
Care giver as	Grand mother	0 (0.0%)	2 (20.0%)	2 (5.9%)	17.665*	0.001	HS
	Mother	4 (66.7%)	8 (80.0%)	32 (94.1%)			
	Father	2 (33.3%)	0 (0.0%)	0 (0.0%)			
Educational level	Illiterate	0 (0.0%)	2 (20.0%)	4 (11.8%)	3.817*	0.701	NS
	Basic	0 (0.0%)	0 (0.0%)	4 (11.8%)			
	Secondary	4 (66.7%)	6 (60.0%)	20 (58.8%)			
	High education	2 (33.3%)	2 (20.0%)	6 (17.6%)			
Socio economic status	Low	2 (33.3%)	8 (80.0%)	24 (70.6%)	10.730*	0.030	S
	Average	4 (66.7%)	0 (0.0%)	8 (23.5%)			
	More than average	0 (0.0%)	2 (20.0%)	2 (5.9%)			
Number of springs	Mean \pm SD	3.33 \pm 1.37	3.20 \pm 0.42	3.24 \pm 1.07	0.033•	0.967	NS
	Range	2 – 5	3 – 4	2 – 6			
Work	House wife	2 (33.3%)	8 (80.0%)	20 (58.8%)	3.464*	0.177	NS
	Employee	4 (66.7%)	2 (20.0%)	14 (41.2%)			
Marital satisfaction	No	4 (66.7%)	0 (0.0%)	16 (61.5%)	11.983*	0.002	HS
	Yes	2 (33.3%)	10 (100.0%)	10 (38.5%)			

P-value > 0.05: Non significant; P-value < 0.05: Significant; P-value < 0.01: Highly significant

*: Chi-square test; •: One Way ANOVA test

Table (5): Relation between sociodemographic data of the care givers and the second dimension of burnout (depersonalization)

		Depersonalization			Test value	P-value	Sig.
		Low	Moderate	High			
Sex	Female	8 (80.0%)	14 (100.0%)	26 (100.0%)	8.333*	0.016	S
	Male	2 (20.0%)	0 (0.0%)	0 (0.0%)			
Age	Mean \pm SD	38.60 \pm 10.30	41.29 \pm 9.92	33.31 \pm 4.76	5.279•	0.009	HS
	Range	30 – 57	30 – 59	28 – 46			
Residence	Rural	2 (20.0%)	2 (14.3%)	8 (30.8%)	1.465*	0.481	NS
	Urban	8 (80.0%)	12 (85.7%)	18 (69.2%)			
Marital status	Divorced	0 (0.0%)	0 (0.0%)	4 (15.4%)	5.651*	0.227	NS
	Married	10 (100.0%)	12 (85.7%)	20 (76.9%)			
	Widow	0 (0.0%)	2 (14.3%)	2 (7.7%)			
Care giver as	Grand mother	2 (20.0%)	2 (14.3%)	0 (0.0%)	13.896*	0.008	HS
	Mother	6 (60.0%)	12 (85.7%)	26 (100.0%)			
	Father	2 (20.0%)	0 (0.0%)	0 (0.0%)			
Educational level	Illiterate	2 (20.0%)	0 (0.0%)	4 (15.4%)	11.810*	0.066	NS
	Basic	0 (0.0%)	0 (0.0%)	4 (15.4%)			
	Secondary	6 (60.0%)	8 (57.1%)	16 (61.5%)			
	High education	2 (20.0%)	6 (42.9%)	2 (7.7%)			
Socio economic status	Low	6 (60.0%)	8 (57.1%)	20 (76.9%)	12.553*	0.014	S
	Average	4 (40.0%)	2 (14.3%)	6 (23.1%)			
	More than average	0 (0.0%)	4 (28.6%)	0 (0.0%)			
Number of springs	Mean \pm SD	3.20 \pm 1.03	3.57 \pm 0.51	3.08 \pm 1.16	1.126•	0.333	NS
	Range	2 – 5	3 – 4	2 – 6			
Work	House wife	6 (60.0%)	6 (42.9%)	18 (69.2%)	2.637*	0.267	NS
	Employee	4 (40.0%)	8 (57.1%)	8 (30.8%)			
Marital satisfaction	No	4 (40.0%)	2 (16.7%)	14 (70.0%)	8.858*	0.012	S
	Yes	6 (60.0%)	10 (83.3%)	6 (30.0%)			

P-value > 0.05: Non significant; P-value < 0.05: Significant; P-value < 0.01: Highly significant

*: Chi-square test; •: One Way ANOVA test

4. Discussion

Parental burnout is a unique and context-specific syndrome resulting from enduring exposure to chronic parenting stress (**Roskam et al., 2017**).

