Psychiatric Burnout and How We Heal

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To the Editor:

As residents, most of what we see and hear regarding remedies for burnout involves sleep hygiene, work hours, and social support. We wish to highlight the unique aspects of psychiatric burnout from a resident perspective and offer ways to combat them.

At a recent ground rounds, a presenter argued that patient suicide is perhaps the greatest emotional stressor in the career of a psychiatrist. Suicide is a painful tragedy that too many psychiatrists must bear. While most of our resident colleagues have not yet dealt with the pain of a patient suicide during training, all of us deal with suicidal patients who bring their immense psychological pain and subjective nearness to death into the room.

All physicians deal with death. Some doctors spend their careers treating the physically moribund knowing that their patients may not be alive the next morning. In psychiatry, we treat both the physically and psychologically moribund. When our patients bring their pain and death into the room, we cannot treat them to cure. We bear witness to the patient, feel what the patient feels, and experience this together. The empathic experience demands our entire selves—all of our cognition, emotion, and spirit. When the therapy hour ends and the patient leaves, the experience does not suddenly vanish and reappear the next week. We carry the death and pain because we experience it and relate to it by virtue of our form of healing.

By all estimations, this should burn us all out. Part of the reason why we can survive in psychiatry is that we are healed in the process of healing. We feel our patients' pain, but we also feel their healing. The transcendental nature of these relationships with our patients often brings a sense of peace despite the rough winds. We are trained to share in our patient's pain, but to be truly great, we must share in their healing

as well. Another way we cope is by embracing the carefully thought out framework and boundaries of treatment. Just as Odysseus ties himself to the mast so he can safely hear the sirens, we tie ourselves to the framework of treatment so that we can listen safely and fully experience what is happening in the room without being engulfed. Part of the framework of treatment that has traditionally been adhered to closely was regular supervision and personal psychotherapy. Regarding supervision, it is our experience that residents often do not fully appreciate the healing effect regular supervision can have not only for our patients, but for us. In our busy schedules, it is often hard to fully invest all of our selves to an hour or two of supervision weekly, and supervision becomes one more thing to do in a hectic day. Given that there is always too much to do with too little time, it is hard to imagine that not long ago, virtually all psychiatry residents were also in their own psychotherapy during training. Now it is far less ubiquitous.

While many programs are trying to introduce new and innovative ways to combat burnout, we believe that a return to the tradition of personal psychotherapy and fully embraced supervision is a large part of what has the promise to heal us. Programs must work with residents to create an environment in which these activities are encouraged and feasible in the resident's work schedule. With structured supervision and psychotherapy, psychiatry as a field has built within it a cycle of healing and learning that extends throughout a career. Continuation of this cycle may be the best antidote to burnout in psychiatry.

Compliance with ethical standards

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