

Staff Burnout in Work With Long-Term Patients

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The seeds of staff burnout are planted when mental health professionals who work with long-term patients do not recognize that such patients vary greatly in their potential for rehabilitation. This situation leads to unrealistic expectations and frustrations for staff. The concept of normalization, if misapplied, can lead to the same result. Contributing to the frustration is administrative pressure on staff to produce impossible results. Staff's ambivalence about gratifying dependency needs of patients and uncertainty about their own needs and motivations also can lead to burnout.

■The realization that thousands of long-term severely disabled patients have been given low priority by community mental health agencies and most other social and community agencies (1,2) has recently led to a flurry of activity to serve these patients. But new problems have been created because services for the long-term patient have been increased without a sound underlying conceptual framework for their care or an understanding of their varying needs and capabilities.

Large numbers of new staff have been enlisted to provide the services. Unfortunately, many of those staff do not have a realistic conception of what they can expect to accomplish (3). Most of them enter the field with enthusiasm and good intentions. But in perhaps a year or two, they get burned out: they lose their enthusiasm; they no longer like their contact with long-term patients; they get bored, frustrated, and resentful. Worst of all, they become ineffective.

A major cause of such burnout has been the failure of mental health professionals to recognize that there are many different kinds of long-term patients. These patients vary greatly in the degree to which they can be rehabilitated. They differ in motivation and in ability to

cope with stress. The severely disabled also differ in the types of stress and pressures they can handle. Some persons who are amenable to social rehabilitation cannot handle the stresses of vocational rehabilitation, for example. For some long-term patients, competitive employment, independent living, and a high level of social functioning are realistic goals; for others, just maintaining their present level of functioning should be considered a success.

The failure of mental health staff to recognize and accept these differences creates major problems. It is tremendously frustrating for staff to attempt to do something faster than it can be done or, even worse, to attempt to do something that cannot be done at all. That frustration can often lead to burnout.

OVERSELLING REHABILITATION

Unfortunately, when mental health professionals finally turn their attention to severely disabled persons, the shift is often from neglect to overenthusiastic and unrealistic attempts at rehabilitation. Rehabilitation may become discredited if we oversell it and make promises we can't keep. We are finally beginning to interest mental health professionals in the treatment and rehabilitation of long-term patients. It is critical that there be attainable goals to offer staff who are willing to undertake what has heretofore been considered a low-status, unrewarding activity.

Mental health professionals must accept the slow pace at which most long-term patients progress. We are not surprised when intensive psychotherapy with persons of greater ego strength takes years to achieve character change. Yet we are frequently dismayed when the long-term severely disabled take years to progress in social and vocational rehabilitation. Further, when patients attempt activities and "fail" or drop out, staff often get discouraged. But the real failure may be that activities within the patient's capabilities were not available.

The concept of normalization can also pose a problem. Certainly we want the long-term patient's social milieu, living situation, and work situation to be as much like those of any other citizen as possible. We hope that the patient's condition will not set him any

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further apart from others in society than is necessary. But we frequently forget that normalization is the ideal and that, for many, normalization will be possible to only a limited extent. Some long-term patients may need to live in a sheltered environment that is by its very nature segregated. They may be able to participate only in community activities that are low key and geared to them and their fellow patients. Their manner and appearance, even with optimal doses of psychoactive drugs and optimal amounts of psychosocial treatment, may set them apart (4).

A lack of understanding of these matters has led many mental health professionals to push long-term patients beyond their capabilities, at times to the point of failure. In so doing, staff have undermined their patients' sense of autonomy and mastery.

There is also the opposite danger of getting caught up in the patient's perception of himself as helpless, and thereby colluding with him in disregarding his ego strengths. Staff need skills in detecting these strengths and the hidden motivation for growth that often manifests itself in distorted or indirect ways.

Maintaining realistic expectations of our patients is necessary if we are to work effectively with them. But to what extent should we push them? Are there times when we pushed because we had unrealistic expectations and a lack of appreciation of the fact that there are many different kinds of long-term patients? We should attempt to sell patients on getting involved in their treatment and rehabilitation, and if we believe they can make progress, we should let them know we think so. But our efforts will be hampered if we push patients because we feel that all patients can and should be rehabilitated, or because we are getting social and administrative pressure to produce results.

Without such pressure to attain results, mental health staff can find working with long-term patients more gratifying. For instance, if staff can get to the point of being satisfied with simply improving the quality of a patient's life rather than increasing his level of functioning, they can enjoy contact with the patient more. Staff can find out how patients feel about their lives and can help them achieve a sense of trust or even closeness, a new experience for many.

