FROM DEDICATED TO BURNED OUT – AND BACK?

A phenomenological exploration of the lived experience of suffering from burnout and implications for medical care

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Dissertation for the degree Philosophiae Doctor (PhD)

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Institute of Health and Society

Faculty of Medicine

University of Oslo

2020

Series of dissertations submitted to the
Faculty of Medicine, University of Oslo

ISBN 978-82-8377-675-1

Cover: Hanne Baadsgaard Utigard.
Print production: Reprosentralen, University of Oslo.

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AKNOWLEDGEMENTS

The PhD project presented in this dissertation has been carried out at the Department of Interdisciplinary Health Sciences, Institute for Health Society, and Faculty of Medicine at the University of Oslo. I am very grateful for their support.

This PhD project started at the Norwegian University of Life Sciences (NMBU) where I was supervised by Ruth Kjærsti Raanaas, Timothy Kevin Richardson and Rani Lill Anjum. Although this supervision did not end in co-authored papers, I have benefitted from their advice and our discussions, especially on what has become paper one in this thesis.

Additionally, several others have contributed with valuable support and this research would not have been possible without them:

The eight co-researchers: I cannot name these individuals for reasons of confidentiality. Nevertheless, they know who they are and I would like to thank them for sharing their personal experiences with me and for giving me their time.

My supervisors Wenche Schrøder Bjorbækmo and Rani Lill Anjum: I want to thank you both for valuable advice and for consistent support throughout the PhD project.

The CauseHealth Team at NMBU, Rani Lill Anjum, Elena Rocca, Samantha Copeland and Stephen Mumford, who have included me in a fantastic international and interdisciplinary network of people. I have been invited to present my research topic at conferences and seminars, where I have gotten valuable feedback on my work. These people, who share the vision to see a paradigmatic shift in medical care, have inspired me academically and supported me in the research I have conducted. At NMBU, there has always been an open door for sharing office, interesting discussions and joyful laughter. My research project would not have been possible without them.

Samantha Copeland: I would like to extend a special thanks to Samantha who has faithfully supported me during the last "critical" days before submitting the articles and given me constructive and helpful feedback on the written text.

My gestalt supervision group, represented by Lill Hallbäck, Siw Stenbrenden, Anne Nielsen Rommen, Hege Nordahl and Solveig Naug, who are all gestalt psychotherapists. I want to thank you for the warm support I have experienced in our encounters, the fruitful exploration of being human inside as well as outside the clinical encounter and for the laughter we have shared and the tears we have shed in a safe and containing environment.

A special thanks to my precious family for being who you are.

This thesis is dedicated to my mum and dad

Karin Mohn Engebretsen

Jeløy, January 2020

LIST OF PAPERS

Article 1, 2 and 3 are published, article 4 is submitted to Qualitative Health Research and article 5 is accepted as a book chapter to be published in 2020.

1) Engebretsen, KM and Bjorbækmo, WS (2019). Burned out or just depressed. An existential phenomenological exploration of burnout. Journal of Evaluation in Clinical Practice, pp 1-8

2) Engebretsen, KM (2018). Suffering without a medical diagnosis. A critical view on the biomedical attitudes towards persons suffering from burnout and the implications for medical care. Journal of Evaluation in Clinical Practice, pp 1150-1157

3) Engebretsen, KM and Bjorbækmo, WS (2019). Naked in the eyes of the public: A phenomenological study of the lived experiences of suffering from burnout while waiting for recognition to be ill. Journal of Evaluation in Clinical Practice, pp 1-10

4) Engebretsen, KM and Bjorbækmo, WS (2019). Out of chaos, meaning arises. A phenomenological study of the lived experience of re-habituating the habitual body. Submitted to Qualitative Health Research (Under review).

5) Engebretsen, KM (forthcoming in 2020). Reflections on the clinician's role in the clinical encounter. In Anjum, RL, Copeland, S and Rocca, E (Eds) Rethinking Causality, Complexity and Evidence for the Unique Patient. A CauseHealth Resource for Healthcare Professionals and the Clinical Encounter, Springer Nature

SUMMARY

This dissertation concerns how persons who suffer from burnout experience their rehabilitation process. An important objective is to offer new knowledge about the phenomenon of burnout. This knowledge is targeted at medical, societal and political stakeholders as well as employers who are responsible for their workforce, aiming to inform their strategies for preventing symptoms of burnout becoming chronic, as well as to offer better support in the rehabilitation process of those who have already become ill. As a psychotherapist, I became aware of how, in the medical system, symptoms of burnout are often translated or reduced to depression rather than being acknowledged as aspects of a complex or at least multifactorial condition. This realisation triggered my extended interest in the phenomenon from the specific perspective chosen in this thesis. My intention is therefore to place burnout within the current debate of evidence-based versus person-centred approaches in medicine and healthcare. The exploration of the research subject takes place within the field of human science and considers some existential aspects of being human. Merleau-Ponty's existential phenomenology forms the basis for the chosen theoretical perspective as well as the applied methodology. This choice implies that burnout is understood as both a subjective and as an inter-subjective phenomenon.

Two men and six women fulfilled the criteria to participate in the study. These criteria selected for individuals between 25 and 65 years who had been employed at least at an 80% position and had been on sick leave for more than 52 weeks prior to the interview. In addition, their burnout symptoms were consistent with Exhaustion Disorder according to ICD-10, F43.8A. The focus of the dissertation was to explore their lived experience of burnout with special attention to the factors they experienced as enhancing or restricting their rehabilitation process. The method for collection of research data was semi-structured interviews to uncover how the participants made meaning of their situation. I am inspired by the interpretative phenomenological analysis (IPA) of Smith, Flowers & Larkin (J. A. Smith, Flowers, & Larkin, 2009) to structure the analytic process. The meaning of the participants' lived experiences was explored using a life-world approach to existential phenomenological reflection and writing (van Manen, 2014).

The dissertation includes five papers. The first one was based on the empirical material of my MSc dissertation (Engebretsen, 2003). My intention behind including this article in the

PhD thesis as a source of information was twofold. Firstly, the findings in the MSc dissertation provided new knowledge of burnout as an intersubjective, lived, contextual and temporal experience. Secondly, the gestalt therapeutic method was useful for gaining a deeper understanding of the causal mechanisms that seem to influence the temporal process of burnout. Additionally, the results from the MSc dissertation motivated the research question for the PhD project. Paper two, three and four are based on the empirical material in the PhD study. The fifth contribution to the thesis is a book-chapter where I reflect on the clinician's role in the clinical encounter and the empirical data is based on a case study from my clinical practice.

All the papers address the importance of encounters. Paper one, exploring the participants' experience of the transition from functioning well to becoming unable to master their life situation, points to how lack of recognition of the participants' illness can seriously have affected their healing process. In paper two, we see how the burnout challenge is related to what counts as knowledge in evidence-based medicine and how accompanying attitudes, norms and values in turn can negatively affect the clinical encounter. Moreover, the challenge is related to understanding burnout as an intersubjective, lived, contextual and temporal experience. Therefore, it is important to take the implications of such factors into consideration both in medical theory and in the clinical encounter. Paper three and four explicitly explore the lived experiences of encounters. Paper three reveals that the participants felt that they were distrusted by their general practitioner and the Social Services, and that they spent much energy in these encounters trying to explain their condition without feeling seen or heard. Their stories show how they, as "knowers" of their own bodies, were ignored, which seemed to worsen their condition. In contrast, in paper four, we see how encounters wherein the participants experienced precious moments of joy from being-with-others had a positive influence by enhancing their experience of well-being and perceived control. In paper five, I focus on the clinicians' role and consider how values, methods and practices can affect the clinical encounter in positive or negative ways.

In light of the phenomenological framework of this thesis, all five papers illuminate how crucial encounters are – especially when those involved are in a vulnerable situation. The summary of the findings points to how clinical encounters are experienced as a main challenge, which can be related to two sub-challenges. The first one is the concept of causality and its implications for understanding the burnout phenomenon. The findings point to how understanding causal mechanisms can offer valuable insight into the challenges that medicine is facing with medically unexplained symptoms. This insight supports the appeal to reconsider the concept of causality as well as what should count as evidence. The second challenge is related to the power of inter-subjective mechanisms in clinical encounters. As revealed by the findings in the empirical material, different encounters contribute to shape the rehabilitation process in positive or negative ways. The clinical or societal provider as well as the client are parts of an inter-subjective relational system where they mutually influence each other. This means that the lifeworld processes of the person who suffers from burnout cannot be interpreted as emanating from him or her in isolation. Thus, this challenge is related to how medical and societal professionals can influence the outcome of the clinical encounter.

As this study shows, the ontological and epistemological stances taken in evidence-based medicine influence clinical practice. Additionally, the papers argue for why a phenomenological perspective can improve the outcome of medical care better than the prevailing biomedical one. In the discussion of the findings, I draw attention to how a phenomenological approach to inter-subjectivity gives a better insight into causal dispositions. I address how narratives applied as methodology for detecting relevant causal mechanisms can provide a deeper insight into how dispositions interact in the specific context. Further, I demonstrate how *self-affection*, *affective intentionality* and *inter-affectivity* can be understood as dispositional causal mechanisms that can play a vital role in enhancing or restraining the rehabilitation process. We, as clinicians can provide the structure and therapeutic environment for supporting the rehabilitation process – or risk doing the opposite of what such processes intend. I argue that every encounter, whether the result is experienced as enhanced wellbeing or quite the opposite, has at its root certain conceptual commonalities that can highlight the burnout problem. The first one is the scientific problem related to what counts as biomedical evidence. In this thesis, I outline a suggested solution to this problem by rethinking the notion of causation and causal evidence, which in turn can contribute to solve the problem related to medically unexplained syndromes. The second is related to how inherent norms, values and attitudes influence clinical practice. To solve this problem, I propose a genuinely person-centred approach. The way forward for supporting persons who suffer from burnout is to consider the condition from a phenomenological perspective. By taking the lived experience of the ailment back to the "owner", we can provide a fertile ground for deepening our understanding of burnout, which can help us to prevent symptoms from becoming chronic – in turn, improving the prognosis for recovery.

