

## Burnout syndrome and analytical hypnosis

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### Summary

The author aims to discuss her experience that patients with Burnout syndromes need to recover in a unique individualised relational therapy and that they need a slower pace than national authorities are implementing through contemporary national guidelines for health and care systems. The author reviews published definitions of the syndrome and then presents two cases to illustrate the principle of finding the patients' own resources, the value of exploring the history of their drive to achieve and also how to utilize resistance as information about defenses and their functions. She uses hypnosis, hypnoanalysis and ego state imagery as a tool for finding the patients' pace, needs and unique ways for recovery.

**burnout / chronic fatigue / hypnosis / hypnoanalysis / manuals**

### INTRODUCTION

#### Purpose

The purpose of this paper is to add to the contemporary understanding of how health and care providers can help the growing number of patients with Burnout Syndromes. I hope to demonstrate the benefit of individualising therapies, which also is a critique of the increasing use of protocol based techniques. My purpose with the two case presentations is to illustrate how analytic hypnosis can evoke unconscious therapeutic resources that would hardly come to the surface had I not flexibly followed the individual unique communication.

#### Method and design of this article

I have chosen the label "Analytical Hypnosis" for the hypnotic method. Method-labels are arbitrary constructs in the sense that they are influenced by the belief system inherent in its theoretical frame and fundament, and each meth-

od could actually be labelled something else by someone from a different orientation and with other "lenses". My choice of concepts and labels, and thus my lense is influenced by Milton Erickson, Erica Fromm and also Helen and John Watkins from the field of hypnosis, to mention only a few. I am also influenced by psychodynamic seniors from the relational traditions, like Donald Winnicott, Harry Guntrip, Harold Searles, Frieda Fromm Reichmann, among many others. Humanistic and existential psychologists like Carl Rogers, Erich Fromm and Victor Frankl are also sources of inspiration. My conviction is that just as each patient and therapy relation is unique, each therapist is also unique and cannot be copied, only used as an inspiration to colleagues. So, the ideal of making a published method replicable, is problematic. The structure of this paper is therefore deviating somewhat from the usual structure of scientific papers. I describe a BACKGROUND first. This is a declaration of my professional experience with relevance for the topic. My rationale for such a disposition of this article, is that my choice of literature is influenced by my professional experience, knowledge and values. Those influences, subjective as they are, are rarely declared in ac-

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ademic articles, but can often be discerned in between the lines. I choose to present them on the lines.

After the BACKGROUND I present a limited but relevant literature review on the topic, under the title DIAGNOSIS. Diagnosis means "through knowledge". I have chosen references which have helped me understand clinically relevant factors in this group of patients.

## BACKGROUND

I have acquired, from 30 years of clinical experience, the impression that patients with Burnout Syndrome should not be pushed to recover. A common cause of the Burnout condition is stress in combination with the life style of "high achievers", so when clinicians and social agencies are pushing the patients to engage in standardized programs, the treatment adds to the stress. These patients want to achieve and they often fail because they have not learned to listen to the body. They give a delusional impression of being fairly healthy. Under the surface of healthy behaviour and compliant attitudes they eventually reveal a psychological conflict between a self-image of efficiency and the felt sense of exhaustion. Every failure to achieve according to a prescribed program cause bad conscience and fear of failure. This causes distress and more symptoms.

My choice of treatment is to evoke the patient's own deep, un- or preconscious knowledge regarding how to heal. Needs to relax have often been neglected, due to an outward, stressful state of mind that does not stimulate introspective exploring. I use hypnosis as an adjunct in therapy with Burnout patients. In academic presentations I use the concepts "analytic" and "hypnoanalysis", meaning that a crucial aspect of the treatment is to explore the roots of symptoms, and to use hypnosis as a means of uncovering and dealing with emotional aspects of symptoms. My exploratory orientation of hypnosis is free from pressure and expectations to achieve results. "Analytic" approaches means to me that therapeutic interventions are based on the hypothesis that symptoms are perceived as messages from sub-conscious levels, which can be interpreted by patient and therapist in a cooperative exploration.

In a paper from 2001, an investigation of patients' evaluations of the healing factors in analytical hypnosis was presented. Eight subjects were interviewed. They reported that they experienced the healing factors of analytic hypnosis as: contact with inner feelings, relaxation and as the result; more "life space" [1].

The last ten years I have treated about fifty clients with Burnout Syndrome. During this period, the National Health Security System in Sweden has withdrawn economic support and put pressure on people to work fulltime. Such politics create an iatrogenic psychological suffering, enhancing the conflict between their strong conscience saying "You should work" and their symptoms saying "You have an accumulated need for rest".

I have found that some of these patients never developed the capacity to soothe themselves as children, but were occupied with how to avoid worrying the parents. Many even felt they had to soothe a parent, to make him/her calm and less anxious or angry. This adds to the pressure to achieve, which later spreads to all spheres of life, and later on, in adult occupations, family and other relationships. When the balance between achievement and rest and also between outward and inward focus of attention, has been uneven for a life time, recovery takes time.

