The Author
Susanna Carolusson, MSc. Psychology, Lic Psychologist, Lic Psychotherapist, authorized supervisor and teacher of psychoanalytic orientation.
She started as a psychologist in paediatrics 30 years ago, continued in psychiatry with adults, then started her private practice and became educational director in the Swedish Society for Clinical Hypnosis 1989 and consulting teacher at Gothenburg University since 2003. She has published two books, co-authored three books and written articles on hypnosis and psychotherapy; clinical, scientific, existential, trauma, brain injury and communication.
Susanna is honorary member and past president of SSCH. She is also teaching and supervising on neuropsychological care and rehabilitation, psychotherapy and hypnosis in Sweden and internationally.

Correspondence: susanna@carolusson.se
Carolusson & Carolusson AB
Erik Dahlbergsgatan 9, SE-411 26 GÖTEBORG, Sweden.
phone office: +46 317118290 / cellphone. +46 705970007

Key words: Burnout, Analytic, hypnosis, manuals

Susanna Carolusson **susanna@carolusson.se**

Burnout and Analytical Hypnosis

ABSTRACT

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' inner resources, the value of exploring the history of their achievement attitude and also how to utilize resistance as information about defences 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.

INTRODUCTION

Purpose

The purpose of this paper, in a general perspective, is to add to the contemporary understanding of how health and care providers can help the growing number of patients with Burnout Syndromes. More specifically I hope to demonstrate the benefit of individualising therapies, which also is a critique of the increasing use of manual or protocol based methods. This is concretely illustrated with two cases. My purpose with the 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

Regarding the title of this article, I have chosen the label "Analytical Hypnosis" for the hypnotic method. Method labels are arbitrary in the sense that therapists are influenced by whatever school they belong to and each method could actually be labelled something else. My choice of concepts and labels, and thus my cognitive constructs are 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 subtle mental guides to my therapist self. It would be a mission impossible to acknowledge all who have influenced the way I work. My conviction is that just as each patient and therapy relation is unique, each therapist is also unique and can not be copied, only used as an inspiration to colleagues.

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 personal professional experience with relevance for this topic; and my rationale for such a disposition of this article, is that my choice of literature is influenced by my previous professional experience, knowledge and values. Those influences, subjective as they are, are rarely declared in academic 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 such literature references which have helped me to understand clinically relevant factors in this group of patients.

BACKGROUND

I have acquired, from 30 years of clinical professional experience, the opinion that patients with Burnout Syndrome should not be pushed to recover. One cause of the Burnout condition is stress and the life style of personalities who are “high achievers”, so when clinicians and social agencies are pushing the patients to engage in programs and manuals, it may be detrimental to their recovery. Programs easily become stressors for these patients. Pressure or expectations that they follow a program or manual, even for their own good, make them feel like they must live up to expectations. They try so hard, they want to achieve, and they often fail because they have not yet learned to listen to the body. They give a delusional impression of being fairly healthy. Under the surface of healthy behaviour and nice 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, since they do not live up to their self image. This causes distress and more symptoms.

My choice of treatment is to stimulate the body’s own healing processes and also evoke the patient’s own deep, un- or preconscious personal knowledge regarding how to heal. It is also my experience that these patients have no previous access to such deeper knowledge. Introspection has often been repressed, due to cultural norms of efficiency. Needs to relax have often been neglected, due to an outward, outgoing stressful state of mind that does not stimulate introspective exploring. I use hypnosis as an effective adjunct in therapy with Burnout patients. The analytic and exploratory orientation of hypnosis has the advantage of being free from pressure and expectations to achieve results. The body’s symptoms are perceived as messages and can be interpreted by patient and therapist in a cooperative reflexion.

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” (Carolusson, et al 2001).

The last ten years I have seen more clients than before, who have suffered from Burnout Syndrome. During this period, the National Health Security System in Sweden has put pressure on people to work fulltime and has withdrawn insurance money after a shorter period of sick leave than before. People with Burnout Syndrome, who come to me as patients, are not lazy people, rather the opposite, and their conscience is badly punished by the Governments attitude that they would recover better if they went back to work sooner. These people love to do their duty, so if we, the health and care clinicians should agree to contemporary politics, we would 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". My experience from these patients is that their path towards recovery, is to listen to their inner voice, their body and their deep emotional needs. They have a great need for self repair and natural recovery.