1.0 THE BURNOUT CHALLENGE

This dissertation explores the lived experience of individuals who suffer from burnout. It responds to attitudes expressed by the medical and social professions, the political government that is responsible for individual wellbeing and healthcare, as well as by employers who are responsible for their work force. In this thesis, I access the sufferers from burnout who struggle to be heard or believed. By giving a voice to this vulnerable and misunderstood group, this thesis aims to invite all stakeholders to reconsider the aspects of medical and societal practices that affect individuals suffering from burnout.

The exploration of the research subject takes place within the field of human science and considers some existential aspects of being human. Although we might be able to explain nature, human beings must be understood rather than explained (van Manen, 2014). Thus, human science involves exploring meaning – and in particular "lived meaning" – which can be described as the way in which an individual understands his or her world as meaningful (Merleau-Ponty, 1945/2003). To explore human experiences requires that we consider phenomena that are obscure or coloured by our personal and theoretical biases or tacit assumptions (van Manen, 2014). This can be seen as a methodological challenge that needs to be addressed. To address this challenge and to be able to grasp the specific lived experience we try to understand, we need to facilitate the path to the immediate experience of the lived meaning. I do this by using hermeneutic phenomenology, which offers a methodology for interpreting and uncovering the more hidden aspects of being human (van Manen, 2014). Hermeneutic phenomenology will then be used to uncover and interpret the lived experience of burnout with a specific focus on the rehabilitation process. This methodological approach can amplify the participants' awareness of their individual needs for support.

An important aim of this thesis is to offer new knowledge about the phenomenon of burnout. This knowledge is targeted at medical and societal stakeholders with an aim to inform their strategies for preventing symptoms of burnout becoming chronic, as well as offering better support in the rehabilitation process of those who have already become ill.

In the first part of this introduction, I describe my own pre-understanding of burnout preceding my academic engagement with burnout that is presented in this thesis. Then I will present eight narratives to give a voice to the participants in this study and to show how the problem of burnout is primarily an individual challenge for those who suffer from this condition. Next, I describe the burnout problem as a societal challenge, from a public health and welfare perspective. Finally, I address burnout as a scientific challenge, showing how burnout as a phenomenon is not sufficiently understood in the medical profession. The section ends with a presentation of my research question and the proposed argument that I will discuss in this thesis, based on the five papers.

1.1 My contextual pre-understanding of burnout

My interest in the phenomenon of burnout started during the early 1990s. At that time, I worked as a management consultant. Several companies re-organised their business due to the economic crisis in Norway and abroad, which triggered comprehensive change processes that affected the staff. These processes inevitably caused a lot of uncertainty at different levels in the organisations. During this period, I worked with management- and project groups to improve communication and co-operation, as well as handling work conflicts. This in turn motivated the work in my MSc dissertation, *Professional burnout. A phenomenological study of how the perceived symptoms of burnout influence the process of burning out* (Engebretsen, 2003).

Later on, during the last fifteen years working as a psychotherapist, I have also seen more clearly than before the importance of supportive relationships and fulfilment of human needs. Organisations can never be effective or perform to their full potential if employees are treated as part of the company machinery. In my clinical practice, I have seen an increasing number of individuals suffering from stress-related symptoms, many of which were work related. Their experiences triggered my interest to explore the phenomenon further in order to gain a deeper understanding of how these individuals make meaning of their situation, especially when trying to regain their ability to work. This is why I decided to write an article based on the empirical material in my MSc dissertation, which could then provide further guidance to potential research questions to be addressed in a PhD thesis. Hence, the first article in this dissertation is based on the empirical material in my MSc dissertation. During this initial work, I found that burnout was not part of the public debate on so-called medically unexplained syndromes, even though, in my own experience, individuals with burnout typically present with several medically unexplained symptoms, such as chronic fatigue, posttraumatic stress or even chronic non-specific pain.

This thesis is written in light of an ongoing debate within philosophy of medicine and healthcare concerning evidence-based medicine (EBM) and its positivist methodological framework. As part of the CauseHealth project team, hosted by the Norwegian University of Life Sciences from 2015 to 2019, I worked with philosophers and clinicians to address the ontological and epistemological foundations of evidence-based medicine (Anjum, Copeland, Kerry, & Rocca, 2018; Anjum, Copeland, Mumford, & Rocca, 2015; Anjum, Kerry, & Mumford, 2015). The full name of the CauseHealth research project was "Causation, complexity and evidence in health sciences", and the research question was "how to understand and study causation in cases of complexity and individual variations", with focus on medically unexplained symptoms. The CauseHealth criticism of EBM includes its almost exclusive epistemological emphasis on quantitative approaches to causation, but also the reductionist and dualist ontological commitments of the biomedical model that is still standing strong within medicine and society. In its place, a more person-centred healthcare was proposed that emphasises holism, causal complexity, context-sensitivity and the medical uniqueness and lived experiences of individuals. This ontological shift also motivates a different scientific methodology, toward a more qualitative and phenomenological approach to causal understanding and evidencing (Anjum, Copeland, & Rocca, Forthcoming; Anjum & Mumford, 2018). The work on this thesis has therefore been influenced and shaped by these discussions and vice versa.

As a psychotherapist, I became aware of how, in the medical system, symptoms of burnout are often translated or reduced to depression rather than being acknowledged as a complex or at least multifactorial condition. This realisation triggered my extended interest in the phenomenon from the specific perspective chosen in this thesis. My intention is therefore to place burnout within the current debate of evidence-based versus person-centred approaches in medicine and healthcare. From what I have seen, there seems to be an enormous gap between how burnout is understood medically and in public debates, on the one side, and how the sufferers experience their own situation, on the other. With this thesis, I wanted to give them a chance to tell their side of the story. In the articles that constitute this thesis, there has been limited space to present the rich material from the participants' stories and get their voices heard. Therefore, I will start by presenting eight short narratives, one from each of the participants in my study. The following stories provide a tiny glimpse into their personal experiences of coming to terms with their condition. By giving them a voice and paying attention to their perspectives, I will be able to throw some new light on the phenomenon of burnout. I have written the narratives based on the transcribed material. All names are fictive, and details are changed for anonymization purposes.

1.2 Burnout as an individual challenge: eight personal narratives

Nina

> *It was autumn and things started to become a bit harder at work. That is five years ago now. I had far too much to do. I never had a holiday or a weekend off. I was working all the time – up to 16 hours a day. It was really crazy. Started at 8 in the morning and worked until 2-3 at night with a few breaks in between. Not many and not long ones. I felt the pressure to get finished. Especially when it was time for delivery. I cannot quite describe the feeling. I know what to do, but there is not enough time. Almost as if I am trapped. Without a way of getting out of it. Couldn't say that I was delayed. Had to deliver on time. My head was boiling. Afterwards I was incapable of doing anything for a week or two. Then it started all over again. It feels a bit like a kind of obsession. When I'm under that kind of pressure it feels a bit like I have an iron bar through my head. It's kind of crosswise and sort of separates my head in two. Two parts locked in a battle with each other. And I don't have a body. It doesn't exist. I sense how very much it means to me to be good at things. To master things well. And the panic when I cannot manage it. Not doing what I should be doing. Letting other people down. Not being good enough. I can feel the sadness. When I was little, I was not seen by "my flock". Wondering if that is why I do this – stand on that stage? Not for others to see me, but for my flock to do so? In this process, I have not figured out why I am as I am. Why things turned out as they did. I have not found the key to happiness or the path forward. My parents are as they always have been. Weekdays, the job, my marriage, finances – well, the world as a whole. But what has changed a bit is the way I look at myself. What I should be and how I ought to live. What's important. I am not quite as angry with myself anymore. I don't punish myself to the same extent. I deserve to be fine. It didn't work to give so much and receive so little in return. I became emptier and emptier and more and more tired. And then I had kids. Then it suddenly said stop. The long redemptive process of pulling threads in the chaotic ball began. Slowly but surely, I have*

started to see how it all links up. There is a lot I cannot change, but I can change my own view of myself. See the positive and believe in it. That is what is happening. Now it is time to return to my life, to good friends and to my job. And to work less. But never work as I did before.

Frida

I felt that this job was sent to me from above. It was a perfect match. I was there six months – and suddenly my body just shuts down. I think it's completely senseless. Would have understood it if it had happened a few years earlier when I was pregnant and extremely tired. Now I am more like exhausted. I spend a lot of time on this sofa and that worries me. How do I get out of it? In a way, it reminds me of my grandma's chair. That brown chair was really ugly. She spent the last years of her life in that chair. It kind of scares me to end up just like she did. If I ever recover, I will have to throw this sofa away. I can recognise myself in her situation, as I am not capable of doing anything. For what I really want is to be outside, be active and moving around, and to be with others. I feel as if my world is this sofa, and that is depressingly limited isn't it…I feel a little stuck here, in a situation where I cannot go out into the world on my own two feet and take part. I become a bit invisible, because I'm not joining in. This settee doesn't really give me a lot of hope. I feel rather small in it. It's a bit big and then I feel a bit small. Right now, this is my life. But I do have some sort of a hope. Or else I will have to accept the limitations of my life.