Alexander Lowen formulated a psychodynamic theory of depression, chronic fatigue and how to heal. He described the deep fear of chaos, anger and unconsciously imagined consequences of letting go of tension [2]. Relational and gender perspectives have been discussed by Harriet Goldhor Lerner, who wrote: "Depression can develop when the Self has been sacrificed and there is an unconscious insight of self-betrayal causing loss of self-confidence." She also discussed systemic perspectives and how the acknowledgements of women's superior caring, nourishing and relating skills may conserve women's stress: "... the more we continue to reify and glorify women's caring and caretaking skills as separate but equal, the less is the probability that men will identify with and use their competence in this area." [3].

My male Burnout patients who were depressed, also had a strong care-taking responsibility; professionally as well as in their private

sphere. This may be a common factor for both sexes.

## DIAGNOSIS

The first publication where I have found the concept Burnout is authored by Freudenberger & Richelson [4]. They describe the risks for highly caring professionals with little influence on organisational decisions, and the costs of caring too much about others and receiving too little in return.

The diagnostic label "Burnout Syndrome" has become known mainly through the research done by Christina Maslach [5-6]. One of her most renowned contributions to the diagnosis and assessment is the Maslach Burnout Inventory [6]. This inventory has been validated with various work populations in the U.S. and is the most common assessment instrument for Burnout.

In the ICD-10 Burnout Syndrome is presented as "Problems related to life management difficulty" [8] and defined as a state of vital exhaustion. Cherniss described 1995, that clinicians have experienced these patients as having a personality which contributes to their unhealthy imbalance between achieving and resting [9].

Such clinical experiences have encouraged me to focus on the needs of these patients to recover slowly without any pressure to "achieve" their own recovery. They need an individual approach, exploring their unique needs for rest, for which they often have a strong resistance.

According to an article on the Swedish situation by Eriksson and colleagues, [10] the condition of Burnout was not a reason for sick leave until 1997, when the Swedish National Board of Health chose to accept "Burnout Syndrome" as a reason for sick leave.

Four years later, in 2001, three percent of those who were on long time sick leave had the diagnosis "Utbrändhet" (Burnout Syndrome) [11].

Diagnostic labels may vary between cultures. The same kind of patients can receive various diagnoses such as "Burnout syndrome", "Exhaustion Depression", "Exhaustion Syndrome", ME, or "Chronic Fatigue". In American nomenclature the diagnosis is sometimes Occupational Stress syndrome. That label may be misleading, insofar as it leads us to think that the origin must

be merely occupational circumstances. But we know that only some people get "burned out" under the same occupational conditions. From a clinical practical perspective the similarities between the various diagnostic labels mentioned above are more relevant than the differences.

## Neurological correlates and the ANS

There is a classical and somewhat discarded study on Type A behaviour. Burnout patients and Type A personalities are both extremely high achievers. In an attempt to understand how personality, emotional stress and ischemic heart conditions interplayed, Friedman and Rosenman coined the concept of "Type A personality". These patients were often high achievers, impatient, workaholics and tense. They showed symptomatic attitudes and a behaviour which demand a high neurological sympathetic activity [12-13].

Two of the criteria for "Type A" are impatience and irritation. From what I have seen of Burnout Syndrome, these patients are not typically impatient or irritated, but they become eventually irritated as a result of stress and overload. Maybe they would have developed heart symptoms had they only been more egocentric and offensive in their personality style, or had they only had the constitutional setup for a speeded sympathetic onset. It is plausible that Burnout patients have a neurological reaction not to fire the ANS into as much adrenal excitation, but their brains activate the HPA<sup>1</sup> axis more excessively on the hippocampus level. According to Rosmond and Björntorp, the Burnout patients have a worn out HPA axis, so that the production of cortisol is not as flexible as it normally would be. The HPA axis becomes literally burned out, the cortisol is low all day and the psychological correlate to that, is a state of helplessness [14].

Before a condition of Burnout Syndrome is a fact, there is probably a state of prolonged stress with concurrent release of stress hormones. Such prolonged stress has been examined in studies on depression and PTSD, where a hypercortisolism has been found. [15] In attitude and behaviour this can take the form of a prolonged

<sup>1</sup> Hippocampus-Pituitary-Adrenal gland, regulating the alert-relaxed, fight-flight hormonal balance.

state of fight-flight vigilance, with an overproduction of anti-inflammatory hormones (cortisol) for protective reasons, which, if this strain on the system is constant, eventually damages the feedback system in the hippocampus, so that the system gives up.

## CASE ILLUSTRATIONS

### Description of treatment

The academic standard for clinical papers in scientific journals is to make the presented treatment replicable, which seems hard to do when the treatment design is individualised. What can be replicable is the therapeutic approach on a general level.

Nevertheless, I have sorted out some main principles for creative individualised psychotherapy including analytic hypnosis applicable with Burnout patients. These principles are:

1. Listen carefully to the history of the predicament. Interview about self-image, family relations, role taking or self-object relations, cognitive pre-sets and motivational factors which have lead up to the syndrome. Ask for the patient's theory of what has caused the problem; in verbal interview and with hypnotic exploration techniques. If the answers don't come easy, Shorr's Imagery tasks can be helpful [16].