In my clinical practice with Burnout patients I have also found that some did not have the capacity to soothe themselves as children, but were occupied with how to avoid worrying a parent. Many of these patients even felt they must soothe a parent, often the mother, to make her calm and less anxious, fearful 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.

In this article I express an experientially acquired opinion. I have been inspired in my theoretical understanding by authors from 30 years ago until now. One of my earliest

encounters with a psychodynamic understanding and theory of depression, chronic fatigue and how to heal was Alexander Lowen. He respected the deep fear of chaos, anger and unconsciously imagined consequences of letting go of tension (Lowen, 1972). Unconscious defences will not submit to quick fixes, in particular if the symptomatology involves somatic functions, which is the case in Burnout Syndrome. 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: "From a systemic perspective we can predict that 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." (Lerner, 1999).
My male Burnout patients who also were depressed actually had an unreasonable care-taking responsibility; professionally as well as in their private sphere. The "betrayal of self", as Lowen called it, may be a common factor for both sexes.

DIAGNOSIS
The first publication where I have found the concept Burnout is authored by Freudenberger & Richelson (1980). They describe the risks for highly caring professionals with little influence on organisational decisions, and the costs of caring too much about others wellbeing and receiving too little in return.
The diagnostic label "Burnout Syndrome" has become known mainly through the research and documentation done by Christina Maslach. One of her most renown contributions to the diagnosis and assessment is the Maslach Burnout Inventory (MBI). This inventory has been validated with various work populations in the U.S. (Maslach & Jackson, 1986) and is the most common assessment instrument for Burnout.
The diagnosis "Burnout Syndrome" tells us that the patient is extremely tired, mentally and physically.
You can not find this label in DSM, but in the OCD-10 it is recognised as "Problems related to life management difficulty" and defined is a state of vital exhaustion. There seem to be some anamnestic data which are shared by this group of patients. Clinicians have experienced that these patients very often have a personality which contributes to their unhealthy imbalance between achieving and resting (Cherniss, 1995).
Such documented experiences contribute to our competence to choose a proper clinical approach and to create hypnotic interventions. It can encourage us to focus on the needs of these patients to recover slowly without any pressure to "achieve recovery". This group of patients have in common that they strongly need an individual approach searching for their unique needs for rest, for which they have a lot of resistance.
According to an article on the Swedish situation by Eriksson, Starrin and Jansson (2008), 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). (Socialstyrelsen, 2010)

Diagnostic labels may vary between cultures. The same kind of patients can receive various diagnoses such as "Burnout syndrome", "Exhaustion Depression" 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.

Many clinicians have seen that these patients very often have a personality which contributes to their unhealthy imbalance between achieving and resting (Cherniss, 1995). From a clinical practical perspective the similarities between the various diagnostic labels mentioned above are more important than the differences.

Neurological correlates and the ANS

My clinical experience is concordant with the 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 (Friedman & Rosenman, 1959), (Friedman & Powell, 1984).

Two of the criteria for "Type A" are impatience and irritation. From what I have seen of Burnout Syndrome, these patients are not characterologically 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 pushy, self-centred 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 constitution which does not fire the ANS into as much adrenal excitation, but their brains activate the HPA[1] 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, so that the cortisol is low all day and the psychological correlate to that neurological phenomenon is a state of helplessness (Rosmond & Björntorp, (2000). Before a condition of Burnout Syndrome is reached, 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 (Sapolsky, 1990). In attitude and behaviour this can take the form of a prolonged 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 this journal is to make the presented treatment replicable. To say that individualised treatments are replicable, is a logical inconsistency. However, what can be replicable is the therapeutic approach on a general level. I have sorted out some guidelines for analytical hypnosis and I will also describe what basic competence is required by therapists who want to practise these guidelines. This is the best I can do to obey the demand for replicability.