Recent research has attributed the triggering of this syndrome to an accumulation of demographic, situational and dispositional risk factors (**Mikolajczak et al., 2017**).

Parents and caregivers of children with behavioral disorders often experience significant burden associated with care of the child (**Liu and Lamber, 2007**).

These comprise financial burden, conflicts between family members, high irritability and overprotection in families, effect on family social life, interruption at work, fatigue, sadness and limitations on time, personal freedom, and privacy (**Myers, 2007**).

Regarding the consequences, positioning burnout on a continuum between parental stress and

depression (**Hakanen et al., 2008**) suggests that depression may be a frequent consequence at the micro-system level. Other likely consequences include the risk of addiction and deteriorating health, as previously demonstrated for job burnout (**Ahola et al., 2006**). Consequences of these at the macro-system level would be a significant increase in health care costs. At the meso-level, parental disengagement and low accomplishment may lead to a reduction of responsiveness, which is known to be related to poor parent child relationships and insecure attachment, harsh, neglecting parenting or maltreatment (**Wiggins et al., 2015**).

The present study aimed to compare the importance of parental burnout symptoms between parents having a child with disruptive behavior disorders and parents with apparently healthy children.

Sociodemographic characteristics of caregivers

The sociodemographic characteristics of the caregivers who participated in the study (Table 1). The majority of caregivers were female (96%) about (88%) were mothers, and (8%) were grandmothers, as regard fathers they were (4%). This agree with previous study where female represent 87% **Mikolajczak (2017)**, and in other study **Dor-Nedonsel et al. (2016)** the female represent 66%. However other study **Meltzer et al. (2011)** 95% of caregivers were mothers.

This agree with **Lindahl Norberg (2007)** who said that women are generally more involved in children's care and upbringing than men.

Another studies **Fathy (2004)**, and **Hamdy (2008)**, demonstrated that about two thirds of caregivers were mothers.

This agree with another study **Abeer et al. (2010)** results revealed that majority of caregivers were parents.

84% of the care givers were married, 8% were divorced and 8%. Similar results were founded in the study of **Dor-Nedonsel et al. (2016)** in which the majority of the patients were married (81%).

This agree with **Abeer et al. (2010)** which showed that. as for caregivers' level of education, slightly more than one third of the caregivers were illiterates.

Most of the patients are secondary educated and this could be explained by that Al-Zahra university hospital are the catchment area of many public areas in which most of the people don't complete their education in addition to low socioeconomic standard of the people living in these areas.

Sociodemographic characteristics of children/adolescents with disruptive behavior disorders .

The majority (80%) of children/adolescents were male and 20% were female.

This agree with world ratio that male: female is and also agree with other study **Dor-Nedonsel et al. (2016)** were male was 80% and female 20%.

ADHD can also adversely affect the daily lives of parents or caregivers and other family members by causing difficulties at home and strain on relationships. The influence of hyperactivity and impulsivity on academic and social functioning also adds to the burden of families of children/adolescents with ADHD (**Cheng et al., 2014**).

Regarding to the burnout experienced by the studied caregivers of behaviorally disturbed children

Important sociological changes in recent decades have increased pressure on parents to bring up healthy, secure and successful children who will become well-rounded and engaged citizens. Combined with a drastic decrease in stay-at-home mothers, these changes have made parenting both

increasingly demanding and increasingly difficult. It is in this context that the concept of parental burnout started to (**Roskam et al., 2017**).

In the current study the results indicated that the three dimensions of burnout symptoms were statistically significant compared to the burn out in the control group.

This concurs with previous literature that highlighted that parents of a child with disruptive behavior disorders experience consistently more burnout than parents with no child with disruptive behavior disorders.

And this agree with previous study (**Gérain and Zech, 2018**).