2. Normalise by explaining the neuropsychological logics behind the fatigue. Explain the depressive symptoms as healthy; a kind of incubation due to the brain's effort to recover by avoiding new input and stimulation. Such a psycho-educational approach can be found in Emmy Gut's excellent book on "healthy depression" [17].

3. Introduce hypnosis as a tool for deep restoring rest. In hypnosis, offer suggestions for reducing stress and suggestions aiming to evoke resources for healing. How such inductions and suggestions can be created is taught in any basic education of hypnosis, which includes relaxation procedures, ego strengthening techniques and evoking resources for healing.

4. Explore obstacles. Obstacles may be in the form of resistances to inductions, or difficulties to follow suggestions. They may concretise somatically through body tensions, itches, coughs, heart pounding, headache, cognitively as "disturbing thoughts" or emotionally as anxiety. Re-

frame resistances into interesting information. How that can be done is illustrated in the cases, in particular the case of Olivia below.

5. Explore the function of resistance. Hypnotic techniques for such exploration have been described in "Ego state therapy" by Helen and John Watkins. They also explored resistance by using the affect bridge technique [18-19].

Erica Fromm [20] presented detailed case illustrations about how to explore resistance as a main technique in analytic hypnosis. David Cheek used ideomotor responses, e.g. finger signals [21] and I have described how to explore resistance in an article about depression [22]. The choice of technique is worked out in collaboration with the patient. Creative inventions of hypnotic techniques can contribute to the spontaneity that often is blocked in patients with Burnout syndrome, due to their ambition and extreme achievement attitude.

6. Create an atmosphere of safety and curiosity. These patients need help to feel safe when relaxing, being in the here and now, and less in control of what happens next. Hypnosis can be used for accepting unexpected feelings and reactions from within to come to surface, with less anxiety and distress than before. The therapist is a model in his/her capacity to trust, hold and constructively use whatever comes up, and thus keeping a kind of secure and safe frame within which the patient is encouraged to open up emotionally in the interest of personal self-realization and healing.

7. Principles and techniques are general tools to keep in the back of the mind, but never to be rigidly followed.

### CASE OLIVIA

Olivia was recommended to contact me by her psychiatrist who had seen her a few times and had prescribed a drug for going to sleep and also an antidepressant. Closely before this therapy, Olivia had been in psychodynamic psychotherapy with a psychologist for a year, once a week, and they had come to a halt. The psychologist had recommended me in the hope that I could help the patient further, with hypnosis.

Olivia had relied very much on that psychologist, gained insight in her problems and agreed that the two of them could not come further. Her

psychiatrist's recommendation was to consult me for "cognitive tools", a suggestion to which I did neither object, nor agree.

Burnout Syndrome had been her diagnosis, made by three health providers; two psychiatrists and the psychologist. According to ICD-10, the most applicable code would be Z73.0 Burn-out [8].

In my clinical interview with Olivia I saw a pattern: She had been occupied with others' needs on the cost of her own health.

She was a nurse, with extra duties, had always worked overtime and slept badly for many years. She had taken care of family members with chronic illnesses. She had been building a house with her husband. Her loved aunt had died. She had never mourned, never rested, but worked more than ever until her collapse, a year before she was referred to me. Then, one day at a staff meeting, Olivia had lost her hearing, started trembling and panicked.

Her emergent feeling at that moment was helplessness, after which she became extremely tired. Her psychologist had offered her supportive therapy to strengthen her and prevent depression. The psychologist informed me that her method was insufficient to help the patient further.

#### **Olivia's symptoms were:**

1. Panic attacks.
2. Inability to concentrate on problem solving, reading or social life.
3. Inability to listen to other people's problems.
4. Extreme fatigue and insomnia.
5. Over-sensitivity to sounds and a need of silence.
6. Lost self-esteem.

My first intervention was to educate Olivia about the HPA axis and how that caused neurological fatigue. I wanted to normalize her symptoms and suggest confidence in the logic of her body's attempt to protect her against further overload.

One of my early interventions was to explore any subtle meanings of her sound-sensitivity.

I asked: "To which particular sounds are you so sensitive?"

She was not oversensitive to every sound, but to sounds that reminded her of time; clocks tick-

ing, the newspaper pushed into her letter box, etcetera. The disturbing factor of sounds was the reminder of everyday demands.

#### **Previous rehabilitation efforts**

In order not to repeat ineffective counselling and to strengthen good experiences, I asked what Olivia had tried before coming to me.

She told me one "ineffective" attempt; she had written a diary for some time and it had made her cry. Her reaction to her own crying was fear. She had stopped her tears as an automatic response and then she had found herself writing only positive affirmations, in order to stop crying. She told me that she was not prepared to cry, but wanted to manage life as she used to, before her collapse.

