



Burnout in Families. The Emotional Burden of the “Traumatized” Families

Francesco Franza^{1,2*}, Gabriella Carpentieri², Serena De Guglielmo², Gianfranco Del Buono^{2,3}, Nicoletta Fiorentino^{1,2}, Mariangela Perito², Barbara Solomita² and Vincenzo Fasano²

¹Neuropsychiatric Centre “Villa dei Pini”, Avellino, Italy

²Psychiatric and Psychological Studies “Neamente” Centre, Italy

³Department of Psychiatry, Salerno Medical University, Italy

*Corresponding author: Francesco Franza, Head Physician Psychiatrist, Neuropsychiatric Centre “Villa dei Pini”, Psychiatric and Psychological Studies Centre, Via Pennini 86/a (83100) Avellino, Italy, E-mail: franza.francesco@virgilio.it

Abstract

Family members of people with chronic health problems can be affected by Burnout. 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 the traumatized and disabled subjects (family and other assistants of the “suffering people) unwittingly, for a long time. 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.

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 [6]. This resulted “in other words, that caregivers ... have been ignored, while suffering, being in the right, for the love of a traumatized person” [5].

According to the model of the Maslach’s...on 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” [7].

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 [1]. Such experiences can occur in those ones who “assist” a series of events, sometimes unexpected, which can generate several feelings and emotions. They 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 too onerous and debilitating [2]. 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” [3], or “a person who intervenes in diagnosing, preventing and treating illness and / or disability” [4]. 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 CR., in 1998 [5]. “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

Burnout in the Organizational Structures

Burnout is the peak of complex personal and business affairs. 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 greater personal involvement, resulting in greater gratification [8]. Organizational structures can be represented by business, education and the family systems [9] 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 burn-out in their members. Among the several critical factors there are listed the overworking, the total disorganization of the structure, the 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.

The traumatic factors can also cause high stress in family system. Therefore, the important difference is that they cannot escape by the “refuge” of their house while they trying daily to have a close contact with their loved one sick.

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 [10-12]. There is a significant relation between patient and caregiver emotional status, not only for patients. Patient and caregiver anxiety and depression develop in concordance and were found to be higher in family caregivers than in a non-caregiving population [13]. Patients with depression highly impact on the caregiver burden, while burden is also discussed to influence caregivers' depression [14].

Younger families have increased risk of Burnout [15], and when financial problems and the poor social support, and poor social network [16,17] are added, the usual daily life is greatly impaired.

Other risk factors in household are the low socioeconomic status [18,19] and conflict within the care team [20].

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". With the fall of 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. The stress response is coping. The individual chooses a specific way in which to deal with the stressful stimulus. The coping is described as the effort of constant cognitive and behavioural change to manage specific internal and external questions that are perceived as burdensome or excessive in relation to the resources of the people [14,21,22]. 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". Coping strategies can fulfil two functions:

- 1) Focusing efforts on the cause of stress (*problem-oriented coping*);
- 2) Reducing individual's emotions following the stressful situation (*emotion-oriented coping*) [23-25].

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 [26-28]. 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 [29-32].

Also the faith is a coping mechanism oriented on emotions that often is 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 [33-35].

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 [36,37].

The Hope Coping Strategy

While demoralization is a common form of "normal suffering" for people, and their family, who have chronic medical illnesses, disabling psychological diseases, the *hope* is an important coping strategy for family members because it helps them members to make sense of life and cope with their current situation. Its definition is difficult as it is complex, multi-faceted, 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. It is most needed but hardest to find when one is caught in the depths of despair. 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 [38]. Thus, the family and its members give meaning to their work and cooperate with each other. It is a 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 [39,40].

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 [41-44]. 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 [45,46].

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" [47].

The operator 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. The operator, therefore, 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. Verhaegen STL et al. (2007) [21] 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.

It must be pointed out, finally, that the presence of a psychiatric symptoms, such as depressive or anxious symptoms, that meets the criteria of the International diagnostic classifications (DSM and ICD) requires a pharmacological intervention. This measure must be regarded also in association with the psychotherapeutic techniques when necessary.

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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