Toivo

I have no clear recollection of the first doctor's appointment, but I tried to explain how things were. I felt absolutely awful. Completely horrible and almost shameful in fact. The worst of it was handling the so-called reality, dealing with people and feeling so incredibly useless and shitty. I feel like it shows on the outside and that it's something everybody can point at and see. I'm sort of in limbo; a place in between where I am neither nor. There seems to be some kind of lid on my existence. The tiredness exists in every cell in my body – all parameters are somehow on minimum. I just have to be me, lie down and disconnect from the rest of the world. What I define as important to discuss with the doctor somehow disappears. I was given happy pills and felt I was *walking around like a zombie. Then the doctor switched pills to something totally different. I actually became hyperactive. I had nothing to keep me going, so I was lying on the sofa, shaking and holding on almost. My doctor has been the source of despair and aggression. And that applies to Social Services as well. Having to shout and jump up and down in order to be taken seriously has definitely been the hardest, and this feeling has not subsided. At Social Services there are always new case workers. I was supposed to have a meeting with them in November 2015. Apparently, they had given me a new caseworker, so it was postponed until January. Postponed and postponed. At last, I was given an appointment for April 1st. I attended – but nobody showed up. After half an hour, I just left. Things will have to run its course. In NAV's [Norwegian Labour and Welfare Administration] own tempo.*

Emma

I experience myself as not functioning any more. I am no longer the person I was. I'm in the middle of chaos. I don't understand myself, can't recognise myself. Cannot fathom why things are as they are. I hardly know who I am. Some friends sort of want to remove my heart and look at it and analyse how I really am. It seems like they have taken a straw and just sucked out all of me and then I'm left with only a skin. I am all empty. I'm not able to do anything. It's tiring. From being active and sociable to only wanting to pull away and be left in peace. Be alone. It's scary. It would have been easier to have a disease that had a status and was something that everyone could actually see. I have dreaded going to the doctor. I was at the meeting with NAV (Norwegian Labour and Welfare Administration) and my employer. My GP (general practitioner) should have been there too, but he didn't show up. He was on the phone for about five minutes when the meeting started and gave his account. So, that was it! You imagine that this is laziness. Pull yourself together. And that's what happened. I started working a bit again in order to pull myself together and try. I feel like a little girl. Quite defenceless. When being with others I have to wear an armor to be able to handle all the requirements, reproaches and questions. I have to be prepared to defend myself. It is pretty tiring carrying around an armor that seems too big for you, you know. That's what I feel I have done. And in the middle of all this I have been a facilitator taking care of all sorts of practical things. It's kind of sick really. Before, I used to have the strength *to drag this armor with me. Now the little girl is exhausted from carrying this armor whenever she leaves the house. Since I lost my energy, the hedgehog has been quite practical. Therefore, the hedgehog seeps through more and more. Then I just roll into a ball, to avoid having to relate to the outside world.*

Tone

I have put up a wall to protect myself from the world. My son comes and goes through it. It is in relation to him I give most of my energy and, I try to provide him with what he needs. Behind the wall, I have a private bubble. When I'm able to be within this "bubble" life feels good. But I'm forced to go in and out of it to see others. When outside, I am aware of feeling empty. Feeling frustrated. Like stamping my feet. I experience being trapped. Especially when the "Bang" feeling hits me and the energy disappears, I feel frustrated and notice that I become easily irritated and impatient because I realize I cannot do anything about it. I'm supposedly the type who is used to acting, doing something in such situations. Now, I just have to get through it as best I can. I have lost braveness somehow. Feeling indifferent. I don't know how long I can stand feeling like this.

Hans

I think the doctor has had a directive from NAV. The woman at NAV has in reality confirmed it. I felt real pressure to be at work. It went as far as my boss telling me to do something. Dreading having to go to the doctor doesn't exactly help me get better. I feel like a little boy at school being told off. Going to see a doctor you know will tear at your soul isn't much good, and you just cannot manage to do anything about it. When you experience hitting rock bottom like that, all your protective walls are knocked down and all your feelings lie exposed, leaving a lot of yourself seeping through. When wearing the job-suit I feel confident. In this world, everything is related to facts and I don't need to expose who I am. Until I hit the wall seven years ago, I was dressed in the job-suit 90% of the time. I did not reveal much of myself as a private person. At this moment, it's no fun. I'd rather get away from being me, as I'm neither the work person nor the private person. I can't accomplish what I want to do. It's shitty to be half a man to put it like that. That's heavy. So, I have to find a solution to the yellow light. The red and the green I know. During the seven years since I last hit the *wall, I have had time to forget. In the day to day when I have good energy and things run well, I just want to do a bit more. But now, I think about this almost every day. Am I doing too much now, or not?*

Gunn

I feel that I have had a long, hard walk. I have followed a narrow path through a deep, dark forest. As I am walking, I can see that the forest become less deep and dark. At the end of the path there seem to be lighter. I have carried this baggage with me since childhood and I have walked all this way alone. Maybe I could have taken a detour and left some baggage behind on the path, but that hasn't been possible due to these blockages that made me just carry on. It's been a long walk where I haven't seen how badly things were going or how tough and difficult it has been. I am in the middle of a process. And I am able to see more clearly now why I have ended up where I am. In a way, it's not my own fault, but at the same time it is because I have neither been able to realize how tough it has been for me nor being able to do anything about it. Although I do have good days when I can manage what many other people manage, there is no space for a job right now. The consequences if I do too much become more severe than for others. Therefore, I have landed in a sort of "this is how it is". But it hasn't come easy. It has been part of a long process for me to accept the situation instead of working against it.

Sonja

Before I became ill five years ago, I had a period with a lot of stress at work. Was stuck with two jobs for a longer period. At the same time, there was an uncomfortable conflict, and a close colleague left because of cancer. I suffered from a lot of headaches. Then I got flu and stayed home for a week. I didn't recover, but my doctor said I could work with an 'active sick note'. I tried to do as much as I could. Worked more or less every day. My boss and my clients said I looked so tired and ill. I nearly fainted and my boss got really scared. Thought I was going to croak. "Shouldn't you stay home?" But the doctor wouldn't put me on (proper) sick leave. I just became worse and worse and ended up in hospital. My pulse was really high. It wasn't a heart attack. I was just tired. Before, I used to be a racer getting written stuff done. Now I couldn't write. The letters kept bumping into each other. I carried on being on 'active sick leave' for two years. I *pushed myself until the elastic broke. Then everything stopped. I couldn't do anything more. I could have spoken up. It's easy to see that now. But I really wanted to cope. Thought that things would pass. I wasn't clear enough about it all being too much. I did say it eventually, but by then it was too late. I became bed ridden. Had to crawl from the bed and into the bathroom. Couldn't talk. Couldn't see and couldn't cope with any sounds. I was dizzy and very ill. After 2 years I got the ME diagnosis from my GP. I am very frustrated over the doctor's lack of understanding. This illness has had such huge implications for me. When NAV did not accept the diagnosis, my doctor referred me to the neurological department at the local hospital for assessment. There I was asked whether I had been given medication for ME. Well, I hadn't, so she prescribed me Cipralex (antidepressants). "But that's for depression and I'm absolutely certain that's not what I have". She was adamant that I should try it – and if it didn't work, I should just increase the dosage. The medication had no effect. Three years went by before I was finally given the diagnosis from a specialist at the hospital. It took ages to get an appointment. In the meantime, it was awfully frustrating and hurtful to experience such unprofessional treatment of my case in my contact with NAV. What I was subjected to was beyond words. During this period, I had one meeting with the caseworker. I tried calling several times, even though it was exhausting having to make these calls. Eventually I was given a caseworker, but she didn't follow up. I just received letters saying they didn't accept the diagnosis. And letters letting me know I could embark on more studying and could just do such and such. This wasn't realistic at all. My application for disability allowance was sent all over the place. Six months would go by and nobody returned my calls. I could never get hold of anyone. And when I finally got hold of someone, I was sent round like a shuttlecock. Nobody took on any responsibility. It was a tremendously difficult process and very downgrading to be treated like that. Just like I was a criminal. I didn't want disability benefits. I wanted to work. There was nothing else I rather wanted. I was asked to resign from my job because I couldn't continue after a year's sick leave. What then is it I'm supposed to be assessed about? Without a job! Where is the logic? And how easy is it to find a job when you have been ill for four years? And been sacked as well. For periods, I was in such despair that if it hadn't been for children and grandchildren, I would have taken my own life. I thought about that a lot. I cannot cope with this. In addition, I was very*

> *ill. Could hardly get myself out of bed and having to face such opposition. Just not being believed. It was shocking. It affected me. I kind of felt as if I was nothing – squashed together like a black hole. I had nothing to live for.*

All the participants in this study have experienced symptoms of burnout for several months and were on work assessment allowance, except for one, for whom the application process simply became too demanding. In this case, the family savings were spent to compensate for the lack of income. During the sick leave, all of the participants have felt a pressure to return to work, despite not feeling well. Seemingly, the medical system and the social security system agree that the subjective health complaints are due to psychopathology and thus do not represent a biomedical problem. Because of this, returning to work is considered a part of the rehabilitation process, as they are not recognised as physically ill. What is particularly problematic about this misconception is that, as we can see from the participants' narratives, the backdrop of having ended up with a fatigue reaction is exactly their relentless dedication to work.

1.2 Burnout as a societal challenge

From what I have seen in my clinical practice as a therapist and as an organisational consultant, the stories of the participants in this study are not unique. In recent years, burnout has received massive coverage in the media, addressing burnout as a stress related illness (Visjø, 2014; Østbø, 2015), but also in academic journals, addressing burnout as a diagnostic challenge (Fagerhaug, 2009; Holmelin, 2018). The burnout phenomenon has been widely discussed as an epidemic that hits individuals in specific occupations such as social workers, teachers, employees in the financial sector, nurses and medical doctors. Suicide among doctors is one concern that has led to an increased interest in burnout as a societal problem and Nunn and Isaacs' (2019) review suggests that burnout is a serious problem in today's society. As told by the participants in this thesis, the work situation was experienced as a pressure in their daily life situation, which resulted in exhaustion followed by more severe mental and physical symptoms of fatigue.