From that information and her trust in me and my competence, I formulated the hypothesis that she lacked what Winnicott called the "holding" capacity [23]. Olivia was unable to sooth herself and unable to cry safely. This holding capacity is developed in the earliest years by the way the parents react to the child's emotional reactions. The "good-enough" parents mirror, accept and acknowledge emotions so they become accepted as part of the child's identity.

#### **Contract, frequency and duration**

We made an open contract regarding the length of therapy. The frequency was initially 45 minutes once a week. After 8 months we decided to meet only once a month, in order to strengthen her self-caring capacity and to use self-hypnosis, between sessions. When I teach patients "self-hypnosis", I give them my recorded CD for deep relaxation and stress management [24], ask them to listen as often as they need it, with the suggestion that they eventually will be capable of giving themselves the kind of hypnosis they need, in order to heal or recover.

This therapy lasted 2 years. The sessions usually started with her reporting the recent events regarding health insurance officers, work and family relations, her emotional reactions and then we used hypnosis to explore her needs on a deeper level, how to take care of these and recover.

### Treatment plan and hypnotic approach; first session

The choice of hypnotic techniques were permissive and accepting. I taught her how to be in a healing state of mind (trance), letting go of achieving ambitions and exploring her true inner voice. Theoretically, I am inspired by Winnicott's concept True Self [25].

In order to find her inner voice and true self, I chose to explore resistances. I realized that her resistances were important informants; they had a function and a purpose, just like ego states, as described by Watkins [18].

This is also how Milton Erickson used resistance; finding out the function of the resistance and then suggesting other ways to satisfy the needs behind these functions, e.g. getting attention, protection, safety, etcetera. While Erickson often invented strategies to resolve resistances without the patient necessarily being aware of how and why, Watkins chose a more insight oriented "analytical" approach.

Olivia's first hypnosis illustrates how we worked without any ambition to achieve anything, not even a deep trance. She entered light trance. But something bothered her. Her heart pounded hard and it frightened her. I used an Ego State approach. In Ego State therapy you address separate parts of the person with an expectation that these parts have their own knowledge about symptoms [18].

I asked: "When your heart beats this way; what does that mean to you?" Olivia's answer was that it meant stress. I then negotiated with her heart as with an ego state. "I understand that you, Heart, become alert in this situation. You have had a habit since long, to help Olivia stay alert and keep on with all her duties. You have avoided relaxation, by some reason you may have feared what will happen if Olivia really lets go or goes to sleep. I will take it easy, respecting whatever you come up with and whatever you want to show Olivia, and I will encourage you to tell her your reasons. I will listen to your information, and Olivia and I will deal with it. Will that be okey with you? Let Olivia know your answer." Olivia nodded her head. "Is it okey with you, Heart, to collaborate with me, for some time on?" Olivia nodded.

### The process

In the therapy process we explored her many obstacles to reach a deep relaxation. She did relax deeper each time she came to me, and my technique did not focus on achieving depth, but on exploring the obstacles to get there.

These obstacles came as "disturbing" thoughts, images, or body tensions. The hypnotic inquiries gave valuable information regarding the function of the tensions and obstacles. She discovered fear, sadness and a need to mourn losses. Olivia's comment after a session in hypnosis was: "My father left my mother when she was pregnant with me, then she married another man. He also left us." I interpreted this as information about her fears to be abandoned. When I offer interpretations, I do that after hypnosis, in the alert state of mind.

During one hypnosis induction she felt like yawning, but couldn't. There was a tension in the back of her jaw. In hypnosis, we explored this resistance to yawn and she remembered a photo of herself as 11 years old. Then she realised a conflict between her self-image of being cheerful and her reserved look on that photo. This conflict re-appeared in a following session as a worry about her professional image: "How will they ever accept me as weak? At work I am strong and cheerful!"

She explored and found memories of family secrets and how she had learned to shut off true intuition, spontaneity and curiosity. One example of how hypnosis helped her trust her inner voice was when her physician had advised to visit her workplace each day, as part of the rehabilitation, but in hypnosis she spontaneously found herself recovering in a beautiful place on the countryside. Her conclusion was: "I will not visit work tomorrow. I recover so much better from nature".

Just like all patients I have seen with Burnout syndrome, Olivia felt a pressure to set a time plan for going back to work. I refused to answer her requests for a professional estimation regarding when she would be ready to work. A settled date would stress Olivia and hinder her capacity to heal. If an expert suggests a time span for the recovery, that would counteract the treatment principle to find and follow her inner knowledge of herself. She and only she can

know, eventually, when there is energy enough to test working again.

Her hypnotic experiences caused a change of her expectations on therapy. Initially she had expected cognitive strategies for going to sleep. After some weeks she asked for hypnosis with the particular purpose to explore her self-image, the roots of her eager-to-please attitude and her excessive achievement drive.

After six months of therapy Olivia knew a lot about her personality and the history of her problem. Olivia found out that she had used her social competence as a defence; be a good girl, avoid conflicts, shut off her reflective ability and deny her personal needs. She had repressed her natural needs to rest from input and demands, until the brain couldn't adapt anymore, but failed to process more input.