A psychotherapist who individualises therapy in general and with hypnosis in particular, ought to have a competence to resonate with the patient; i.e. be attentive to verbal and nonverbal communication, estimate how such communication can be helpful and be creative in transforming fear, anxiety and resistance into material to be explored and used constructively. Timing is another skill, without which analytical hypnosis can enhance anxiety. This means that the therapist must have a feeling for when and how much the patient

[1] Hippocampus-Pituitary-Adrenal gland, regulating the alert-relaxed, fight-flight hormonal balance.

can explore resistance and other defences. Therapists who are familiar with analytical theory of defence mechanisms have well elaborated structures for understanding the functions of defence and the meaning of timing.
This means that the therapist has a creative competence to develop different and unique processes with each patient. It is not within the scope of this article to teach how to be a creative hypnoanalyst. 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 patients' 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 (Shorr, 1998).
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. A source of inspiration for such a psych-educational approach can be found in Emmy Gut's excellent book on "healthy depression" (Gut, 1989).
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- or self strengthening techniques and how to find resources for healing.
4. Explore obstacles. Obstacles may be in the form of resistances to inductions, or various difficulties to follow suggestions. They may concretise in the body through tensions, itches, coughs, heart beat, head pain, cognitively as "disturbing thoughts" or emotionally, as anxiety. Reframe 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 Watkins (1997). They also explored resistance by using the affect bridge technique (Watkins, 1971). Erica Fromm presented detailed case illustrations about how to explore resistance as a main technique in analytic hypnosis (Brown & Fromm, 1986). Before that, Cheek used ideomotor responses, e.g. finger signals (Cheek, 1968) and I have described how to explore resistance in an article about depression (Carolusson, 1998). 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. While these patients' pattern of excessive responsibilities, stress and care for others is part of their problem, they 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 being secure and interested. 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 and in the interest of personal self realization and healing.
In the presented cases you may find that I use more or less of the six principles above. That is an illustration of how the individualised process makes us adapt flexibly to what develops in the process – which is principle number
7. Principles and techniques are general tools to keep in the back of the mind, but never to be rigidly followed.

CASE OLIVIA

My first case is a woman whom I call 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 a change of antidepressant. The SSRI prescribed by the first physician a year earlier, had some bad side effects and Olivia felt maltreated by that psychiatrist. Closely before the onset of therapy with me, Olivia had been in psychodynamic psychotherapy with a psychologist-psychotherapist 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 the psychologist-psychotherapist, gained insight in her problems and agreed that the two of them could not come further. She trusted the recommendation from her psychologist to continue with me for a deeper therapy. Her psychiatrist's recommendation was to consult me in order to receive "cognitive tools".

Burnout Syndrome had been her only diagnosis, and that label was used by all three health providers; the two psychiatrists and the psychologist. According to ICD-10, the code is Z73.0 Burn-out.

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

She was a nurse, with various extra duties, had always worked overtime and had slept badly for many years. She had taken care of a big family and relatives with chronic illnesses. She had been building a house with her husband. A loved relative 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 then she panicked.

Her emergent feeling back then was helplessness, after which she became extremely tired. In her therapy with the psychologist she had received supportive therapy to strengthen her and prevent resignation and depression. The psychologist informed me that her method was insufficient to help the patient further.

Her most pregnant symptoms were:

1. Panic attacks.
2. Unable to concentrate on problem solving, reading or social gatherings.
3. Unable to listen to other people's problems.
4. Extreme fatigue and insomnia.
5. Oversensitive to sounds and in 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 thought she needed a normalising of her symptoms and a confidence in the logic of her body's attempt to protect her against further overload.

My intervention to help her manage her sensibility to sounds, which also contributed to her insomnia, was to explore together with her, the personal meaning of these symptoms.

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 ticking, the newspaper pushed into her letter box, etc. She found out that 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 Olivia what she had tried before coming to me.

Olivia 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 my opinion I formulated the hypothesis that she lacked what Winnicott called the "holding" capacity. Olivia was unable to sooth herself and unable to cry safely. The 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 (Winnicott, 1965).