Until recently, burnout has not been an official diagnosis anywhere in the industrialised world except in Sweden and the Netherlands. In Sweden, the diagnosis

Exhaustion Disorder (ICD-10, F43.8A) is one of the most commonly used psychological diagnoses (Norlund, Fjellman-Wiklund, Nordin, Stenlund, & Ahlgren, 2013). The condition is operationalized under "other reactions to severe stress" and the disorder is closely linked to the symptoms that are described in the burnout syndrome (Norlund et al., 2013; Åsberg et al., 2003). On 28th of May 2019, the World Health Organisation (WHO) decided to include a more detailed definition of burnout in the International Classification of Diseases (ICD-11) as an "occupational phenomenon". Thus, burnout is now classified as a diagnosable condition. Although burnout is not included as a medical diagnosis in ICD-11, the inclusion can be seen as a positive development of the clinical guidelines. This development will help medical doctors take both personal well-being and symptoms of stress seriously. However, before the diagnosis can be applied, other possible conditions with comparable symptoms must be excluded. This demand can prove difficult to accommodate because each patient seems to have a unique combination of biological, social and psychological factors leading to complex heterogeneous symptoms. Thus, this might also be part of the explanation why, all around the world, this patient group struggles to be understood and believed, including the participants in this study.

In Norway, two different governmental authorities regulate the healthcare and welfare system. The Ministry of Health Care Services is responsible for the medical system and the sick-leave compensations and the Ministry of Labour and Social Inclusion (NAV) is responsible for work assessment allowance (AAP) and social security benefits. All citizens are offered a general practitioner (GP), who will serve as their "family doctor". The GPs are part of the primary care service and are responsible for diagnosing and the treatment of less complex diseases. They refer patients to the secondary care system for treatment and for investigation of conditions that are more complex. The GPs are responsible for the medical contact between NAV and their patients. The NAV social caseworkers are responsible for sick leave compensations. NAV and representatives for the workplace are mutually responsible for supporting the patients to get back to work during the first 52 weeks of sick leave. When still not able to work after that period, employees ordinarily lose their job. Then, NAV and the GPs are responsible for the support and the recovery process during the period of work assessment allowance (AAP).

According to the Norwegian Labour and Welfare Administration (NAV, 2019), about 95.000 individuals receive work assessment allowance (AAP) due to psychological and pain-related diseases. These two categories represent 70% of the total number of individuals who are on long-term sick leave receiving AAP. The government is not passive in respect to the economic consequences of the challenge related to sick leave. In 2018, the government decided to shut down the nationwide "quicker-recovery" programme, which intended to support individuals on long-term sick leave back to work. Instead, individual programs are now available to support rehabilitation. The intention of the reform is to reduce long-term sick leave by being more restrictive when granting AAP. To receive AAP, NAV requires an active contribution from the individual to the process of returning to work. This contribution includes committing to an agreed, individual, specified "return to work plan", attending the agreed meetings with NAV, providing the necessary information and documentation that NAV requires and completing the agreed activities in the "return to work plan". Not completing the agreed activities can lead to a termination of the AAP. After one year, we have seen that the number of individuals on disability insurance has increased and the number of individuals on AAP has decreased (NAV, 2019). We will have to wait and see what the long-term results of the reform will be.

Some of those who experience symptoms related to fatigue and pain do eventually recover and manage to get back to work. Research shows, however, that the recovery process is often demanding and time consuming (Øyeflaten, Lie, Ihlebæk, & Eriksen, 2012). The participants' experiences revealed in this study offer a glimpse into how burnout is related to a societal problem, and their personal narratives of suffering with a condition that is not recognised by the healthcare system or society provide a demonstration of the broader points made in this thesis, namely to provide a deeper understanding of burnout for informing the medical system about the needs of individuals who suffer from burnout.

Since burnout was not accepted as a diagnosis until May 2019, the participants had been given various other diagnoses, such as Myalgic Encephalopathies (ME) or depression. A study that investigated which diagnosis general practitioners in Scandinavia give patients with severe subjective health complaints showed that the nine patients in the study were given between 13 and 31 different primary diagnosis and a large variety of secondary and tertiary diagnosis (Maeland et al., 2012). The absence of a known biomarker for burnout means that it falls under the category of medically unexplained syndromes (MUS), which is related to a deficiency of what is acknowledged as adequate medical knowledge. The challenge related to diagnosing patients with several severe subjective health complaints, like the symptoms of burnout, is related to the lack of reference standards for the diagnosis (Aiarzaguena, Grandes, Salazar, Gaminde, & Sanchez, 2008) and is linked to deeper epistemological issues, such as lack of a causal explanation, lack of diagnostic descriptions, and lack of a treatment or medical interventions. This lack of knowledge has proved challenging for both the healthcare system and for the sufferers themselves and their families. Despite a broad societal plea to find a solution and treatment of burnout, this uncertainty about how to explain burnout has been grounded in a continuing debate in the medical profession whether burnout actually exists or if it is nothing but depression (Ahola & Hakanen, 2014; Bianchi, Schonfeld, & Laurent, 2014; Hallsten, 1993). For the sufferers, however, there seems to be no doubt that burnout is experienced as a real and serious condition on its own. This fact raises questions about the implications this dearth of knowledge can have for clinical practice, the society and not least for the individual sufferer who might experience a permanent dropout from work-life.

1.3 Burnout as a scientific challenge

This section provides a brief review of the research on burnout that has been conducted within social psychology and environmental medicine. I will address what has been the chosen research focus, which can give us an indication of the reason why burnout has ended up as a contested diagnosis.

In 1974, Freudenberger introduced “Professional Burnout” as a scientific concept into social psychology. He did this after having described and systematised information about a mental condition he observed in some of his colleagues, which he also recognised in himself (Freudenberger, 1974). He characterised burnout by several physiological symptoms, such as exhaustion, fatigue, headaches, sleeplessness, shortness of breath and gastro-intestinal disorders. Additionally, he described several behavioural signs, such as frustration, anger, suspiciousness, cynicism, omnipotence and depression. He also observed that personality factors, such as dedication and commitment, seemed to predispose to burnout. Linking these observable symptoms as reactions to demanding working contexts, he focused on intervening at an organisational level rather than on just an individual level. Freudenberger represents the origins of the research on burnout, as we know it today, while Maslach has conducted most of the research within this field. Her focal point seems to have contributed to redirect the research away from an organisational level towards an individual level (Maslach & Schaufeli, 1993).

Maslach is still one of the most prominent scholars in this field. Her team of social psychologists focused mainly on how burnout can be measured (Maslach, 1976; Maslach & Jackson, 1981a; Pines & Maslach, 1978). The invention of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981a) marked a turning point that influenced the research focus in the field. The MBI appeared to provide a common understanding of a coherent mental condition and its social implications. Based on this tool, the phenomenon was defined as a work-related chronic stress syndrome. Thus, burnout is recognised as a generic name for a state of physical fatigue, emotional exhaustion and cognitive weariness due to prolonged exposure to unavoidable stressors. The result of the experienced arousal is understood as a gradual process of disillusionment, resulting in depersonalisation and the loss of self-confidence (Maslach, Schaufeli, & Leiter, 2001).

Burnout is characterised by several severe subjective health complaints that often overlap with symptoms seen in other conditions such as neurasthenia, chronic fatigue syndrome (CFS) and Myalgic Encephalopathies (ME). One of the core components in for instance CFS as well as in burnout is fatigue: these two diagnoses share several overlapping symptoms that can be a source of confusion. Due to the similarities between them, they can be seen as belonging to two sides of the same coin (Leone, Wessely, Huibers, Knottnerus, & Kant, 2011). Despite the similarities, fatigue has been studied from different perspectives according to the assumed cause of the condition. Thus, fatigue related to the work situation has been studied in social psychology and environmental medicine. On the other side, fatigue assumed as relevant to somatic processes has been studied in medical fields such as immunology and virology. Due to my professional background rooted in psychology, I will focus on the research related to burnout rather than on fatigue in general.

The majority of the empirical work on burnout consists of cross-sectional correlation studies. Additionally, several longitudinal studies and randomised controlled studies have been conducted (Ahola & Hakanen, 2014). Hence, the phenomenon has mainly been studied by applying quantitative research methods and measurements, which has a historical and philosophical basis in the empiricist scientific tradition. The quantitative paradigm can be described as objective, measurable, reductionist, positivist/post-positivist, modernist and mechanistic (Moses & Knutsen, 2012). This paradigm can be described as "an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalisations of the theory hold true" (Creswell, 1998, pp 1-2).

The main contributions of the research on burnout can be described within three primary categories (Heinemann & Heinemann, 2017):

1. the causal explanation of burnout,
2. the prevalence of burnout, and/or
3. testing methods that might alleviate and prevent burnout.

A large body of this research is based on data provided by the MBI or different variants of MBI (Maslach & Jackson, 1981a), and consequently the accuracy of the outcome is dependent on the validity of these tools (Lindell & Whitney, 2001; Pines & Aronsen, 1988). By comparison, the focus on describing the following categories has been minimal:

4. psychological and somatic symptoms,
5. psychometry, and
6. biomarkers.

The unequal distribution in research focus on these six categories can have contributed to the vagueness of the burnout phenomenon (Heinemann & Heinemann, 2017). One reason for this vagueness is that research has mainly studied causal relations and associated factors in addition to measuring the prevalence rates of burnout based on a mental state that is not properly defined (Heinemann & Heinemann, 2017). Any vagueness concerning the phenomenon can thus be the result of an unclear understanding of the psychological and physiological foundations of the phenomenon, rather than pointing to the nature of the phenomenon itself.

So far, I have presented a very brief review of the current status of knowledge in this field. Despite a huge effort to understand different aspects of the phenomenon, burnout remains a contested diagnosis. The reason for this can be a lack of focus on exploring the nature of burnout, which in turn has added to the blurriness of our understanding of the phenomenon.