After almost one year, Olivia told me that she needed me further. She was still suffering from insomnia and she needed my help for the analytic introspection in hypnosis, which she could not do on her own. We had a break for summer. When Olivia came back, she told me how she had not been able to explore and accept feelings beneath her anxiety. Someone had advised her to divert anxiety with a cognitive technique, by counting her steps while walking and she had done so. But as she counted steps she became angry – and that frightened her even more.

I interpreted and confirmed that anger was the feeling beneath her anxiety. I encouraged her to explore this anger in hypnosis. She found an angry but also a young frightened Olivia. I asked the young Olivia to express herself. She found two ego states; one angry adult Olivia and one frightened young Olivia. The angry one feared weakness and abandonment. "I am afraid of the doctor, my workmates and my neighbours, that they will be disappointed at my slow recovery." She could now empathise with her weakness and she decided to use the angry part's power for supporting the frightened one, and the conflict dissolved. So did the anxiety.

During the last half year of therapy Olivia strengthened her ability to care about herself and listen to her inner voice. Grief had become a familiar feeling and she often cried. After a cry she felt relieved. That was possible as she could now hold and accept herself while crying.

Olivia's self-esteem had grown and she trusted her inner locus of control, her own judgment, needs and feelings and also how to set limits.

### End session

Olivia wanted hypnosis even in her final session. In this hypnosis, Olivia was surprised by what she found, namely that she never had liked to take care of patients. She realised that her motivation had been to be confirmed by colleagues. We finished therapy and she felt confident.

After 9 months we had a follow up. She informed me that her sick leave was prolonged and transformed to temporary disability pension. She was convinced she would eventually find a new occupation. She felt capable of finding her own capacity and to take care of herself.

Two years after the end of therapy, she contacted me again to find confidence and peace with a recent insight. At 59 years of age, she was still not back in work, but she had started studying part time and helped her disabled son and his prematurely born daughter, part time. She felt that as long as she stayed away from occupational demands she could be creative and take care of herself and family members. She relapsed whenever she pressed herself to plan for occupational training. In this follow up session she decided to enjoy her improved health and be proud of her parental and grandmother role and also allow herself to postpone occupational training until the social security system would demand a decision for either retirement or being at the market's disposal. She had nine months to enjoy and recover optimally, until such a decision would be demanded.

### Results

My preferred outcome measure in individualised therapies, is to discuss regularly with the patients how they experience the therapy and our co-operation and if they want any changes of focus, content or technique. I avoid asking them about "results". They may easily interpret the word "result" as a pressure to achieve full time employment again.

I will present the results, first with my observation of Olivia's initial symptoms through my patient records and her verbal reports. They were:

### *Panic attacks*

They disappeared immediately after the first sessions and after I had explained the mind-body logic of her symptoms.

Inability to concentrate on problem solving, reading or social life

She became gradually more able to concentrate on family members and grandchildren, and also taking care of herself. She had some remaining difficulty to concentrate on reading which she interpreted as a symptom of too much input. She became more tolerant to her personal withdrawal and not to be with people who meant very little to her.

### *Inability to listen to other people's problems*

After she realised that she had supported other people to the cost of her own health, this inability was not defined as a problem anymore. She did not have to listen.

### *Extreme fatigue and insomnia*

Her excessive fatigue disappeared almost altogether. By the onset of therapy she had to withdraw and rest several times each day and by the end of therapy she was alert most days, but could still react with a need for a day of rest, e.g. when she had been with the grandchildren for a weekend. When she started this therapy she woke up in the middle of the night and stayed awake for hours, despite medication. After therapy, she was still on medication, but slept all night long and could use self-hypnosis to go back to sleep if she woke up.

### *Oversensitivity to sounds and a need of silence*

Initially in therapy she heard and was annoyed by the ticks of my table clock – a sound almost inaudible. This sensitivity was not there by the end of therapy. She was not disturbed by night or early morning sounds anymore.

### *Lost self-esteem*

She respected her own needs regarding how to heal and she accepted not to be identified as “strong and cheerful”. She had learned to soothe herself. She cared less about the opinion of others.

### **Olivia's feedback and follow up reports with relevance for results**

Olivia changed her value system during the therapy process. She did not go back to her previous work and she judged this as a good result of the therapy, which was a total change of her previous attitude to achievement. The discovery by the end of therapy; that she actually never had liked to work with patients was almost shocking her, but yet a relieving insight, which explained much of her previous panic.

Her notion at a follow up meeting, that if she “stayed away from occupational demands” she could be “creative and take care of herself and family members” was a personal announcement of her choice and her enhanced self-esteem, and a restructuring of conscience, values and motivational drives to achieve.

Follow up contacts after nine months and after two years showed that the improvements were consistent and she was free from symptoms. She appreciated that her self-esteem continued to be strong. She had confidence in future happiness as a family mother and grandmother, despite the fact that she had not been able to go back to employment. She valued her acquired capacity to help her children and grandchildren.

### **CASE IAN**

Ian's G.P. had diagnosed him as depressive, with severe anxiety, Burnout syndrome and insomnia. His diagnosis according to ICD-10, was code is Z73.0 Burn-out [8].

