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Review paper

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USING SCHEMA THERAPY TO UNDERSTAND COVID-19 RISK OF BURNOUT IN MENTAL HEALTH PROFESSIONALS

Abstract

Studies show that mental health professionals' burnout has different contributors such as shared trauma, work overload, lack of control, insufficient reward, and problems in the organizational environment. All these factors tend to be very high in the current COVID-19 pandemic. Fewer studies have explored the role of personal factors in levels of stress and burnout, although we see that not caring adequately for ourselves, our unmet needs, our Early Maladaptive Schemas, or past traumas could add to our levels of emotional exhaustion and possibly trigger unhelpful coping mechanisms. Studies confirm that the lack of self-care combined with unhelpful coping patterns intensifies the possibility that mental health professionals might experience burnout, compassion fatigue, or vicarious trauma. Drawing on Schema therapy concepts and our experiences as trainers and supervisors of mental health professionals working with stress and trauma, this paper explores the role their Early Maladaptive Schemas and Schema Modes play in working with COVID-19 related issues and self-care. Additionally, we offer specific recommendations that promote creative, compassionate self-care.

Key words: Schema therapy, Mental health professionals, Burnout, COVID-19, Self-care

Introduction

COVID-19 pandemic as the "work setting" for mental health professionals

The COVID-19 pandemic has added to the already existing problems and mental health challenges putting mental health professionals (MHP) in a position to offer counseling and psychological first aid in various context and circumstances. As Dastagir (2021) put it: "When a world in pandemic shut down, the mental health professionals did not. They kept working, many more than ever, counseling patients on how to survive something they'd never seen before, something they feared themselves". They counseled while managing their own

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virus-related stressors and sometimes their own losses, while homeschooling their children, with other stressors such as political turmoil (elections, protests), with new technologies they had to master and with very limited information about the virus itself. Many had not experienced working with collective traumas, and many had "too much" experience of this kind, since they accumulated years of shared trauma they had to work through and process (like in Former Yugoslavia).

Studies (see Freedman & Mashiach, 2018; Skovholt & Trotter-Mathison, 2016) show that mental health professionals' burnout has different contributors such as shared trauma, work overload, lack of control, insufficient reward, and problems in the organizational environment. As all these factors tend to be very high in the current COVID-19 crisis, it is expected (and confirmed by some as Dastagir, 2019) that the pandemic has put mental health workers at an even greater risk of burnout. All of this gets even more worrying if there is a history of personal trauma or personal factors that add to the list of stressors. This is not rare, as a significant proportion of mental health professionals report adverse childhood circumstances (e.g., Simpson, Simionato, Smout, van Vreeswijk, Hayes, Sougleris, Reid, 2019). Professionals who have experienced trauma or neglect while growing up may have increased capacity for empathy but may also be more at risk of developing maladaptive beliefs, coping mechanisms, and associated psychological distress (Simpson et al., 2019).

However, the role of personal factors in levels of stress and burnout in mental health professionals has seldom been explored. Having had the opportunity to supervise many (N=100+) psychologist and psychotherapists who worked with shared trauma (including COVID-19 crises), we wanted to share the experiences we had gathered, hoping that this could help in "weathering this and other storms" that await us. With this paper, we hope to shed some light on the experienced stressors, personal factors that contribute to burnout and compassion fatigue of mental health professionals. Additionally, we wish to offer specific recommendations that promote creative, compassionate self-care. In doing so, we will use concepts from Jeffrey Young's Schema therapy (1990) and experiences gathered from supervising volunteers providing COVID-19 related psychological support for *Serbian Union of Associations for Psychotherapy* and *Association of Psychologists of Republic of Srpska*, as well as supervisions for Schema therapy trainees and volunteers working with homeless people and refugees.

Mental health professionals' childhood experiences - Schema therapy view

Schema therapy (ST) is an integrative approach, bringing together elements from Cognitive-behavioral therapy, Attachment and object relations theories, Gestalt, and experiential techniques (Young, Klosko & Weishaar, 2003). Schema therapy aims to help patients understand their core emotional needs and learn ways of getting those needs met in an adaptive manner. This requires altering

long-standing cognitive, emotional, relational, and behavioral patterns (Rafaeli, Bernstein & Young, 2011).