Social and vocational rehabilitation can significantly enhance the quality of life for many long-term patients, leading, in many cases, to a full and satisfying social life, competitive employment, or both. For some, however, any attempt at rehabilitation or socialization may cause intolerable stress (5). Therefore, mental health professionals should avoid adopting the philosophy that all of their patients must ultimately become self-reliant in competitive employment and independent living and significantly improve their ability to socialize. At the same time, staff should remember that some patients who appear to have no potential and to be making no progress can, after long periods, blossom, and accomplish more than could have been predicted.

Mental health professionals must also reconcile themselves to the fact that many patients will opt out

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and flee from rehabilitation efforts (6). Perhaps it is the patient's feelings of inadequacy and fear of failure; perhaps he realizes that he will never be able to measure up to staff's expectations. Perhaps he fears losing his Supplemental Security Income, which provides a great sense of personal security (7).

Even if a patient refuses to participate in social and vocational rehabilitation, staff should still offer him whatever services he will accept, be they only medication and crisis intervention. Sometimes they are all the patient can handle at that particular time. If staff leave the door open, the patient may return to avail himself of other services in the future. If mental health staff do nothing more than help him stabilize in the community, they are still making an important contribution to his life.

Staff should offer patients rehabilitation, make it attractive to them, and even urge them to participate if, in fact, they possess sufficient ego strength. But if they do not, and staff see them becoming symptomatic or beginning to run from their efforts, staff must reduce their pressure on the patients. Staff must learn how to let patients decline such activities gracefully and without fear of censure.

STAFF MOTIVATIONS AND NEEDS

Mental health staff must become aware of their own motivations for working in the helping professions. They should explore such questions as "What needs of mine are being met?" and "Am I trying to use my work to meet needs that could or should be fulfilled elsewhere in my life?" Motivations of self-gratification are rarely absent in members of the helping professions. They are not necessarily bad, providing they are held in moderation and do not adversely affect one's work, and providing one is cognizant of their existence.

More specifically, staff must ask themselves "To what extent do I get vicarious gratification from my patient's accomplishments or acting out? How much does my sense of being productive depend upon my bringing about significant change in my patients? To what extent am I in this field to get help for myself and to resolve my own problems? How much do I need to have contact with verbal, attractive patients and to be admired and loved by them?"

Staff must have a realistic view of long-term patients and the wide variations in their needs and potential. And staff must not be subjected to administrative pressure to accomplish the impossible.

If staff can answer and resolve such questions for themselves, it may alleviate the problem of trying consciously or unconsciously to have patients meet their needs. There is a danger for all mental health staff, whether professional or paraprofessional, that patients will come to play too large a role in validating staff's own worth. Inappropriate staff needs can also be a factor in unrealistic expectations of long-term patients. Healthy striving on the part of staff for a sense of productivity should not be denigrated, but staff should be reminded that there is a delicate balance between meeting their own needs and those of their patients. Enlisting patients to participate in the process of meeting our own needs in a way destructive to them may be an occupational hazard and, on a deeper level, may relate to our motivations for "helping" others. In any case, the disciplined therapist needs to reappraise these issues periodically throughout his "helping" career. A clear awareness of one's own motivation and needs can be a crucial factor in preventing later disillusionment or burnout when long-term patients fail to meet staff needs.

MEETING DEPENDENCY NEEDS

Another significant factor in staff burnout is confusion about the extent to which nurturing patients and meeting their dependency needs is desirable and appropriate. While it is generally taught that "good" patients "work" in treatment, for a sizable proportion of long-term patients, the primary role of mental health staff may be to provide not therapy, but support. It is especially important to provide support in the form of sheltered housing, sheltered work, sheltered social situations, and supportive interpersonal relationships. Staff must become comfortable in gratifying dependency needs and realize that all patients need some degree of support. Such support can be given without undermining the client's push toward whatever level of autonomy he is capable of.

But because the dependency relationship can become burdensome, limits must be set on gratification of dependency needs. For instance, patients must know it is inappropriate to call staff at all hours of the day and night, except at times of crisis. If staff members work as a team in treating long-term patients, the dependency

relationship can be dispersed among the individual team members and the team as a whole. Thus a relationship that may become exhausting for the individual professional, as well as more than the patient can handle, can be avoided.

Aside from such considerations, however, there must be an awareness of the basic moral disapproval in our society of dependency, of a passive, inactive life style, and of accepting public support instead of working. Though often covert, such disapproval pervades all strata of our society. The mentally ill do not seem to be exempt from this disapproval. Perhaps no other factor is so likely to lead both to staff resentment and to unrealistic expectations and, ultimately, to staff burnout.

Staff must have a realistic view of long-term patients and the wide variations in their needs and potential. And staff must not be subjected to administrative pressure to accomplish the impossible. They must be able to make clear, open decisions about their willingness to work with long-term patients. Then they will not be as likely to become frustrated and burned out, and either abandon the long-term patient or unwittingly drive him away. ■

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