Treatment plan and hypnotic approach; first session

Since it is crucial for these clients to avoid any pressure to achieve, the choice of hypnotic techniques are permissive and accepting. My interventions followed the purpose of teaching her how to be in a healing state of mind (trance), letting go of achieving ambitions and exploring her true inner voice. In my theoretical basis for using a concept like "true inner voice" I am again inspired by Winnicott, in his concept of True Self (Winnicott, 1971). In my hypnotic inductions, the same principles governed my choices of words and what to suggest. In order to find her inner voice and true self, I had to help her explore the resistances. Thus, resistances were important informants; they had a function and a purpose, just like ego states, as described by Watkins (1997). This is also how Milton Erickson used resistances to cure; 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, etc. While Erickson often invented strategies for resolving resistances, without the patient necessarily being aware of how and why, Watkins chose a more insight oriented approach. I prefer the latter in cases of Burnout, due to my treatment plan to help them get relief from their achievement complex and also gain a deeper self awareness in a longer perspective.

Olivia's first hypnosis is a good example of how we worked without any ambition to achieve anything, even a deep trance.

She entered light trance. But something bothered her. She told me that her heart pounded too hard and it frightened her. I used an Ego State approach, inspired by Helen Watkins. In Ego State therapy you address separate parts of the person with an expectation that these parts have their own knowledge about symptoms, more or less accessible to other parts and often not to the observing central ego, the one in charge on a conscious level (Watkins, 1997). 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 OK with you? Let Olivia know your answer.” Olivia nodded her head. “Is it OK 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. I told her this in her waking 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 the hypnotic state, we explored this resistance to yawn and she associated to 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 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 this: 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 own 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 cured and ready to work. My refusal was concordant with my clinical experience and knowledge of these patients. 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 or deeper 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. When she started her therapy she had expected cognitive strategies for going to sleep. After some weeks in therapy with me, 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 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 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 empathize with her weakness and she decided to use the angry parts 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 judgement, needs and feelings and also how to set limits.

End session

Olivia wanted hypnosis even in her final session. No obstacles occurred, and no anxiety resisted an unexpected discovery in hypnosis, namely that she never had liked to take care of patients. Her motivation had been to be confirmed, by colleagues. We finished therapy. 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 liked herself (self esteem) and felt capable of finding her own capacity and needs 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 French 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 needed my help to accept this situation, i.e. that she functioned well with her life now. She relapsed whenever she pressed herself to plan for occupational training. In this follow up session she decided that she would enjoy her improved health and be proud of her parental and grandmother role and also allow herself to postpone every thought regarding 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. No more follow up has been done.

Results

Results can be measured in many ways. My favourite way 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. In consequence with the theory that Burnout patients have been too high achievers, it is no good idea to ask them about "results". By the time they end therapy, they may easily fall back into interpreting the concept of result as a pressure to achieve full time employment again. Therefore it can be more beneficial for their future process of continuing recovery, if I accept their personal way of evaluating the result of therapy.

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

Panic attacks
Panic disappeared immediately after the first sessions and after I had explained the mind-body logic of her symptoms.
Unable to concentrate on problem solving, reading or social gatherings
She became gradually more able to concentrate on family members and grandchildren, but not as much as before her illness. She had some remaining difficulty to concentrate on reading which she respected as a symptom of too much input. During the therapy she learned how to listen to her own needs and a consequence of that was to be more tolerant to her personal withdrawal and avoidance of groups which meant very little to her.
Unable to listen to other people's problems
After a few months of therapy she asked me to help her explore the roots of her pleasing attitude to others. She also realised that she had supported other people to the cost of her own health. Thus the symptom was not defined as a problem anymore.
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. Regarding the insomnia; when she started her therapy with me she woke up in the middle of the night and was awake for hours, although she used medication for going to sleep. After therapy, she had not managed to wean from the pills, but slept all night long and could use self hypnosis to go back to sleep if she woke up.
Oversensitive to sounds and in 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
I judge it as a sign of gained self esteem that she listened to and respected her own needs regarding how to heal and she accepted not to be the "strong and cheerful" Olivia she had appeared to be. She had learned to soothe herself. She cared less about the opinion of others and listened more to herself.