While as regard to the level of burn out in the three dimensions of burn out.

Thirdly level of lack of personal achievement in the care givers 20% low, 24% moderate, 56% high compared to control group 80% low, 20% moderate, 0% high.

The current study result agrees with another study **Abeer et al. (2010)** demonstrated that, slightly more than three fifths of the caregivers were suffering from burnout.

Investigating the coping patterns utilized by the studied caregivers of behaviorally disturbed children, concentration on the problem was most utilized strategies used by caregivers as a positive pattern of coping, while self-blame and withdrawal from the problem were least used strategies.

These results were confirmed by **Abeer et al. (2010)** which showed that the majority of caregivers were used concentration on the problem as coping strategies.

Mosyczynsk and Haney (2002), who found. That, coping responses included efforts to alter the problem, the problem focusing coping was identified as the most helpful way of coping with trauma.

The current study examined the relationship between socio- demographic characteristics of the behaviorally disturbed children and caregivers' burnout level.

The current study examined the relationship between socio-demographic characteristics of caregivers and burnout.

In the current study marital satisfaction has highly significant relation to lower burn out of care giver as regard emotional exhaustion and depersonalization but no significant relation to lack of personal accomplishment.

This agree with **Mikolajczak et al. (2017)** study which said that marital satisfaction, co parental agreement, low exposure to conflict, low family disorganization and increased closeness marginally explaining lower levels of parental burnout.

This is especially important when providing care as a parent, where the partner's support is essential. These results also complete previous research highlighting the deleterious impact of poor-quality couple relationships on burnout in a care giving context (**Lindström et al., 2011; Riva et al., 2014**).

In the current study, regarding descriptive variables, being a mother of child with disruptive behavior disorder is a risk factor for burn out. Both for emotional exhaustion, depersonalization and Lack of personal accomplishment being a mother appeared to increase burnout.

This agree with other studies showed increases of burnout symptoms among mothers (**Jaramillo et al., 2016**), others did not consistently find such a gender difference (e.g., **Lindahl Norberg, 2007**).

In the same line **Kash et al., (2000)** and **Sciancalepore (2003)** who reported that feminine category would be experiencing greater distress and burnout.

On the other hand, **Gérain and Zech (2018)** found the most surprising result lies in the unexpected risk factor of being a father with a CSN. Both for EE and LPA – with a tendency for ED – being a father appeared to increase burnout. This adds confusion to an already disputed literature about the impact of gender on Primary care giver burnout.

As regard socioeconomic status. there was negative relation between the three dimensions of burnt and socioeconomic status of the care giver, the lower the socioeconomic state the high burn out.

And agree also study of **Abeer et al. (2010)** there were highly statistically significant relations between caregiver's socioeconomic status and, and burnout.

These findings are confirmed by **Demir et al. (2003)** who reported that, higher socio-economic status decrease the burnout level among formal caregiver.

As regard to education level, these were no significant relation between educational level of care giver and the three dimensions of burn out.

And disagree with study of **Abeer et al. (2010)** in which the study results have demonstrated that, there were highly statistically significant relations between caregiver's educational level and, and burnout.

These findings are agreeing with **Hayden and Heller (1997)**, who found that younger caregivers were experiencing more stress and were more predisposed toward seeking outside help than older caregivers.

As the caregivers' coping patterns used and their relation to perceived burnout in the current study, there is a significant relation between burnout domains (emotional exhaustion and lack of personal

achievement) and searching for support as positive type of cling strategies.

In congruence with this study findings **Scott (2003)**, reported that, a significant reduction of depression, and anxiety were associated with positive interpretation and positive thinking. As well **Wong et al. (2001)** and **Albanesi (2003)**, confirmed that formal caregivers who engaged more often in positive coping and less in negative coping would have better mental health. In congruence with the previous findings **Dorz and Novara (2003)**, reported that personal accomplishment was better predicted by positive coping strategies.

Conclusion

From the results of the current study the following was concluded:

- Caregivers of children with disruptive behavior disorders have high levels of burn out, because most of their children having problems in their daily life activities and cause burden on the caregivers.

- Generally, more than 60% of the caregivers have burnout.