1.4 Framing the burnout challenge

There are relatively few philosophical contributions to the burnout debate (Heinemann & Heinemann, 2017). Therefore, I will consult the field of philosophy of medicine and its research on medically unexplained syndromes (MUS) in general. The way we investigate burnout will affect our ontological understanding of the phenomenon. Therefore, I argue that consciously reflecting on how different worldviews (ontology) can provide different types of knowledge (epistemology) is crucial (Anjum & Mumford, 2018) because it can provide a deeper understanding of the burnout phenomenon. Although burnout has not been a part of the MUS debate, many of the concerns about it have also been raised in relation to MUS. While it is not the aim of this thesis to offer a contribution to the field of philosophy, applying philosophy and philosophical debates as a means to clarify how *knowledge* is gained will strengthen my theoretical arguments. Hence, I will primarily focus on how the epistemological stance taken in evidence-based medicine has influenced the status of knowledge in research on burnout. For this reason, I appeal to arguments from the philosophy of medicine about the nature of MUS to frame the burnout challenge I describe.

Research on MUS has pointed to several epistemological limitations related to evidence-based medicine for understanding these syndromes properly. One such limitation is a strict empiricist approach that prioritises comparative studies and randomised controlled trials (RCTs), based on regularity theory and difference making, respectively (Cartwright & Munro, 2010). The epistemological approach taken by evidence-based medicine regards these statistical methods as the gold standard for providing new knowledge, particularly about causation (Anjum, 2016; Anjum & Mumford, 2018; Cartwright, 2010). Medically unexplained syndromes are described as context sensitive, heterogeneous and multifactorial without a common cause (Eriksen, Kerry, Mumford, Lie, & Anjum, 2013). The symptoms are often ambiguous and overlapping with no clear division between psychological and somatic symptoms. Moreover, there seems to be a whole range of symptoms caused by biological, psychological and social factors without a clear-cut one-to-one relation between them. Consequently, one of the MUS challenges is related to the multiple heterogeneous factors involved (Voigt et al., 2010) and to how evidence-based medicine seeks to frame health experiences in simple cause-effect terms. That is, the search for causal explanations for these syndromes has not proved to be easily resolved with statistical data (Eriksen et al., 2013; Eriksen & Risør, 2014). Epistemology denotes the philosophical study of knowledge;

accordingly, the challenge related to the blurriness of the burnout phenomenon can be due to the epistemological stance taken in evidence-based medicine.

The chosen epistemology in evidence-based medicine seems, then, to miss much of the complexity, heterogeneity and ambiguity related to medically unexplained conditions. As stated in the introduction, I propose seeing burnout as a complex, heterogenic condition like other MUS, rather than as depression. Accordingly, the lived experience of individuals suffering from burnout is not properly understood and it is only to a minimal degree appreciated that these individuals are coping with more existential challenges in their lives (Juster et al., 2011).

1.5 Research questions and findings

The purpose of this thesis is to contribute to filling a knowledge gap by exploring the lived experience of burnout. My concern about what knowledge we need is two-fold:

a) knowledge for providing a deeper understanding of the phenomenon of burnout;
b) knowledge for informing the medical system about the needs of individuals who suffer from burnout.

Ultimately, this thesis provides new evidence that will fill the knowledge gap theoretically, by providing a deeper understanding of burnout, and pragmatically, by providing evidence for supporting the needs of the persons who suffer from burnout. Accordingly, my aim is to provide new knowledge about the phenomenon of burnout, which I hope will contribute to the political discussion about decisions related to the medical care and societal support of these individuals. Consequently, the research question for the study in this dissertation was the following:

> *"What is the lived experience of burnout and how can we support individuals who suffer from burnout in their rehabilitation process?"*

The empirical study and the papers are an attempt to answer this question in five steps. While paper one, three and four are more empirical, paper two discusses burnout within the context of philosophy of medicine, applying the empirical findings of the study in the discussion. Hence, paper two, three and four explore the burnout phenomenon from different angles, based on the empirical material from my study. Paper 5 is based on a case study from my own clinical practice and discusses the reflexive methodology that I use.

Each subsequent paper builds on the results and analysis of the previous paper, aiming to fill in new knowledge like pieces of a puzzle. The following figure illustrates how the five papers are related, as I will then go on to present in detail.

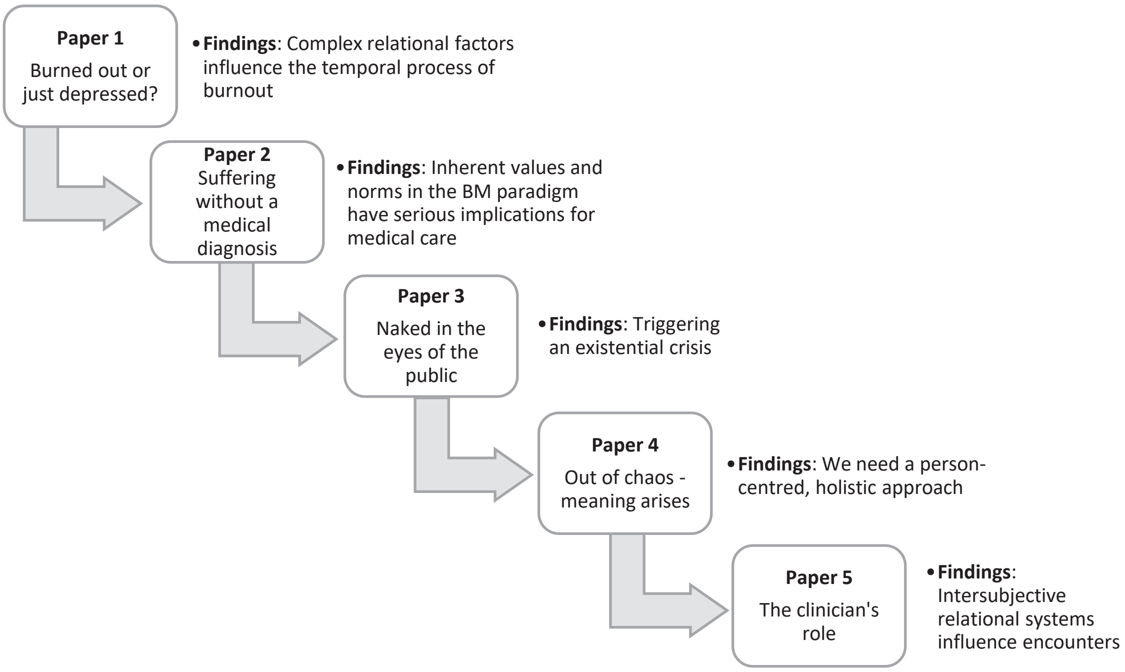

FIGURE 1: An overview showing how the papers relate to each other

Question for paper 1: "What is the lived experience of burnout?"

Findings of paper 1: *Four narrative phases mirroring burnout as a temporal sequence stood out; Achievement, Pressure, Psychosomatic Collapse, and Personal Meaning and Reorientation. The lack of societal recognition can have affected the healing process negatively. Thus, the study contributes to a deeper understanding of how complex relational factors influence individual vulnerability and lead to a fatigue reaction.*

Question for paper 2, motivated by the findings of paper 1: "How do the inherent values in the biomedical paradigm affect clinical care and what changes are required if we are genuinely concerned about the needs of the individual patients?"

Findings of paper 2: *Within the framework of evidence-based medicine and the biomedical model, there is a limited acceptance of heterogeneous, subjective health complaints with an unknown aetiology. As a result, the needs of the patients remain neglected. A way forward for supporting persons who suffer from burnout can be to see burnout from a phenomenological perspective and take the subjective lived experience of the condition back to the "owner". Both mechanisms and the whole person should be understood as individual, relational, and contextual. Therefore, there seems to be a need to re-discover the perceived world to explore the burnout phenomenon further for understanding and taking care of human needs.*

Question for paper 3, motivated by the findings of paper 2: "How does the clinical and societal encounter affect the lived experience of suffering from burnout?"

Findings of paper 3: *The lack of recognition of the participants' condition seemed to influence the process of contextualizing the illness and in turn had a negative effect on the healing process. Feeling seriously distressed without acknowledgement of their situation, triggered an existential anxiety, frustration, despair and hopelessness. This fact seemed to result in a disconnection from their habitual lifeworld, which in turn triggered a shame reaction. The participants' need to withdraw from others as well as from themselves became acute and three of them explicitly considered suicide as a way out.*

Question in paper 4, motivated by the findings in paper 3: "How do sufferers from burnout on long-term sick-leave deal with the process of coming to terms with their lived body as ill?"

Findings of paper 4: *During the experienced existential crisis, the inherent human ability to adjust to the never-ending temporal processes of life seems to take place. The participants demonstrated deliberate choices and reflective self-cultivation to adjust to their present situation. By being able to demonstrate new habitual actions, the participants might be able to constitute a "new" defined self, which in turn can result in a re-habituation of the lived body.*

Question in paper 5, motivated by the findings in paper 4: "How important is the clinician's role in the clinical encounter and how does the clinician influence the clinical encounter in positive or negative ways?"

Findings of paper 5: *The ontological stance we take, either consciously or unconsciously, will influence our norms and methods and in turn, the way we practice. As part of the therapeutic process, the client's lifeworld processes cannot be interpreted as emanating from the client in isolation but must be seen as emerging as part of an inter-subjective relational system.*

Returning to the research question, "What is the lived experience of burnout and how can we support individuals who suffer from burnout in their rehabilitation process?" the five papers together offer an answer in form of the following argument:

> *Complex relational mechanisms can modify the temporal process of burnout and influence the experience of bodily fatigue. The biomedical paradigm influences clinical practice. The norms, values and attitudes inherent in the biomedical model and evidence-based medicine can lead to ineffective treatment, which has serious implications for medical care. The psychosocial experience of burnout can lead to an existential crisis and a shame reaction. The need to withdraw from others as well as from themselves became acute and three of them explicitly considered suicide as a way out. The experienced existential crisis seems to promote a search for meaning, which enhanced new habitual actions and a "new" defined self that can promote a re-habituation of the lived body. As part of the therapeutic process, the client's lifeworld processes cannot be interpreted as emanating from the client in isolation but must be seen as part of an inter-subjective relational system.*

The summary of the findings points to how clinical encounters are experienced as a main challenge, which can be related to two sub-challenges:

1. *the concept of causality and its implications for understanding the burnout phenomenon*

and

2. *the power of relational mechanisms in clinical encounters.*

1.6 Overview of the dissertation chapters

The thesis consists of six main chapters, followed by the five papers.