Schema therapy integrates theory, diagnostics, treatment, prevention, and research. Development in its application and treatment, went alongside vast research resulting in numerous validation studies that proved Schema therapy to be highly effective in both reduction of various symptoms and improvement of quality of life (see Mirović, 2018).

Schema therapy model asserts that the etiology of difficulties in adult life lies in the extent to which the core developmental needs of childhood go unmet (Farrell & Shaw, 2018). These basic needs are for: 1. Secure attachments to others (includes safety, stability, nurturance, and acceptance) 2. Autonomy, competence, and sense of identity 3. Freedom to express valid needs and emotions 4. Spontaneity and play 5. Realistic limits and self-control (Young et al., 2003). If these needs are not met, it leads to the formation of: *Early Maladaptive Schemas* - EMS (there is 18 of them), *Schema Modes* (10 of them) and three *Maladaptive Coping Styles*. These further lead to different symptoms and problems (Mirović, 2018).

Young (2003) defines EMS as a broad pervasive theme or pattern regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree. Existing studies (see Vallianatou & Mirović, 2020) indicate that three of the most common EMS amongst mental health professionals are *Self-Sacrifice* (SS), *Emotional Deprivation* (ED) and *Unrelenting standards* (US).

People with the *Self-Sacrifice* schema voluntarily meet the needs of others at the expense of their own gratification (Young et al., 2003). They do this to spare others pain, avoid guilt, gain self-esteem, or maintain an emotional connection with someone they see as needy (Young et al., 2003). *Self-Sacrifice* schema is one of the most common schemas in psychotherapists (Haarhoff, 2006; Saddichha, Kumar & Pradhan, 2012). Therapists with this schema are acutely sensitive to their patients' reactions to them and may fear abandonment or feel guilty that they are better off than the patient. If a therapist surrenders to SS schema, she/he can engage in a number of self-defeating behaviors, going "overboard" to meet the patients' needs while ignoring the signs of fatigue and exhaustion (Vallianatou & Mirović, 2020). At the same time, a therapist with a SS schema might have difficulties to act assertively and set appropriate boundaries (Haarhoff, 2006).

Self-sacrifice schema is often linked with *Emotional Deprivation*, as the therapist may have learnt to meet others' needs in order to maintain an emotional connection (Vallianatou & Mirović, 2020). The *Emotional Deprivation* schema is the expectation that one's desire for emotional connection will not be adequately fulfilled. It involves deprivation of nurturance; deprivation of empathy and deprivation of protection (Young et al., 2003). If combined, SS and ED schemas push therapists to give too much, while neglecting their own needs. This might go as far as forgetting or not having time to properly eat and sleep or overworking with no time for socializing or fun (Vallianatou & Mirović, 2020).

Unrelenting Standards is another very common schema in therapists and has also been linked to burnout (Simpson et.al., 2019). The US schema is the sense that one must strive to meet very high internalized standards, usually to avoid disapproval, failure, or shame. This manifests itself as a perfectionism and a belief that it is never good enough, feelings of constant pressure, rigid rules, preoccupation with time and efficiency - all these leading to significant impairment in the one's health, self-esteem, relationships, or experience of pleasure (Young et al., 2003). When they surrender to US schema mental health professionals seek perfection and push themselves too hard, seriously neglecting their needs for rest, spontaneity, and play. They might work long hours, see too many clients, or fail to take breaks (Vallianatou & Mirović, 2020).

When schemas get triggered, we flip into a *Schema Mode* (Farrell & Shaw, 2018). Schema modes are defined as the emotional, cognitive, behavioral, and neurobiological states that are currently activated (Young et al., 2003). They are the predominant state that person experiences at any given point in time. They reflect aspects of self that are not entirely integrated, and a person flips from mode to mode in response to external and internal stimuli (Farrell & Shaw, 2018). There are four groups of Schema modes (for detailed explanation see Farrell & Shaw, 2018 or Young, 2003): Innate Child modes (*Vulnerable Child*, *Angry Child*, *Undisciplined Child,* and *Happy Child Mode*), Parental modes (*Demanding Parent Mode*, *Punitive/Guilt inducing Parent Mode*), *Healthy Adult Mode* and *Maladaptive Coping Modes*. Maladaptive Coping modes primarily consist of actions or behaviors and are defined as an overuse of survival-based coping styles: fight (Overcompensation), flight (Detachment and Avoidance), and freeze (Surrender). All three coping styles have the goal of protecting the person from experiencing distress (e.g., sadness, anxiety, anger, fear).