- The caregivers burnout was affected by their, age, sex, relation to the child, marital satisfaction, work, and socio-economic status to which they are belonging, and also affected by the sex of the child, type of disruptive behavior disorders, severity the disorder of a however, it had no relation with the caregivers' educational level residence, or marital status.

- The caregivers used many coping strategies.
- The most used coping strategy is concentration on the problem.
- The least used coping strategy is self-blame.

References

1. Ahola K, Honkonen T, Pirkola S, Isometsä E, Kalimo R, Nykyri E, Aromaa A, Lönnqvist J. Alcohol dependence in relation to burnout among the Finnish working population. *Addiction*. 2006; 101(10):1438-43.
2. Albanesi, N., (2003): Burnout in Group of Nurses at a General Hospital, *Revista, Iberoamericana de Diagnostico Evaluation Psicologica*;14(2): 87-101.
3. Brooks, N., Campsie, L., Symington, C., Beattie, A., & McKinlay, W. (2017). The five year outcome of severe blunt head injury: a relative's view. *Journal of Neurology, Neurosurgery, and Psychiatry*, 49(7), 764-770.
4. Canino G, Polanczyk G, Bauermeister JJ, Rohde LA, Frick PJ. Does the prevalence of CD and ODD vary across cultures?. *Social psychiatry*

- and psychiatric epidemiology. 2010; 45(7):695-704.
5. Cheng, C., Lau, H. P., & Chan, M. P. (2014). Coping flexibility and psychological adjustment to stressful life changes: a meta-analytic review. *Psychological Bulletin*, 140(6), 1582-1607.
 6. Dor-Nedonsel E, Thümmeler S, Ménard ML, Sakarovitch C, Salle-Collemiche X, Poinso F, Olliac B, Fontas E, Maria F, Tosello AL, Askenazy FL. 1.47 Early-onset schizophrenia: a prevalence study in a pediatric population of French psychiatric and medico-social centers. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2016; 55(10):S114-5.
 7. Dorz, S., & Novara, C., (2003): Predicting Burnout among HIN, AIDS and Oncology Health Care Workers, *Journal of Psychology and Health*; 18(5): 677-684.
 8. Du Rietz E, Coleman J, Glanville K, Choi SW, O'Reilly PF, Kuntsi J. Association of polygenic risk for attention-deficit/hyperactivity disorder with co-occurring traits and disorders. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging*. 2018; 3(7):635-43.
 9. Epstein RA, Kuhn TM, Ebert JS, Gracey KA, Chapman GL. Evidence-based interventions for adolescents with disruptive behaviors in school-based settings. *Child and Adolescent Psychiatric Clinics*. 2015; 24(2):305-17.
 10. Fathy, N., (2004): Assessment of Parental Perception of Support Needed to Care for Their Mentally Retarded Children, Master Degree in Pediatric Nursing, Faculty of Nursing, Cairo University.
 11. Gérard and Zech (2018) Parental Burnout Among Caregiving Parents patients. *J. Clin. Nurs*. 23, 352–360.
 12. Hakanen J, Rennert D. Perfectionism in school teachers: Relations with stress appraisals, coping styles, and burnout. *Anxiety, stress, and coping*. 2008; 21(1):37-53.
 13. Hamdy, E., (2008): Burden Facing Schizophrenic Caregivers: Model of Supports System, Master Thesis Submitted to Faculty of Ain Shams University.
 14. Hamilton, RN., Kilburn, J., (2008): Burnout: Coping with Chronic Illness: Stress: <http://www.rsingCEU.com/nursingcontinuingeducation>;7(1): 46-55.
 15. Hayden, M. F., & Heller, T., (1997): Support Problem – Solving Coping Ability, and Personal Burden of Younger, and Older Caregivers of Adults with Mental Retardation. *Mental Retardation*; 35(5): 364-372.
 16. Jaramillo, S., Moreno, S., and Rodríguez, V. (2016). Emotional burden in parents of children with trisomy 21: descriptive study in a colombian population. *Univ. Psychol*. 15,29–38.
 17. Kash, K. M., Roland, J. C., & Bretibart, W., (2000): Stress and Burnout in Oncology, *Oncology Nursing*; 14(11): 1621- 33.
 18. Lindahl Norberg A. (2007). Burn out in mothers and fathers of children surviving brain tumour. *J. Clin. Psychol. Med. Settings*14,130–137.
 19. Lindahl Norberg, A. (2007). Burnout in mothers and fathers of children surviving brain tumour. *Journal of Clinical Psychology in Medical Settings*, 14(2), 130-137.
 20. Lindström, C., Åman, J., Anderzen-Carlsson, A., & Lindahl Norberg, A. (2016). Group intervention for burnout in parents of chronically ill children - a small-scale study. *Scandinavian Journal of Caring Sciences*, 30(4), 678686.
 21. Liu M, Lambert CE, and Lambert VA. “Caregiver burden and coping patterns of Chinese parents of a child with a mental illness: feature article,” *International Journal of Mental Health Nursing*, vol. 16, no. 2, pp. 86–95, 2007.
 22. Masi G, Pisano S, Milone A, Muratori P. Child behavior checklist dysregulation profile in children with disruptive behavior disorders: A longitudinal study. *Journal of affective disorders*. 2015; 186:249-53.
 23. Meltzer H, Ford T, Goodman R, Vostanis P. The burden of caring for children with emotional or conduct disorders. *International journal of family medicine*. 2011;2011.
 24. Mikolajczak, M., Raes, M. E., Avalosse, H., and Roskam, I. (2017). Exhausted parents: sociodemographic, child-related, parent-related, parenting and family functioning correlates of parental burnout. *J. Child Fam. Stud*. 27, 602–614.
 25. Mikolajczak, M., Raes, M. E., Avalosse, H., and Roskam, I. (2017). Exhausted parents: sociodemographic, child-related, parent-related, parenting and family functioning correlates of parental burnout. *J. Child Fam. Stud*. 27, 602–614.
 26. Mosyczynsk & Haney (2002): Stress and Coping of Canadian Rural Nurses Caring for Trauma Patients Who Are Transferred Out, *Journal of Emergency Nursing*; 28(6): 496- 504.
 27. Murray J, Farrington DP. Risk factors for conduct disorder and delinquency: key findings from longitudinal studies. *The Canadian Journal of Psychiatry*. 2010; 55(10):633-42.
 28. Myers J, “Understanding the influences of parenting a child with oppositional defiant disorder on the marital relationship: a phenomenological study,” *The Sciences and Engineering*, vol. 67, no. 12, p. 7000, 2007.