Olivia's feedback and follow up reports with relevance for results
How we measure results is a matter of values. 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 personality traits, such as conscience, values and motivational drives to achieve.
Follow up after nine months and after two years showed that the improvements made, were consistent, that her symptoms had not come back. 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. I regard that as a sign of good self esteem. 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. My diagnosis according to ICD-10, was code is Z73.0 Burn-out.
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.
I used Imagery diagnostic procedures as described by Joseph Shorr (Shorr, 1998).
According to this test, Ian's logic and reason informed that he had hope, did not need anything, would eventually run away, but secretly could observe his own self. His emotional part informed that he was kind, strong, would eventually come back 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 acted out with violent temper tantrums. Ian was motivated to understand himself better, i.e. have an insight-oriented therapy.

Ian quickly began to attend to his anxiety with curiosity instead of devaluing himself trying to escape with sedatives. His depression seemed to be a symptom of self contempt and a fear of losing the capacity to support his family and function in the society. He realised about his past, that his previous relations in business, friendships and marriage 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.

Rehabilitation

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 for this society. We worked much 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. Thus 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 then he invented a hypnotic induction technique; he 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 him:
"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, when sad or upset. 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"[2] mind to help him find some trust in between our sessions. He found dolphins. These dolphins

[2] The concept "subconscious" was probably used first by Pierre Janet as a part of his theory of dissociation and hypnosis.

communicated with him from a distance, i.e. from the sea. The images of dolphins were clear and safe and they appeared again when he was back home, without me.
I interpreted the dolphins as transitional phenomena (Winnicott, 1965). 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 experienced his trust in me as deeper as it ever had been with his parents.
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 told me. This opened for a period of therapeutic regression. I interpreted it as constructive, that he had the courage to admit dependency and thus accept a part of him that was needing. He went through a period of dependency and an identity crisis, confused about his motivation to live. After two months of dependency he became much 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.
His marriage had started to change. 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 their respective needs and he told his wife about his own feelings of being used. Neither of them felt any sexual attraction toward the other anymore, but nevertheless agreed 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 cruising ships. He felt relieved, 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 in his attitude: He was not motivated by 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 in a company of his liking. He had the competence and 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 didn't mind, but promised Ian could start working in his own pace. Ian was happy to start working again, 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 own health, why would he say no to a good job opportunity? In hypnosis, I asked his "subconscious" mind. He then remembered in detail his last visit at the office and how he had walked around the workplace, meeting the employers. He attended to his feelings and told me:
"The atmosphere in this company is distressed, there is a pressure, and I am not able to withstand the group pressure and the atmosphere of such a high achievement anxiety in that office". He had now been in therapy for two years.

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 product manager in an international company and he never allowed himself to become used, distressed or tense. He was appreciated by employers as well as by employees, became chairman of the Union and continued to listen to his intuition.
Two and a half 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 as a manager. 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 my impression of what he had expressed.
After another year without therapy he came back to receive some support in another attempt to cope with his marital problems. They were now seeing a family counsellor. The Burnout symptoms were gone and he was protecting himself very 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
As mentioned in the presentation of results with Olivia, the outcome of therapy can be measured in various ways. With Ian as well as with Olivia, I chose not to use formal outcome instruments, since I knew of no instrument that is free from implicit presuppositions regarding symptom removal, health and therapy goals. I have declared my reasons for individualising therapy with Burnout patients. The same reasons yield for the evaluation of results. I therefore estimated that the patients' self report, in his/her own words are the best instruments available, for this patient group[3].
An attempt to structure the results according to initially presented symptoms will include *irritation, lost self confidence, lost patience, extreme fatigue and a high heart rate.*

Irritation
As illustrated in the case the irritation was a symptom of frustration. As therapy developed Ian found that his frustration was about an inner conflict between his personal 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
One example of his gained self confidence was his choice by the end of therapy, to explore why he felt ambivalent to an apparently attractive job opportunity. A sign of improved confidence was his choice to respect his doubt and through hypnotic introspection realize his need not to take that employment. Another sign of improved confidence was Ian's self respect in his discussions with his wife.

[3] 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).

Lost patience
The analytic hypnosis explored feelings and needs behind symptoms of impatience. Ian realised that lost patience was a symptom of imbalance between personal needs and his habit of being there for other people. His attitude to "lost patience" 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" was thus, through analysis, something that changed its meaning from being ideal to being questioned.