What do these modes look like in mental-health professionals? One of the modes that is most easily observed is the *Compliant Surender mode* – state in which one surrenders to the schema (e.g. if schema is SS/ED, gives up own needs for others, or in case of US spends inordinate amounts of time trying to be perfect (Young et al., 2003). When in this mode, the one acts on everything that *Self-Sacrifice* and *Unrelenting Standards* schemas or a *Demanding Parent / Guilt Inducing Parent* messages tell it to do. Instead of looking after their own needs first, instead of taking time to rest, socialize and play, many MHP avoid guilt and feeling of not being good enough by surrendering to taking care of others, learning/studying/working more. They protect themselves from "being bad, selfish or not good enough" (Parental mode messages) by *Overcompensating* (engaging in excessive work, excessive responsibility and control, "having to do it all ourselves" mode...) or going into *Compliant Surrender Mode*. Their inner *Vulnerable child* (we can call it "Little therapist") feels overburden, frustrated, tired and deprived. Their *Angry Child* and *Happy Child Mode* protest. Their *Healthy Adult* tries to make a change, but the abovementioned schemas, parental and coping modes get the last say. They continue doing what they normally do (overcompensate and surrender), employing the *Detached protector* to cut off their own feelings and needs and/or *Detached Self-Soother* to distract or sooth by filling the emptiness that the deprivation leaves.

Many mental health professionals that we had supervised recognize the abovementioned patterns and know what they need to do in order to change them, but still fail to do so. It is as if they have no control over these behaviors. They see themselves "rushing into" burnout but cannot seem to stop. The guilt, unrelenting standards and responsibilities for others often gets the best of them. They cannot stop what they do, which is actually, what they were thought to do as children. It is our experience that many MHP fail into the category of "parentified children". Parentification in the family system is defined as a functional and/or emotional role reversal wherein the child sacrifices his or her own needs in order to accommodate and care for emotional or logistical needs of a parent (Chase, 1999). By doing this, the parentified child learns that his or her needs are less important than others' and that the way to connect and get family's and cultural validation (and self-worth) is by serving and achieving. It also learns that "the faith of others/family" depends on its actions, which makes it almost impossible to step down and say no without feeling scared, guilty and selfish. Assuming adult (age inappropriate) tasks generates a lot of anxiety and the only way to cope with this sense of being inadequate and ill-prepared is to overcompensate with unrelenting standards, excessive preparation, and over-control.

In the following part of the chapter, we will discuss how the afore-described childhood experiences, Schemas and Modes tend to make MHP's work during the pandemic even more challenging.

Application of Schema Theory in working with mental health professionals during Coronavirus pandemic

The abovementioned childhood experiences generate schemas and modes that can seriously impede balancing other-care and self-care, which has proven essential for preventing burnout. Finding this balance tends to be even more difficult in Corona times. Mental health professionals that we had supervised, reported feeling even more responsible / guilty (*Self-sacrificing*) than usual. There was a sense that they have to help others because others "had it worse"- they "didn't have coping skills as we do", "they weren't able to keep their jobs/work online as we did" and so on. Many had (*Demanding/Guilt inducing*) beliefs telling them that it is not ok to stop or slow down, no matter how exhausted they felt. The reason behind this view was simple enough - "it is the pandemic". Others felt that they need to step in to make up for other systems that failed. Most continued working full day shifts with clients while initiating additional volunteer tasks (joined COVID-19 help lines, organized online workshops for free, wrote additional psychoeducational materials etc.).

The time and intake pressure became huge, the sense of *deprivation*, exhaustion and being overwhelmed increased, but they could not stop. Furthermore, many were juggling all of this while, simultaneously, taking care of

children, working online (or by phone) from shared spaces at home or working live in COVID-19 hospitals while wearing masks and other medical equipment. A significant number of them did all this while dealing with illness and losses of loved ones. Many of our supervisees reported feeling numb (*Detached*) or overwhelmed with the increased tendency to self-sooth (*Detached Self-Soother*) through binge eating, drinking alcohol or smoking cigarettes. Faced with their own vulnerability (their own *Vulnerable child*) many felt guilty and "weak" (*Punitive/Guilt inducing messages)*. This was not surprising, as mental health workers have a propensity to minimize their own vulnerability whilst continuing to expose themselves to excessive work pressures (Simpson et al., 2019). This vulnerability is among other things characterized by self-blame for showing signs of stress or vulnerability; striving to reach higher (*unrelenting*) standards whilst denying (*depriving or detaching*) personal needs and emotions; and a reluctance to set boundaries and ask for support due to *self-sacrifice* and fears of letting others down (ibid).

