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THE EMOTIONAL AND PSYCHOLOGICAL BURDEN OF THE "BURNOUT" IN FAMILIES OF PSYCHIATRIC PATIENTS

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SUMMARY

People, who assist patients with chronic health problems for work, voluntary or for family reasons, may be affected by burnout. This is defined as an excessive reaction to stress caused by one's environment that may be characterized by feelings of emotional and physical exhaustion, coupled with a sense of frustration and failure. A person who assists a suffering person, beyond the professional role, is indicated generally by the term "caregiver". The definition of Burnout in families is fairly recent, because the psychology of trauma has ignored a large segment of traumatized and disabled subjects (family and other assistants of "suffering people") unwittingly, for a long time. The burnout of secondary stress is due to one's empathic ability, actions through disengagement, and a sense of satisfaction from helping to relieve suffering. Figley (1995) claims that being a member of a family or other type of intimate or bonded interpersonal relationship, one feels the others' pain. Closely associated with the suffering of the family caregiver is the concept of compassion fatigue, defined as a state of exhaustion and disfunction-biologically, psychologically, and socially - as a result of prolonged exposure to compassion stress and all that it evokes. In families, this can be the cause of serious conflicts and problems, quarrels, verbal and physical aggression, and broken relationships. The intervention on families requires practice and effectiveness approaches performed by experienced professionals. Some approaches focus more specifically, such as those that adopt a cognitive/behavioural technique with direct exposure, implosion methods, various drug treatments and family group psychotherapy. One of the most common models of intervention is based on the principle that the observation unit for the understanding of the disorder is not the single individual but the relationship between individuals.

Key words: burnout - caregiver - family members - compassion fatigue

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INTRODUCTION

The family care of a person affected by a chronic disabling disease can be characterized by a complex system of experiences, emotions, changes, opportunities, fatigue and stress (Stajduhar & Cohen 2009). Such experiences can occur in those ones who "assist" a series of events, sometimes unexpected, and they can generate several feelings and emotions, which can be simple and immediate, such as apprehension and alarm, or more complex and specific such as anger, despair, sense of abandonment and loneliness, impotence, inability. The consequences, often inevitable, on their current and future personal stories and on process of care were often poorly estimated and little valued, although they prove to be onerous and debilitating (Ursini & Nardini 2007). A person who assists a suffering person, beyond the professional role, is indicated generally by the term "caregiver". This term refers to a person who takes care of an addict and / or sick and / or disabled subject. The caregiver may be "a person who helps to meet the needs of a depending individual" (Johnson et al. 2016), or "a person who intervenes in diagnosing, preventing and treating illness and / or disability" (Nielsen et al. 2016). Caregivers can be divided into professional and non-professional subjects. The members of the families of the disabled person are included in this second group. "Conceptually, the term" burnout "in families may seem odd" observed Figley, in 1998 (Figley 1998). "After all, the dictionary

definition of Burnout is a noun meaning "termination of the powered portion of a rocket's flight upon exhaustion of the propellant" (Random House Dictionary). Similarly, burnout families can be considered as a signal that a family member is "left without gas". The definition of burnout in families is fairly recent, because the psychology of trauma has ignored a large segment of traumatized and disabled subjects (family and other assistants of the "suffering people") unwittingly, for a long time (Franza et al. 2012). This resulted "in other words, that caregivers ... have been ignored, while suffering, being in the right, for the love of a traumatized person" (Figley 1998). According to the model of the Maslach " burnout does not only affect the parties engaged in specific social and health professions, but all those who care for people or working in close contact with people for long periods of time, it points out, however, the specificity for all the helping professions" (Maslach 1982).

BURNOUT IN THE ORGANIZATIONAL STRUCTURES

Several complex personal and business affairs can produce burnout. In any form of work and care there are potential sources of stress; some organizational structures can create more stress and tension, while others can provide more stimulation and offer the possibility of a greater personal involvement, resulting in a greater gratification (McTiernan & McDonald 2015). Organizational structures can be represented by business,

education and the family systems where personality, motivations, interlocutors of the subject, dynamics of the organizational structure, the hierarchy and the type of activity constantly interact. Business and families' organizational structures are subject to malfunctions that affect the development of inadequate lifestyles and burnout in their members. Among the several critical factors there overworking, total disorganization of the structure, ambiguity of the role of each component of the system, a dysfunctional hierarchical structure, the lack of attention to human resources and, finally, economic difficulties are listed. The traumatic factors can also cause high stress in family system. Therefore, the important difference is that they cannot escape from the "refuge" of their house while they are trying to have a close contact with their loved one sick daily. In all organizational structures, and particularly in health care structures, the customer is hosted, heard, cared, and finally, discharged for by professionals. At the end of the care pathway there is the customer's separation. The detachment stage cannot be in the family. The family system experiences a continuous cycle. For this reason, the family members are more exposed to high levels of stress.