In Chapter 1, 'The burnout challenge', I have so far addressed my contextual pre-understanding of burnout and addressed the burnout phenomenon in different contexts as an individual, societal as well as a scientific problem. From this situated standpoint, I have shown how the five papers contribute to this knowledge, by outlining the research question, the findings and the proposed argument of the thesis. I also identified a main challenge and two interrelated sub-challenges to be addressed in chapter five.

Chapter 2, 'A phenomenological framework', proposes the phenomenological framework as an overarching theoretical approach, which encompasses and connects the theoretical contributions of the papers. I start by giving an illustration of the theoretical framework of this thesis by disclosing how my worldview is interrelated with my motivation for the project. Accordingly, the theoretical framework outlines a common ground from which I will discuss the main challenges related to the research question of this dissertation. Starting by addressing the debate of knowledge, I explain why this thesis calls for a hermeneutic ontology and an interpretative epistemology that allows in-depth exploration of lived experience and meaning, by elaborating on Merleau-Ponty's phenomenology of the lived body.

In chapter 3, 'Research approach', I first describe the methodological framework, including the process founded on the research design decisions, which I presented in chapter two. I also identify my interest in the project, making provision for reflexivity. Then, I present the procedures for recruitment, data collection and data analysis as well as ethical and quality implications. Hence, this chapter deals with the rationale and procedures for arriving at a deeper understanding of the individuals' lifeworld.

In chapter 4, 'Summaries of the papers', I give brief summaries of the five papers in this dissertation. Then in chapter 5, 'Discussion', I elaborate on the relation between the contributions provided by each of the papers as well as their joint contribution to discuss the proposed argument to answer the research question. Additionally, I will address the theoretical implications of the findings and the contribution of the thesis to its field of research.

Chapter 6, ‘Conclusion and further research, concludes the contribution of the thesis and offers suggestions for the way forward and for further research.

2.0 A PHENOMENOLOGICAL FRAMEWORK

In this chapter, I will introduce the theoretical framework of this thesis. First, I will disclose how my worldview is interrelated with my motivation for this project. This part is based on my background as a gestalt psychotherapist and supervisor, which is partly a feature in my PhD work. Several years ago, after a few years of psychology studies at the University of Oslo, I decided to go for a clinical Master of Science in gestalt psychotherapy. To me this was a deliberate choice to adopt a paradigm. Korb refers to her experience with the gestalt-therapeutic method as a feeling of "coming home" and it resonates with me when she says:

> My home rests upon the satisfaction of my lifelong hunger for personal validation, spiritual sustenance and my longing for the numinous in human relationships. I am and will always be a learner, but I am not the seeker I once was. I know the "ground of being" and that it is unshakable; I am sustained in my daily work and play; and, in my connections with others who share the I-Thou experience, I have a community of beings with whom I belong (Korb, 1988, p 105).

Via my clinical work, I have bit by bit digested and taken aboard the five cornerstones on which the gestalt theoretical perspective rests; *dialogic encounter, existentialism*, *field theory*, *constructivism* and *humanism*. With Korb's words as a backdrop, I would like to briefly present my own philosophical worldview, which has influenced and motivated the way I chose to design this study.

2.1 My philosophical worldview

I see philosophy as the core of inquiry. It influences the way I see, interpret and hypothesise as well as it is the essence of how I work as a gestalt psychotherapist. It also influences my analysis when doing research. Fundamental questions like 'What do I really know?' and 'How do I connect with what is?' are of concern to all of us. Not so much in terms of "I", but more so in relation to "we", and thus essential in the encounter with others.

I see the meeting between the client and myself as a *dialogic encounter* (Hycner, 1993; G. Yontef, 1993) of shared phenomenology. This implies that each intervention and each moment of therapy is a moment of interpersonal contact rather than a technical event. Within the humanistic tradition, the therapist is not a detached observer giving “expert” interpretations of the client’s abnormal behaviour, but rather one who accepts all phenomena as creative adjustments that are adequate in relation to the person’s subjective reality (Perls, Hefferline, & Goodman, 1951/1998). The existential phenomenological worldview offers pivotal contributions to therapeutic encounters (Hycner & Jacobs, 1995). For me, ‘existential’ means *being in the world*. Existential phenomenology emphasises that a person’s subjective experience is their “truth” and that our body is the original knowing subject and the centre for our actions. This approach views human beings from a relational perspective and thus it understands existence as being-in-the-world, as a co-constituting self-other relationship (Merleau-Ponty, 1945/2003).

From a field theoretical perspective, the human being is conceptualised as existing in a continuing interplay with the organism-environment field (Merleau-Ponty, 1945/2003; Perls et al., 1951/1998). Field theory embraces a holistic view where everything exists in connection with everything else, so that any change in any part of the field affects all other parts of the field. This implies that any process is a function of the relationship between the interacting therapist and client and the field as a whole. An event is not caused by a single preceding event, but phenomena are interrelated in complex processes, where nothing appears in isolation. Everything is co-created, including meaning. Accordingly, the psychotherapist and the client will influence each other in a field of mutual reciprocity (Merleau-Ponty, 1945/2003). We exist not only in reciprocal differentiation from each other, but also in reciprocal influence (Crocker, 1999; G. Yontef, 1993). Hence, the field is co-constructed as an integral part of the therapist/client experience.

Field theory supports and guides the therapeutic process and suggests that everything is in flux and that fields of energy shape our reality (Merleau-Ponty, 1945/2003). Thus, field theory – and constructivism – is a potentially emancipatory concept directing the therapist to focus on awareness of those factors that are relevant to the particular client, rather than assuming that certain factors will be relevant. Constructivism sees the mind as active in the construction of knowledge into abstractions and concepts in order to make sense of experience (Alfred Schütz, 1899-1959). In this sense, constructivism is the view that we as human beings do not ‘find’ or ‘discover’ knowledge so much as ‘construct’ or ‘create’ it, and, in light of new experiences, we continually test and modify these constructions. Importantly, we do not construct our interpretations in isolation. Instead, this construction takes place within a conceptual framework of shared understandings and practices through which the world is described and explained. Thus, human knowledge and meaning is socially co-created within a historical and sociocultural framework or Zeitgeist.

This theoretical framework also has a more formal part, to which I now turn. A question debated for centuries within the philosophical tradition is “what is knowledge and who is the knower?” This question is of importance for the argument in this thesis, as I aim to explore the lived experience of burnout and to discuss how we can support the rehabilitation process of individuals who suffer from burnout. Lived experience has been conceptualised mainly in two, conflicting ways. Firstly, it can be understood as “the true origin of a phenomenon”, or it could, due to its subjective nature, be taken as lacking objectivity. Hence, the truth about what we can know of the phenomenon is contaminated by subjectivity. Epistemology is the study of knowledge and justification (Schwandt, 2001). How do we generate or gain knowledge? That is, how do we know what we know? Do we gain knowledge via method, reason, sensory experience or intuition? Schwandt has addressed the way philosophers of social science and social scientists define the nature and aim of social inquiry. He points to the critique of the Enlightenment tradition:

> We are now experiencing a period characterised by various critics of notions that form the core of the Enlightenment tradition: the necessity and universality of reason; the autonomous, disengaged, atomistic, sovereign, rational subject; knowledge as representation; the separation of philosophy from rhetoric and poetics; and so on. (Schwandt, 2001, p 70)

In the rest of this chapter, I outline a common ground for the conclusions of this dissertation. I start by tracing the debate of epistemology of knowledge situated in space and time. My aim is to show how phenomenology emerged as a countermovement to a positivist worldview, and also to clarify that phenomenology is not one single theory but many – some of which are more compatible with positivism. I then go on to elaborate on the application of interpretative phenomenology as the chosen strategy for understanding the lived experience of burnout.

2.2 What counts as knowledge? A philosophical debate

There are several schools of thought that have taken up the epistemological questions "what counts as knowledge and how can we know". I will here focus on two main traditions that held opposite beliefs about these questions: the positivistic and the hermeneutic paradigms. *Paradigm* is understood as "the philosophical stance taken that provides a set of beliefs that guides action" (Creswell, 1998, p 254; Kuhn, 1962).

The 17th and 18th centuries have been described as an Age of Enlightenment (Schwandt, 2001). This ideological perspective, 'Englightenment', is really a family of theories and perspectives, which moved the thinking beyond superstition and theological dogma and established trust in the powers of reason and humanity. From this fertile ground, the modernist project evolved (Howard, 2000), which I will address below to give a brief contextual background that leads up to the phenomenologist worldview.

The positivist paradigm, coined by August Comte, indicated a philosophy of strict empiricism, which asserts that the only genuine or legitimate knowledge claims are those founded directly on observation or sense experience (Moses & Knutsen, 2012). The role of science is then to examine the matters that *really* exist in the external world that we can verify through empirical evidence. Empiricism is one of the theories of epistemology and is often contrasted with rationalism (Howard, 2000). The former argues that true knowledge is derived from sense experience, while the latter claims that reason provides a kind of certainty that the senses cannot provide (Moses & Knutsen, 2012).