Having all of this in mind, we believe that the pandemic presents a great threat to mental health professional's mental health. The fact that it is shared trauma (characterized by an ongoing treat, immobilization, isolation, lack of resources, losses, financial and other uncertainties etc.), that has been going on for long, and is unclear when it will end presents additional mental health challenge. Furthermore, there is a high risk for vicarious traumatization among those who utilize high empathy and personal histories of trauma (Perris, Fretwell& Shaw, 2012), which is many of MHP.

The risk for burnout and compassion fatigue is great and the situation that is causing it can hardly be changed. What can change is the way we, as mental health professionals treat ourselves. The path to prevention is creative and compassionate self-care. In the part that follows, we will give specific recommendations how to do so. Recommendations too, came from Schema therapy literature and our own experiences as mental health professionals, COVID-19 volunteers, trainers, and supervisors.

Several studies indicate that not taking adequate care of ourselves combined with our unhelpful coping patterns intensifies the possibility that we experience burnout, compassion fatigue or vicarious trauma (e.g., Thomas & Morris, 2017; Simpson et.al., 2019). This is a reason why we ought to be aware of unhealthy coping patterns, schemas and modes. Awareness is therefore, the first step. Once that is done, we can move forward to dealing with our schemas and modes. The antidote for our *Unrelenting standards* and *Parent Modes* is to practice self-compassion and being in a *Happy Child Mode*. It is essential to remind ourselves that nothing is "a must" and that there is a cost to our *overcompensating* behavior. We pay a great price – we pay with significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships (Young et al, 2003). Therefore, we need to practice slowing down, accepting mistakes and setbacks, and incorporating more fun activities in our lives. We need to concentrate on our unmet needs and to keep on track with our self-care plan (Vallianatou & Mirović, 2020). Our *Healthy Adult Mode* needs to keep in mind our tendency to *self-sacrifice*

or *emotionally deprive* ourselves and gradually learns to prioritize our wishes and unmet needs. It also is very important that we actively change our personal life so that meaningful relationships and personal experiences enhance positive feelings and provide relief and self-care plan (Vallianatou & Mirović, 2020).

When shared trauma occurs self-care can be challenging. Supervision and peer supervision groups seem to be an excellent approach to dealing with shared trauma (Tosone et. al., 2012). In these groups we can investigate ways to manage personal stress, our emotional reactions during crises, grey areas of professional / volunteer practice and problem solve. Our supervisees reported that these kinds of encounters made them feel safer and less lonely. The group can also organize soothing activities that promote wellness such as mindfulness practice (Vallianatou & Mirović, 2020). This is especially important now when the pandemic makes usual self-care recommendations such as exercise, hobbies, travelling, going out etc. unsafe or impossible. As an alternative to these and instead of conclusions, we offer the following tips:

1. Remind yourselves that your needs and your life matter too – we are helpers, but we are people too; people with needs and problems same as anyone else's. Employ your *Compassionate Healthy Adult* to create a balance between personal and professional life – between your needs and needs of others.
2. Be mindful of your schemas and modes. Work on replacing self-sacrifice, guilt-inducing, unreasonable standards and demands with self-care, self-kindness, and realistic limits.
3. Be mindful of the problems and situations that trigger you and think of healthy ways to self-sooth. Try not to detach and overcompensate. Formulate a self-care plan that fits with your needs and life circumstances.
4. Remember that it is a difficult time for everyone – including you. Acknowledge that you may experience feelings that may not go away. Show yourself the same compassion and care you give to others.
5. Prepare for the long run – this crisis will last, and the aftermaths will ask for continuous support. You will need to support yourself continuously as well. Self-care plan should be a lifelong plan, nor just an emergency aid.
6. Look after your little self! Remember to engage in *Happy child Mode* activities that help you connect, relax, laugh, play, and have fun!
7. Take care of your own health - stay healthy and stay safe!

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