FACTORS OF VULNERABILITY IN HOUSEHOLD

Several family vulnerability stress factors in relative caregiver have been described. Among the main factors of vulnerability in family members there are anxiety and depression (Sander et al. 2003, Davis et al. 2009, Sady et al. 2010). There is a significant relation between patient and caregiver emotional status, not only for patients. Patient and caregiver's anxiety and depression develop in concordance and they were found to be higher in family caregivers than in a non-caregiving population (Yan et al. 2019, Haun et al. 2014). Patients with depression highly impact on the caregiver burden, while burden is also discussed to influence caregivers' depression (Krug et al. 2016). Younger families have increased risk of burnout (Stancin et al. 2010), and when financial problems and the poor social support, and poor social network (Aitken et al. 2009, Taylor et al. 2002) are added, the usual daily life is greatly impaired. Other risk factors in household are the low socioeconomic status (Bøe et al. 2018, Anderson et al. 2005, Urbach & Culbert 1991) and the conflict within the care team (Ganesalingam et al. 2008).

COPING STRATEGIES IN THE FAMILY

When the traumatized family's components have high levels of stress, the whole family environment remains involved. This family can be described as "family with burnout". Because of a low self-esteem, the family's member begins to think not to be able to provide the necessary assistance: he/she is not able to do his/her homework and solve any daily difficulties. The family members are no longer able to control the space,

they lose control of their role, and feel be "invaded" by their work (Tsaras et al. 2018). The stress response is coping. The individual chooses a specific way in which to deal with the stressful stimulus. Each family develops its own coping strategy to manage the "family turmoil". When this attempt to restore a balance fails, the family develops the crisis. For, example, a highly disabling disorder child constitutes a major violation to the family homeostasis. However, the family seem to possess a greater degree of protection because it tends to be more prone and motivated to tolerate a higher level of stress. The family system acts also as an osmotic system. A set of different coping behaviours is known as "coping strategy". The most common coping strategies in families focused on the emotions described in the literature as the refusal and the removal or the avoidance, these families often seek refuge in forms of abuse (alcohol and drugs). The use of anxiolytics and hypnotics drugs in the "traumatized family " is very high, more than double than the general population (Stevens et al. 2015, Enoch 2011, Hall et al. 1994). Family members suspend the relationships with the surrounding world avoiding to give explanations. Divorce can be seen with a sense of escape from the situation and a coping mechanism focused on emotions. The decision to divorce can be, in turn, a source of guilt and anxiety to social rejection (Rajani et al. 2019, Shrubbs 2013). Also, the faith is a coping mechanism oriented on emotions and is often the basis for an effective coping. A possible explanation is that the aid with prayer leads to a state of calm, emotional rest, that makes family members to think more clearly about how to adapt and solve their problems (Superdock et al. 2018, Krägeloh et al. 2015) The interruption and abandonment of the workplace have been studied in literature as a coping strategy centred on the problem. But this technique rather than reduce, increases stress. A family member who leaves the job becomes more isolated socially and with the deteriorating economic situation. The search of social support, often charities, is a coping strategy of problems frequently used and which has a positive impact on our own stressful life (McGilton et al. 2018, Burton et al. 2016, Claxton-Oldfield 2016).

THE HOPE COPING STRATEGY

While demoralization is a common form of "normal suffering" for people, and their family, who have chronic medical illnesses or disabling psychological diseases, the hope is an important coping strategy for family members because it helps them to make sense of life and cope with their current situation (Smith et al. 2019). Its definition is difficult as it is complex, multifaceted, multi-dimensional and prone to oversimplification. Hope is described as an emotion, an experience, a need, a characteristic, a state or a dynamic process with affective, functional, contextual, temporal, and relational dimensions. However, hope can be a good coping strategy to help family members to fight the burnout. In

this context the psychotherapy (for example, individual, group psychotherapy) can help family members to recognize and reach the awareness of their suffering (Griffith & Dsouza 2012). Thus, the family and its members give meaning to their work and cooperate with each other. It is the crucial part of the experience of the family and a prominent appearance in each story, regardless of the clinical situation, the relationship with the patient and the personality of the family member (Sampson et al. 2014, Milberg & Strang 2011).