The G.P. had prescribed an anxiolyticum and an antidepressant. Ian was also on sick leave. He described his symptoms as: irritated, lost self-confidence, lost patience, extremely tired but with a high heart rate. His own “cause analysis” was that he was a “Type A” personality; he had loved challenges, been calm in his appearance and helped other people, but had secretly suffered. He had demanded too much of himself and he had been frustrated in all kinds of previous occupations, due to an overload of responsibilities and too little influential power. His personal needs for giving good service and selling products of high quality were frustrated by short sighted economic interests from company owners.

### Contract, frequency and duration

We made an open contract regarding the length of therapy. The frequency was initially 45 minutes once a week. After one year we decided to meet twice a week for two months duration, then back to once a week, and after two years, once a month another year. Like Olivia, Ian became more skilled in using self-hypnosis in between sessions. The sessions usually started and continued the same way as with Olivia described above. Ian's therapy lasted three years plus five follow-up sessions during another two years.

### Treatment plan and hypnotic approach; first session

I used Imagery diagnostic procedures as described by Joseph Shorr [16].

According to this test, Ian's logic and reason informed that he had hope, was not aware of any needs, wanted to escape, and had a hidden capacity to observe his own self. His emotional part informed that he was kind, strong, would eventually recover and secretly was very kind.

Ian had a history of many removals. As a child, his family had been moving every fourth year due to his father's career. He had never complained but supported his mother in the attempt to soothe her, worried as she was about Ian's brother who had frequent violent temper tantrums. Ian wanted to understand himself better, so we planned an insight-oriented therapy.

Ian quickly began to attend to his anxiety with curiosity instead of devaluing himself or trying to escape with sedatives. He realized that his depression covered a fear of losing the capacity to support his family and function in the society. He realised that his relations had come to a crisis, partly because of his own generosity to others, helping people and working too much, but never asking for anything in return. The therapy focused on introspection in the hypnotic state.

### The process

Ian's initial preoccupation was the question: "Will I have enough energy to work soon?". We found that beneath that question he had a fear of not being good enough. We worked with his guilt and self-devaluation and reframed it to a too-kind-to-be-healthy attitude, which had led

him to his state of exhaustion. When he after some months in therapy asked "do I have the energy to work?", I reframed the question into "am I strong enough yet, in my confidence, to set limits?".

Through hypnosis Ian found a way to let go of worries and let himself recuperate in a deep rest. Now and then a resistance came up. One session, he lay down and I induced hypnosis through relaxation. He then asked me to lay my hand on his forehead (he was not aware that Freud used that technique). After a long silence he said: "This week I have been depressed and I don't see why, I have had a wall of worries." I asked: "Imagine that wall ... And now, look behind it. What is there behind that wall?" Ian answered: "There are early deficits, there is grief."

He realised that nobody was there to soothe him as a child. So we worked on the lack of holding and the grief from early childhood. After some more time in therapy he had some difficulty relaxing without my presence. So I asked his wise "subconscious"<sup>2</sup> mind to help him find some trust between our sessions. He found dolphins. These dolphins communicated with him from a distance. The images of dolphins were clear and felt safe and they appeared again back home, without me. This was his unique way to learn self-hypnosis.

I interpreted the dolphins as transitional phenomena [23].

Transitional objects can be concrete things, animals or even ideas, which function as a substitute for the caregiver's presence, in the process to independency. Ian said he trusted me more than he ever had trusted anyone.

After a year, in a phase which lasted two months, Ian wanted to see me twice a week, but was afraid to ask for it. He feared that I would deny him that, which would have been more painful than he could stand. He enacted a therapeutic regression. I interpreted it as constructive, that he had the courage to admit dependency and thus accept a part of him that was in need. He went through a period of dependency and identity crisis, confused about his motivation to live. After two months of dependency he became stronger.

After a year of therapy I asked Ian to evaluate the treatment so far. He said:

"I receive energy, I drain you on energy, I live on that energy for several days, and then I feel a strong need for you again. But I am slowly developing an ability to refill also from a distance."

Two months later he said: "I used to think I will never cope without you, but now I can imagine an end of therapy."

After almost two years of therapy Ian asked me to plan for a long weaning period.

Ian realised that his impatience was a symptom of having taken too much responsibility for the children, and also taking care of his wife who behaved impulsively and immature. He had initiated discussions about their relation and they decided to try to be as good parents and friends as possible. They showed each other more respect, but Ian felt it was up to him to remind his wife not to fall back into negativism and manic episodes.

During the summer break, Ian worked as a skipper on cruisers. He enjoyed his capacity to fully concentrate and to have full responsibility. He trusted his own judgment and so did the crew. Stormy weather demanded his full attention and intuition, which he managed well. He appreciated the dolphins who made them company. Back home again he became depressed and feared a relapse. The reason seemed to be marital problems. He started working part time, with small free-lance jobs, repairing sailing boats.