Extreme fatigue
Ian could eventually, after 1½ years in therapy, 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 while he did so, he 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 creating fear, whenever he experienced a high heart rate, he used the 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 an internal body communication.

Ian's follow up with relevance for results
After two and a half 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 in these cases gave valuable information about the function of obstacles to let go of tensions. In both case illustrations, 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 felt anxiety while their previous self image of being high achievers was out of function. Olivia feared what other people would think of her and Ian went through an identity crisis. Their Burnout condition; 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). My approach is related to the Freudian advice to analyse resistance, as a main technique in psychoanalysis. The advantage of analysing the resistance is that all signs of resistance are met with respect and as valuable information. Technically, hypnosis has an advantage over a mere talking psychotherapy, which is that we don't offer complex interpretations to a client when in trance. Long complicated interpretations are sometimes helpful in the talking sessions, i.e. when the client is wide awake. In the waking state the clients can reflect

critically to our suggestions, which we encourage them to, in order to counteract their compliant attitude. In light or deeper trance however, analytical interpretations should not be given, because they demand intellectual reflection. Such cognitive processing is hard to achieve in the trance state and it also hinders the access to crucial emotions. To let go of intellectual reflection and effortlessly explore, facilitates a kind of restructuring of psychological patterns on a deeper level.

The cases illustrate how in hypnoanalysis, the analytic technique is restricted to inquiries and respectful mirroring of the clients' emotionally loaded communication, accepting it as it comes and finding out how the material helps to understand the patients' situation. This understanding, 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 is probably a combination of gaining self respect through insight and a "corrective emotional experience" (Alexander, 1956), i.e. the interpersonal repairing qualities of psychotherapy. Therapists' "holding" is an example of that. In order to find the clients' emotional resources, the functions of resistances and the inner locus of control, which I would rather call "inner locus of feelings and reflection", I have found hypnoanalytical techniques combined with Ego State Therapy interventions 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. The technique is also by Milton Erickson who used whatever resistance he encountered, with curiosity and a wish to know more (Short, 2005).

Most of all, my experience with these and other patients with Burnout syndromes, is that they heal from being encouraged to find their individual healing resources and they had better not unreflectedly obey external authorities. In Winnicott's sense, it is a way to help them find their true self. 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 can offer quick symptom relief, are therapy approaches which are repetitively encouraged by national health authorities worldwide. These cases illustrate that healing hardly can be scheduled in a time plan.

CONCLUSIONS

To draw conclusions from clinical qualitative material is an act of interpretation. Out of a mass of possible conclusions I can present some, which I can discern or discover. 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. This is an art which can not be manualised, but in order to learn something from this qualitative documentation, I will present some common principles regarding how to treat patients individually. In order to make a unique process possible, you can see that 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 therapy. Analytic hypnosis does not utilise the patients' motivation to achieve or be compliant. The therapist accepts 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

In analytical hypnosis with Burnout Syndrome patients, it seems to be a beneficial approach that the therapist respects the patient's uniqueness. This respect is implemented by the abstinence from anticipation or suggestion of achievements and results. Anything that is expressed 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.

Both cases illustrate that when someone impose or suggest time plans and goals for recovery, these patients show more stress symptoms and anxiety. The presented patients responded with relief and relaxation 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 what I have experienced with Burnout patients generally, namely that hypnosis is a healing state of mind, given that they can be helped to accept and appreciate this state and let go of their achievement anxiety.

A conclusion regarding attitude is that the therapist conveys an attitude of acceptance of the patients symptoms; exhausted, unconcentrated, introvert and unsocial. They can be reframed as functions of natural recovery. 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 re-fuelling of energy. A main problem is when these patients experience a self contempt due to their 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 healing: 1. relational factor: acceptance and non-judgemental yet confirming attitude and 2. hypnosis factor: hypnosis as a healing state of mind.

Analytical Hypnosis seems to be a reasonable choice of therapy for Burnout patients. Results indicate that that they heal through deep relaxation and they also improve their sleep. 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.