INTERVENTION STRATEGIES IN FAMILIES

Psychoeducational interventions are techniques that provide information about the disease, help the individual to learn and develop problem-solving techniques; they do acquire strategies and coping skills, improve communication, deal with conflicts, reduce hypercriticism, hyper-emotional, and hostility towards the patient (Chi et al. 2015, Fiorillo et al. 2011, Magliano et al. 2006). Furthermore, they reduce sick family member's expectations, increase the social support networks, and reduce the family burden. In this area, it is inserted the role of the health care workers and, in particular, psychotherapist. They may, in fact, provide the information and the basis on the strategies and techniques to improve patient management. They can identify the primary and support caregiver and, finally, use a communicative and flexible approach especially in the family where compliance and acceptance of the disease is poor (Sin et al. 2017). In a recent study the authors assessed the effectiveness of a psychoeducational intervention in young people who had a family member with a mental health disorder such as depression, anxiety, and/or substance abuse. The program was based on a series of literacy and coping programs. The research concluded that over 90% of the youth reported an improved use of positive coping strategies from pre-to post intervention (Riebschleger et al. 2019). Some specific interventions aim to foster all the goals that are essential to improve the living conditions, including defining and planning goal, emotional perception, effective communication for negotiation, practical interpersonal and intrapersonal problem-solving (for example, structured psychoeducational and salutogenetic approach) (InteGRO) (Veltro et al. 2018). The intervention on families requires family psychotherapeutic techniques performed by experienced professionals. One of the most common models of intervention is based on the principle that the observation unit for the understanding of the disorder is not the single individual but the relationship between individuals. As a general principle for health professionals we can show that when a family member has a post-traumatic reaction, social support among family members can prevent the post-traumatic stress disorder and the secondary disorders to the stressors. Unfortunately, many family members have difficulty in providing mutual aid and may engage in an endless battle in search of strategies to solve a crisis.

There is not "a culture that is committed to consider the patient, the operator and their needs and pay attention to family relationships, social and organizational" (Anastasiadou et al. 2015). Furthermore, there are numerous evidences that the administration of self-management interventions improves outcomes for people with severe mental illness and that this intervention can help family members to manage the care burden of their sick family (Lean et al. 2019). Healthcare professionals must be aware that with his work, he/she is part of a system with rules and balances and he/she has to test the changes imposed by the disease. He must learn to hone the skills of listening and observing, before acting, in order to capture the necessary information to identify the mode of intervention more suitable and effective. He must learn not to make judgments, because it is unnecessary to determine "who is wrong or who is right" and "who is good or bad," since the story and the balance of the family system are not known. It's essential to "photograph" the situation, to understand the problems and strengths of the system. The achievement of this purpose is to make it necessary to build an efficient system of support, formed by people aware of the importance of their role and adequately training, that can allow to exploit the individual skills and able to understand the peculiarities of discomfort working. Therefore, the operator has to learn to observe and listen not only the patient, the family, but also himself, in order to grab his potentialities, but also his limits, to prevent or at least reduce the risk of burnout. Verhaeghe STL et al. (2007) in a review have concluded that families' members do not receive the indispensable attention and that health workers often meet the needs of family members in an inadequate and superficial manner, although there is a general consensus that the involvement of "traumatized" families is important and have a positive effect on families, patients and the entire healthcare system and perhaps pharmacotherapy for those termed unsuccessful with psychotherapy. Finally, it must be pointed out, that the presence of psychiatric symptoms, such as depressive or anxious symptoms, that meets the criteria of the international diagnostic classifications (DSM and ICD) requires a pharmacological intervention.

CONCLUSIONS

The research conducted on the psychological reactions of the family members of "traumatized" patients has been precious and valuable. The scale of problems is clearer. Research has shown that family members are particularly vulnerable: partners, children, families with economic problems and doctors. A support from health experts reduces stress by encouraging the members to work together effectively. Conflicts with health caregivers should be avoided as they cause stress. Work on families becomes part of a rehabilitation process. Support patterns and long-term care that can alleviate the burden in family members are urgently needed. Future research should be directed to the mode of reaction of

the family system and addressed to each member of the family. It may also be important to investigate the typical ambivalence among family members on the patient trauma; e.g., the associated hope and despair, factors that influence each other. The research on the genesis and evolution of the reaction of the family members to trauma and the onset of the next steps appear to be necessary. Certainly, not all the aspects of the problem were evaluated and further research is needed to allow the creation of intervention programs more effective and targeted.

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