Naturalism, with a tendency toward materialism, evolved during the late 19th century. This paradigm holds that the human sciences should have as their goals both prediction and causal, statistical explanation of human behaviour (Schwandt, 2001). This tradition is briefly contrasted with Transcendentalism, which emphasises subjective intuition over objective sensory experiences as held by Naturalism. As we shall see, transcendentalism influenced Husserl's phenomenological approach to science. Positivism and logical empiricism did not remain unchallenged in 20th century meta-theory (Howard, 2000). Until now, knowledge of social phenomena was predominantly regarded as an extrapolation of the natural sciences, which could easily be gained as empirical evidence. The Hermeneutic paradigm, concerned with interpretation, arose as part of a countermovement to the positivist tradition. It has its basis in the subjective, humanistic, interpretive, and post-modern traditions. Hegel was dominant in philosophy for at least a century after his death and he is an example of this counter-response. He was unhappy with naïve empiricist fascination with fragments and simple sense impressions, and therefore sought wholeness and integration via the “dialectic” of thesis, antithesis and synthesis (Howard, 2000).

Phenomenology emerged as a philosophical movement and an epistemological idea, founded by Husserl in the middle of the 19th century. Phenomenology could be described as perception-based empiricism, in that we cannot conceive anything that is not perceived or perceptible. This approach differs radically from Hume’s classical empiricism when it comes to what counts as data and the method of verification of observations, as it is not inductively empirically derived (Howard, 2000). Phenomenologists reject scientific realism and the accompanying view that the empirical sciences have a privileged position in identifying and explaining features of a mind-independent world (Schwandt, 2001). Phenomenology draws directly on the phenomenological tradition of philosophy and involves a focus on human experience and how the things that are perceived appear to the person (Husserl, 1931/2012). As held by the phenomenological worldview, the direct access is not of the world but of our own experience. Later in this section, I will bring up the different focus held by phenomenology and classical empiricism when I outline the reason for my methodological choice.

With phenomenology as a foundation comes the recognition of the way the researcher may have preconceptions about a topic and how to deal with this challenge when studying that topic. Three steps related to the reduction of data characterise the phenomenological method coined by Husserl. The first step, related to verification, is known as the rule of *epoch*. Here the researcher intends to keep a stance of openness towards what is observed, which means to set aside, or bracket out, everything other than the primary data of the observation (Finlay, 2011). Epoché is a Greek word for explaining how we can attempt to abstain from our presuppositions. This involves an attempt to set aside our natural attitude regarding how to see the world and to keep a stance of openness towards what is observed. The second step in the phenomenological method is known as the rule of *description*. This means that the researcher allows any patterns, themes and categories to emerge from the observation, rather than being imposed on him/her either prior to or during the process of observation and analysis (Moustakas, 1994). The third step is known as the rule of *horizonalization*. In analysing the observation, the researcher tries to avoid placing any hierarchies, in terms of significance or importance, upon items that make up descriptions. This includes treating keywords, statements and themes as having equal value and significance (Moustakas, 1994). By following these three steps, the researcher will arrive at an explanation derived from immediate experience and not based on abstract, biased speculation (Moustakas, 1994; Spinelli, 1989).

One of the most important concepts in phenomenology is *intentionality*, which refers to the fact that whenever we are conscious, we are always conscious *of something* (Husserl, 1931/2012). This gives the researcher the opportunity to attend to what is experienced (noema) and how it is experienced (noesis). This includes a focus on human experience and how things that are perceived appear to the person (Howard, 2000). In phenomenology, intentionality is related to a transitive verb. Simply understood, this can mean that the person is orientated towards something inside or outside him or herself. Intentionality is complex, as human beings intend in different ways, or they may have differing lived experiences of the same object. Husserl's philosophy coined the basis for what was recognised as the phenomenological method, which offers an approach to systematise ways of understanding and explaining the nature of human experience (van Manen, 1990). Husserl was concerned with the essential structures of conscious experience, which represents a move from exploring just one person's specific experience of burnout to the exploration of the underlying structures of this specific experience. The process of moving from the individual to the universal was termed eidetic intuition (Finlay, 2011; Langdridge, 2007). To be more specific, the aim of Husserl's phenomenology is to identify the essence of a phenomenon. Phenomenological essence is very close in meaning to the everyday understanding of the term. A researcher asking, 'What is the essence of burnout?' would want to know what distinguishes burnout from some other similar illness experience, such as for instance chronic fatigue syndrome, as well as establishing its particularities.

The eidetic intuition attempts to understand human nature based on a range of perceptions and different modes of intending. In the move to *imaginative variation*, the researcher tests the limits of this intuition by anticipating whether some specific features are related to the phenomenon, but others are not. For example, eidetic intuition involves a synthesis of how different individuals experience a phenomenon, and a move into imagination to depict the essence of the phenomenon (Langdridge, 2007). After monitoring several individuals with similar characteristics, the researcher may confirm that this intuition is indeed a generalizable feature. Thus, to identify the essence of the experience, the invariant structures that underpin the experience as it appears to perception are tested (Langdridge, 2007).

In summary, Husserl's phenomenology offers a framework for articulating and understanding lived experience as different ways of being in the world and of knowing the world (Langdridge, 2007). This includes different modes of awareness of objects to be studied; the natural attitude of lived experience; the phenomenological attitude (epoché) for systematically studying the knower and the known, and the eidetic intuition of essences. In this context, Husserl proposed that experience should be studied free from personal assumptions, founded on the transcendental tradition. Thus, Husserl's phenomenology is actually situated within the positivist paradigm as he asserted that the task of the human was to integrate body, mind and emotions so that we may become conscious of the "self", develop our willpower, and thus set ourselves free from being automatically driven by associations and reactions (Howard, 2000). The foundation for the phenomenological tradition was accordingly the world as concretely lived, which paved the way for further development of the *lifeworld* concept, which I will address later.

The existential movement resulted in a radical transformation of phenomenological philosophy, away from the positivist ideals (Howard, 2000). Existentialism also arose as a countermovement to the Age of Enlightenment, represented by philosophers such as Kierkegaard, Nietzsche, Heidegger, de Beauvoir and Sartre. This philosophical doctrine gave priority to mental phenomena and denied that we can ever have access to a mind-independent reality. The human being was no longer seen as an abstract being but as a part of the concrete societal environment (Howard, 2000).

The existentialist philosophers were in their methodology more or less phenomenologist, and the ideas within existentialism provided a significantly different means of examining and dealing with ontological questions. Their main concern was the immediate understanding of "what is" and how the human being is connected to the world and other human beings. Through intentionality, phenomenology dynamically links person and world (Schwandt, 2001). The extent to which researchers who are studying different instances of a particular lived experience can separate themselves from this close interconnectedness is key to ontological and epistemological positioning when conducting phenomenology. The transcendental aspect of Husserl's philosophy is thus called into question (Schwandt, 2001). Such criticism is related to whether it is possible to bracket off our preconceptions about an experience. Thus, the tension between these two philosophical traditions concerns the extent to which understanding lived experience should be based on interpretation or objective description. This is also partly explained with respect to the natural and phenomenological attitudes (Langdridge, 2007). The interpretative alternative assumes that the meaning of human actions is inherent in action, and that the task of the researcher is to unearth that meaning (Schwandt, 2001). Therefore, knowledge of lived experience can only be gained through an interpretative procedure.

Interpretive approaches to phenomenology emerged with the work of Heidegger. In his development of phenomenology, Heidegger focused on the problem of what it means to exist in the world (Howard, 2000). When something is perceived, it cannot be experienced without being apprehended in terms of a meaningful world. According to Husserl, consciousness is an inextricable part of the bodily entity. Heidegger built on the phenomenology of Husserl and took that view further, by claiming that we always find ourselves in relation to something else and that I-myself is part of this relationship. Thus, the hermeneutic tradition arose, especially focused on how our way of existing must be seen within a cultural context. The focus on consciousness and experience is essential in hermeneutics. The term *hermeneutics* generally refers to the philosophy of the interpretation of meaning of an object (Schwandt, 2001). Predominant in philosophical hermeneutics, Heidegger's ontology aimed to understand the human-being-in-the-world – referring to human subjectivity and our understanding of the nature of existence itself (Howard, 2000). The revolution brought about by Freud's discovery of the conscious and paved the way for the further extension of the idea of hermeneutics into the epistemology and methodology of the human sciences (Howard, 2000). Moreover, Merleau-Ponty, amongst others, contributed to restoring a concern with the body related to our thinking about epistemology. According to Merleau-Ponty (1945/2003), the body is the original knowing subject and the centre of our actions. During the twentieth century the "mind - body split" was replaced by the idea that the lived body was not an object in the world distinct from the knowing subject. Rather, we experience the world as embodied subjects (Merleau-Ponty, 1945/2003).

In this section, I have presented a brief overview of the debate related to what counts as knowledge. My aim in doing this was to show that, although phenomenology emerged as a countermovement to the positivist worldview, it has actually from the start held to a positivist perspective. As previously mentioned, phenomenology focuses on human experience and how the things that are perceived appear to the person. Thus, a direct access is not of the world but of our own experience. As we have seen, the existential phenomenological approach first introduced by Heidegger generated the phenomenological turn in philosophy. The theoretical framework I have presented in this section is meant to outline a common ground for the conclusions of this dissertation and to explain my methodological choices for answering the research question. Now, I will turn to the specific rationale for those choices.

2.2 The rationale for an interpretative phenomenological method

Creswell (1998) makes a distinction between epistemological and ontological questions that has direct implications for choosing a methodology (Cresswell, 1998). So, for example, in asking, “What knowledge do we need?” and, “how can knowledge contribute to better support in the rehabilitation process?”, there is an epistemological focus. On the other hand, when asking, “What knowledge do we need for understanding the burnout phenomenon?”, this question emphasises the day-to-day experience of the reality for those individuals who suffer from burnout and therefore it is more ontological.

According to Denzin “ontological questions force a movement beyond method and logic to the underlying question of meaning in human affairs” (1984, p 261), which can be understood as a suggestion that the exploration of *meaning* requires the application of interpretation rather than logic. Exploring ontological questions can be a challenge because embodied knowledge is often hidden due to its pre-reflective character. Meaning can thus provide insight into what it is like to be a meaning maker as well as creating awareness of life-world phenomena (van Manen, 2014). This claim calls for an interpretative ontology, in which reality is constituted through being in the world, and an existential epistemology that accesses individual experiences.