He realised a change: He did not depend on other people's appreciation of him, but rather by his own satisfaction to engage in activities and create something. He acknowledged his own intuition as his most important source for decision making.

Then he was head-hunted for an employment. They knew him by his good reputation. He informed the manager about his condition and his time off from work since two years. The employer promised Ian could start working in his own pace. Ian was happy, but felt a doubt which he could not understand.

We did hypnosis on the issue. In hypnosis he felt a "No" from deep inside. He was confused. After such a long break and such an improvement in his health, why would he say no? In hypnosis, I asked his "subconscious" mind. He then remembered in detail his last visit at that office and how he had walked around the

workplace, meeting the employers. He focused on the feelings:

"The atmosphere in this company is distressed, there is a pressure, and I am not able to withstand the atmosphere of such a high achievement anxiety in that office".

The dolphins assisted him frequently, both in our sessions and in between sessions, in his self-hypnosis and while going to sleep. After another six months he was employed as a manager in an international company. He was appreciated by employers as well as by employees, became chairman of the Union and continued to listen to his intuition.

Three years had gone since he started therapy. He was healed from the Burnout Syndrome. Minor symptoms, like a pain in solar plexus, occurred occasionally, which he attended to as body communication. Ian consulted me for five follow-up sessions during his first two years in his new job. On those occasions he used me as a kind of facilitator to his self-hypnosis. He lay down on the couch, told me about his current preoccupations, then I laid my hands on his forehead and was silent. Ian went into a trance and did his own exploration, first in silence, then telling me what he experienced. By the end of the session I confirmed or just mirrored what he had expressed.

After another year without therapy he came back for some support in another attempt to cope with his wife. They were now seeing a family counsellor. The Burnout symptoms were gone and he was protecting himself well against such stress that had caused his Burnout condition. Ian's own prognosis was that he would enjoy his work even more than before, love his daughters and find ways to develop a friendly marital relationship or go through a divorce.

## Results

With Ian as well as with Olivia, I chose not to use standardised outcome instruments. I estimated that the patients' self-report, in his/her own words are the best instruments available, for this patient group<sup>3</sup>. An attempt to structure the results according to initially presented symptoms will include irritation, lost self-confidence,

<sup>2</sup> The concept "subconscious" was probably used first by Pierre Janet as a part of his theory of dissociation and hypnosis.

lost patience, extreme fatigue and a high heart rate.

### *Irritation*

Irritation was a symptom of frustration. Ian's frustration was about a conflict between his needs to rest and his "Type A" behaviour. His irritation decreased together with his increased ability to respect his needs for rest and his ability to consult his subconscious mind for advice.

### *Lost self confidence*

An example of self-confidence was his choice by the end of therapy, to explore why he felt ambivalent to an attractive job opportunity and his choice to respect his doubt and through hypnotic introspection realize his need not to accept the employment. Another example was Ian's self-respect in his discussions with his wife.

### *Lost patience*

Ian realised that his impatience was a symptom of imbalance between personal needs and his habit of being there for other people. His attitude changed, so when he felt impatient, he could explore in what way his personal needs had been ignored and what he needed. Ian did not expect from himself anymore, that he should be patient with people who expected the impossible from him. The concept "patience" changed its meaning from being ideal to being questioned.

### *Extreme fatigue*

Ian could eventually be alert enough to concentrate when he was in command of cruising ships. He gradually gained more energy and could work again, first part time and after one year's follow up; full time. He reported that he could work, only on the condition that he continually listened to his inner voice and respected his need for a balance between activity and rest. He acquired a capacity to respect fatigue as a need to rest, and eventually became less tired. A change of attitude had taken place; fatigue was initially frightening and at the end of therapy, he regarded fatigue as a need for rest that deserved respect.

### *A high heart rate*

Instead of fear when he experienced a high heart rate, he used this symptom as a message from his body that his unconscious mind needed his attention. So, the incidence of high heart rate was reframed from a problem to a message.

### **Ian's follow up with relevance for results**

After three years of therapy, Ian kept sparse contact during the following two years. There was no relapse and he only used me as a kind of facilitator to self-hypnosis. Ian then was out of contact with me for one year.

Then he came back in order to discuss his marital problems. This follow up demonstrated clearly no symptoms at all of the Burnout condition.

### **DISCUSSION**

The exploring technique, which I label analytic, gave valuable information about the function of obstacles to let go of tensions. In both cases, part of the distress seemed to be caused by an ambitious, self-sacrificing, eager-to-please attitude. Both Olivia and Ian had a history of complying too much, detrimental to their health. They were both reluctant to realise their personal needs and feelings. They both had reacted with anxiety when their self-image of being high achievers was shaken. Olivia feared what other people would think of her and Ian went through an identity crisis. Their anxiety and fatigue, hindered them from continuing as before. I used hypnosis with the aim of assisting them to find their personal needs for recovery. When they experienced obstacles, I used hypnosis to help them find the feelings and needs behind these resistances. Resistance introduced itself on a somatic or symbolic level, for example as the heart pounding (Olivia) and the wall of worry (Ian). The advantage of analysing the resistance was that all signs of resistance were met with respect and as valuable information. There is a crucial difference between the analysis of resistance in psychoanalytical talking therapy, and the way we "analyse", or rather; explore, in hypnosis. Analytical interpretations should not be offered a patient in hypnosis, because that demands cognitive processing, which is hard to achieve in the trance state. Cognitive reflection

also hinders access to repressed emotions. To let go of intellectual reflection and effortlessly explore, facilitated a kind of restructuring of psychological patterns on a deeper level.