An important observation is that the measurement of therapeutic results is a matter of presumptions and expectations and therefore subject to change. Through 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 through reflection and improved self knowledge. My presented theory in BACKGROUND and DIAGNOSIS was that Burnout patients achieve too hard and adapt to others' needs, as a cause to their syndrome. It is plausible that this group hampers their recovery if they continue to adapt to others expectations and values; be it employers', friends', authorities or care providers'. A crucial task in therapy is thus to change patients' attitude and premorbid lifestyle, and to do that from within the patients.

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.

REFERENCES

Alexander, F. (1956) *Psychoanalysis and Psychotherapy: Developments in theory, technique and training.* New York: Norton.

Brown, E. & Fromm, D. (1986) *Hypnotherapy and Hypnoanalysis.* Hillsdale, N.J: Erlbaum.

Carolusson, S. (1998) Hypnosis and transference in the treatment of depression. *Hypnos, vol XXV, no 2, 1998.*

Carolusson, S. & Bjurhammar, M. 2009. Utvärdering av behandling. Info: susanna@carolusson.se

Carolusson, S ,Garphem, B, Scherman, M & Spalde, G (2001) Psychodynamic Hypnotherapy - A Study of Client Perspective. *Hypnos 2001-1,* pp 23-34.

Cheek, D. (1962) Ideomotor questioning for investigation of subconscious "pain" and target organ vulnerability. *American Journal of Clinical Hypnosis, 5, 30-41.*

Cherniss, C. (1995) *Beyond Burnout*. Helping Teachers, nurses, therapists and lawyers recover from stress and disillusionment. New York: Routledge.

Eriksson, U-B., Starrin, B., & Janson, S. (2008) Long-term sickness absence due to burnout - absentees experiences. *Qualitative Health Research, 18, 5, 620-632, 2008*

Freudenberger, H J & Richelson, G. (1980). *Burnout. The High Cost of High Achievement.* Garden City, New York: Doubleday.

Friedman, M & Rosenman, R H Association of specific overt behaviour pattern with blood and cardiovascular findings. *Journal American Medical Ass.*1959;169:286-1296.

Friedman, M & Powell, L H. The diagnosis and quantitative assessment of type A behaviour. *Integr. Psychiatr.* 1984;2:123-129.

Gut, Emmy (1989) *Productive and unproductive depression. Success or failure of a vital process.* New York: Basic Books.

ICD-10 (1994): International Classification of Diseases. Geneva: World Health Organisation.

Lerner, H.G. (1992,1995,1999) *Kvinnor och psykoterapi*. Stockholm: Natur & Kultur.

Lowen, A. (1972). *Depression and the Body.* Penguin books.

Maslash, C. (1982). *The cost of caring.* New Jersey: Prentice hall.

Maslach, C. & Jackson, S. E. (1986) *Maslash Burnout Inventory (2nd ed.)* Palo Alto, CA: Consulting Psychologists Press.

Maslach, C. (1997*). The truth about burnout. How organisations cause personal stress and what to do about it.* Jossey-Bass Inc. Publishers.

Rosmond, R & Björntorp, P. Låg kortisolproduktion vid kronisk stress. *Läkartidningen* 2000; 38:4120-4124.

Sapolsky, RM. Effects of stress and glucocorticoids on hippocampal neuronal survival. In: Brown, MR, Koob, GF, Rivier, C. (red.). *Stress: Neurobiology and Neuroendocrinology*. New York: Marcel Dekker Inc. 1990.

Shorr, J. (1998) *The Psychologists Imagination and the Fantastic World of Imagery*. Sa Barbara: Fithian Press, Daniel and Daniel Publ.

Short, D, Erickson, B A & Erickson, R (2005) *Hope and Resiliency.* Crown house Publishing. Wales, UK.

Socialstyrelsen (2010) http://www.socialstyrelsen.se/regelverk/lagarochforordningar/halsoochsjukvardslagen%28hsl%29

Watkins, H (1971) The affect bridge; a hypnoanalytic technique. *International Journal of Clinical and Experimental Hypnosis 19, 21-27.*

Watkins, H. & J. (1997) *Ego States. Theory and Therapy.* New York: W.W. Norton.

Winnicott, D. (1965) *The Maturational Process and the Facilitating Environment.* London: Hogarth Press.

Winnicott, D. (1971) *Playing and Reality.* London: Tavistock Publications.