29. Perkins JD, Taylor MJ, Austin CC, Edwards JL. Sociohistorical privilege in higher education: Implications for African American student psychological adjustment, resiliency, and success at predominately White institutions. In *Health Disparities Among Under-served Populations: Implications for Research, Policy and Praxis* 2012; (pp. 241-261).
30. Riva, R., Forinder, U., Arvidson, J., Mellgren, K., Toporski, J., Winiarski, J., et al. (2014). Patterns of psychological responses in parents of children that underwent stem cell transplantation. *Psychooncology* 23, 1307–1313.
31. Roskam, I., Raes, M.-E., and Mikolajczak, M. (2017). Exhausted parents: development and preliminary validation of the parental burnout inventory. *Front. Psychol.*8:163.
32. Schulz R and Tompkins CA (2010). "Informal Caregivers in the United States: prevalence, caregiver characteristics, and ability to provide care, "in *The Role of Human Factors in Home Health Care: Workshop Summary* (Washington, DC: National Academies Press), 322.
33. Sciancalepore, R., (2003): *Gender Related Mediators of Post Traumatic Stress Symptoms in A World Trade Center Tragedy Sample*, Doctorate thesis, Hofstra University.
34. Scott, B., (2003): *Faith Supportive Group Therapy and Symptom Reduction Unchristian Breast Cancer Patients*, Dissertation Abstracts International; 63(12): 6107-6108.
35. Wiggins JH, Prager J, Goldstein R, Freeman M. Perinatal dyadic psychotherapy for postpartum depression: a randomized controlled pilot trial. *Archives of women's mental health.* 2015; 18(3):493-506.
36. Wong, D.F., Leung, S.S., & Lam, D.O., (2001): *Mental Health of Chinese Nurses in Hong Kong: The Roles of Nursing Stresses and Coping Strategies*; *Journal of Issues in Nursing*; 5(2): 32-48.

10/5/2019