The cases illustrate how the analytic technique was restricted to inquiries and respectful mirroring of the clients' experiences, accepting these as they appeared and finding out how the material helped to understand the patients' situation. This acceptance and respect for emotions as a main tool in the treatment process, seems to be what these clients have lacked in their background. Therefore the cure was probably a combination of creating self-respect through insight and a "corrective emotional experience", [26] i.e. the interpersonal repairing qualities of psychotherapy. In order to discover the clients' emotional resources, explore the functions of resistances and enhance introspective skills, I have found the combination of hypnosis and Ego State Therapy helpful, as is illustrated in these cases. My choice to talk directly to Olivia's heart, as it reacted with vigilance when I hypnotised her, is inspired by Ego State Therapy where body parts can be addressed to as ego states. Milton Erickson used whatever resistance he encountered, with curiosity and a wish to know more [27].

My experience with these and other patients with Burnout syndromes highlights the importance of finding unique resources and stop attending to others' needs to such an extent as they used to. In contemporary society this is not an easy task and contemporary politics are detrimental to people with Burnout syndrome. Achieving efficacy, achieving short term therapies and comply with evidence based techniques which promise quick symptom relief, are repetitively encouraged by national health authorities. These cases illustrate that healing hardly can be scheduled in a time plan, nor follow a generalized protocol.

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<sup>3</sup> At the time we had not yet printed our evaluation sheet for "quality assessment", in which the patients evaluate their experience of the therapy with a V.A.S. 1-10, regarding such factors as how they were "seen, heard and understood", how their situation had changed with relevance to the presented problem and other patient centred questions regarding quality and outcome, from a subjective patient perspective (Carolusson, 2009).

## CONCLUSIONS

To draw conclusions from clinical qualitative material is an act of interpretation. In this act I am influenced by my presumptions and preconceptions. I declared in the BACKGROUND the theory that each patient is unique and thus deserves a unique treatment. In order to make a unique process possible, the dialogue in the presented cases is aiming for a mutual understanding of the patient's symptoms interpreted as messages about the individual's specific needs and resources in the process to recovery. A main principle for therapeutic interventions in analytical hypnosis is the respect for the patients' genuine personality, history, resources and reactions in the therapeutic relation. I don't utilize but rather interpret patients' pattern to achieve or be compliant. I accept whatever comes up in the therapy in or out of hypnosis, with an attitude of not knowing, but being interested and curious. Thus the process is a mutual excursion with findings that can surprise both patient and therapist.

### Conclusions about this diagnostic group; Burnout Syndrome

It seems to be beneficial that the therapist respects the patient's uniqueness. Respect is implemented by the abstinence from anticipation or suggestion of achievements and results. Anything that the patient expresses in hypnosis is accepted and used for insight and healing. It is not judged as good or bad – an attitude that is inherent in the psychoanalytic principle of "neutrality", not to be mistaken for indifference.

The presented patients responded with relief to my refusal of suggesting time plans for their recovery. My conclusion is that suggested time assessments are counterproductive. My refusal to adapt to such a pressure and my expressed opinion that nobody can know the time needed for recovery was consistent with my theory that every attempt to speed up recovery will hamper it.

Both cases illustrate that hypnosis can be a healing state of mind, given that the patients are supported to accept and appreciate whatever comes up. The therapist is a model of that, by accepting the patients' symptoms as interesting and something that covers something beneath

symptom level. Burnout patients are often erroneously diagnosed as depressed and I suggest a reframing of that diagnosis as not depression, but a state of healing from within, and a withdrawal in the service of re-fuelling. A major aspect of depression may be a self-contempt due to the loss of former achievement capacity. Self-contempt complicates the ability to use the fatigue for re-fuelling and takes the form of depressive inertia. Therapy and hypnosis therefore needs to nourish patients' self-esteem, so they can appreciate the need for rest. Two factors seem to contribute to that: 1. relational factor: acceptance and non-judgmental yet confirming attitude and 2. hypnosis factor: hypnosis as a healing state of mind.

These cases indicate that the hypnotic state, the analytical approach, the gained insights (self-knowledge) and the therapist's accepting and constructively reframing of communication contributed markedly to their healing.

In the process of therapy the patients' definition of recovery may change. For instance, if a patient's initial goal is to function as before the illness, that goal may change. A crucial task in therapy is thus to challenge the patients' attitude and premorbid lifestyle, and to do that from contact with a deeper true self.

There is reason to conclude that analytical hypnosis with an accepting, curious exploring attitude, in an individualised process without pressure to achieve, is a method of choice with Burnout patients.

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