In this dissertation, my aim is to explore what the lived experience of burnout is and how we can support individuals who suffer from burnout in their rehabilitation process. The research question provides the centre around which to build the methodology. Accordingly, the research question traces the development of thoughts and ideas that led to the adoption of the chosen methodological strategy and demonstrates the relationship between the research question and this methodology. I started to disclose how my theoretical worldview is interrelated with my motivation for this project. As part of the philosophical debate, related to what counts as knowledge and how we can know, I explained why this thesis calls for a hermeneutic ontology and an interpretative epistemology that allows in-depth exploration of lived experiences and meaning. In the next section, I will explain my choice of Merleau-Ponty's phenomenology as a strategy for understanding the lived experience of burnout.

2.3 Merleau-Ponty's philosophy for studying lived experiences

In my work on burnout, I am particularly inspired by the philosopher Maurice Merleau-Ponty's phenomenological approach and his theory of human existence as basically a bodily, inter-subjective and situated existence. This part of the text is mainly based on his work "Phenomenology of Perception" (Merleau-Ponty, 1945/2003) which I will refer to as (PP, p. xx) in what follows. Additionally, I will refer to the theoretical approach of gestalt psychotherapy that is founded on the phenomenological approach.

The notion of lifeworld is central in Merleau-Ponty's philosophy. Our lifeworld is the world we have access to through our bodies:

> The body is the vehicle of being in the world, and having a body is, for a living creature, to be intervolved in a definite environment, to identify oneself with certain projects and, to be continually committed to them. (PP, p. 94)

The lifeworld is phenomenologically both relational and personal, in that the person and the world co-exist. To be a human being in Merleau-Ponty's words is to be part of the world:

> The phenomenological world is not pure being, but the sense which is revealed where the paths of my various experiences intersect, and also where my own and other people's experiences intersect and engage each other like gears. It is thus inseparable from subjectivity and intersubjectivity, which find their unity when I either take up my past experiences in those of the present, or other people's in my own. (PP, p. xxii)

Our existence is thus also *situated*:

> In so far as I have a body through which I act in the world, space and time are not, for me, a collection of adjacent points nor are they a limitless number of relations

> synthesised by my consciousness and, into which it draws my body. I am not in space and time I belong to them; my body combines with them and includes them. (PP, p, 162)

While empiricist philosophers such as David Hume may agree with this, the difference is that phenomenology would deny any form of direct or naïve empiricism that assumes that we have neutral and direct access to an objective, mind-independent reality through our senses.

The phenomenological focus is to attend to the embodied consciousness of the lived experience of being human. Accordingly, the lived experience of health and illness can be understood within the phenomenological framework. The healthy body is transparent as we have a pre-objective sense of certainty that our body will support us in the activities that we engage in. This includes the experience of anything that happens in the flow of living, which involves our immediate, pre-reflective consciousness of life. This consciousness is a self-given awareness – an awareness that is unaware of itself. This way of understanding the lifeworld is fundamentally a pre-reflective way of being in the world. I will now turn to how this pre-reflective way of being in the world relates to experiences of health and illness.

In the usual course of events, the functionality of the body is taken for granted and not attended to. When experiencing illness, however, what the body is capable of doing is altered. Everything feels changed; the body does not only feel different, also, how it has been lived, what it has been capable of and how it has been experienced in the past, have changed. According to Merleau-Ponty, illness can be understood as a disruption of the lived body, which causes the sufferer to explicitly attend to his body as body, rather than simply living it unreflectively. When the body is no longer lived unreflectively, it is suddenly perceived as a thing that is external to the self.

> This representation of the body, this magical experience, which he approached in a detached frame of mind, was himself; he lived it while he thought about it. (PP, p.110)

In this moment, the body is transformed from lived body to object body. If I reflect on having a particular experience, then the reflective awareness removes me from the immediate lived experience. Likewise, the application of language to describe lived experience can only happen when standing back in some way from the experience. This objectification can be experienced as an alienation of the lived body.

Lived experience, being pre-reflective, is also a tacit form of knowledge. Therefore, we possibly know more than we can express:

> The union of body and soul had not been brought about once and for all in a remote realm; it came into being afresh at every moment beneath the psychologist's thinking, not as a repetitive event which each time takes psyche by surprise, but as a necessity that the psychologist knew to be in the depth of his being as he became aware of it as a piece of knowledge. (PP, p. 110)

Illness triggers a fundamental change in the relation between self and body where the body is experienced as a sensitive source of information. A person who suffers from burnout can be especially sensitive to bodily signals. We can for example recognise a bodily change without being able to describe exactly how the body is changed. This develops the idea of tacit knowledge as something that remains hidden, despite attempts to articulate what the bodily signals are that alert us. The hidden knowledge can illuminate how meaning can be attached to the lived experience without the person being aware of what the underlying tacit knowledge is. Therefore, when making claims to describe and interpret lived experience, it is important to realise that one can only access the knowledge that is consciously available through reflective awareness. Due to the tacit knowledge that is linked to the experience we have, it is however likely to contain meaning and interpretations of our lived experiences that remain implicit.

Despite being pre-reflective, tacit knowledge can become consciously available through the process of *contact*. In phenomenological terms, the interaction between the person and his or her phenomenal field can be described as a contact process.

> In the present dialogue I am freed from myself; for the other person's thoughts are certainly his; they are not of my making, though I do grasp them the moment they come into being, or even anticipate them. And indeed, the objection which my interlocutor raises to what I say draws from me thoughts which I had no idea that I

> possessed, so that at the same time that I lend him thoughts he reciprocates by making me think too. (PP, p. 413)

In the dialogue with the other, we become a dual being, where the other and I are no longer separate. We are collaborators for each other in a divine reciprocity. Gestalt theory embraces Merleau-Ponty's holistic view of the human being, conceptualized as existing in continuing interplay in the *organism-environment-field*. The organism-environment-field is defined as a systematic web of relationships, which can be described as a totality of mutually influencing forces that together form a unified interactive whole (G. Yontef, 1993). Out of this intersubjective field, "figures" emerge. The configuration of a figure against a ground displays the meaning, and meaning is achieved only through relations in the field.

> It is the darkness needed in the theatre to show up the performance, the background of somnolence or reserve of vague power against which the gesture and its aim[6] stand out, the zone of not being *in front of which* precise beings, figures and points can come to light. (PP, p. 115)

Thus, the relationship between the ground of the field and the figures that emerge is what gives meaning to the whole. In dialogue, our perspectives merge into each other and we co-exist through a common world. If we take language as both spoken and bodily expressed as an example, dialogue is destined to play a crucial role in our perception of others.

> In the experience of dialogue, there is constituted between the other person and myself a common ground; my thought and his are inter-woven into a single fabric. (PP, p. 413)

In this process, the awareness of sensations evolves into consciousness that in turn is mediated, preserved and integrated and results in a "new" organisation of meaning. My words and those of the other interact in a shared operation. The very fundamental understanding is that this new organisation, because of this process, is always an *emergent* phenomenon. The complexity of factors that influence each other always cause unforeseen effects in ways that are different from the mere sum of the factors that are in play. Therefore, we can never predict, dictate or control the shape of this new outcome. This phenomenological thinking may be considered a beginning expression of the organisation that emerges out of a multifactorial context, which I will concider in chapter five.

Perception is intimately linked to possibilities for action and is inseparable from the consciousness it has – or rather, that it *is* – of reaching the thing itself. As such, the body is situated and intends towards emerging figures that stand out from the ground in its environment. Thus, perception is the realization of my access to the world via my perceiving and inter-relational body that cannot be separated from my world. This unity can be seen as the seat of personhood. In the experience of illness, the significance of past, present and future is changed, which is experienced as a chaotic disturbance in the person's world. The experience is located in the person's embodied, intersubjective relations with others as much as it also occurs "in" the body.

The unity of the mind and the body is paramount; to be is to have a body that constantly perceives the situation of which we are part. The felt change in how the body is experienced can be difficult to accept because the body is the medium through which we interact within the world and express ourselves. Illness generates feelings of helplessness and represents a concrete loss of independence. This change is profoundly felt, not only as a loss of bodily integrity but also more importantly as a diminishment of selfhood. Thus, the disruption of the lived body strikes at the very self. Accordingly, human experience is a construction arising out of dynamics between self and world, partly expressed by the concept of *intentionality*. Stemming from the Latin "intendere", meaning to aim in a particular direction, intentionality captures the dynamic correlation between the person and the world. This correlation is based on the assumption that conscious individuals are always oriented towards something, even if tacitly.

> As soon as there is consciousness, and in order that there may be consciousness, there must be something to be conscious of, an intentional object, and consciousness can move towards this object only to the extent that it "deralizes" itself and throws itself into it [..] only if it is a pure meaning-giving act. (PP, p. 140)

Whereas our embodied capacities ordinarily provide the background to the figure of our worldly involvements, in illness the body becomes itself the figure of our intention against which all else is merely background. As perceiving subjects, we are always in a reciprocal connection to the context we at any time are engaged in. Our consciousness is underpinned by an *intentional arc* that projects around us our past, our future and, our human milieu. Thus, the intentional arc describes our relation to the world and focuses on the unity of the interaction between the individuals and their worlds. What we perceive is at any given time perceived from the specific point of view of a perceiving and situated individual. When "I cannot" is frequently confirmed, the certainty of "I can" can change into "I might be able to" due to the awareness of the experienced inability to act. When we are unable to act as before, the focus is on the kinds of things we are unable to engage in.

> Consciousness [..] is subtended by an "intentional arc" which projects round about us our past, our future, our human setting, our physical, ideological and moral situation, or rather which results in our being situated in all these respects. It is this intentional arc, which brings about the unity of the senses, of intelligence, of sensibility and motility. And it is this which "goes limp" in illness. (PP, p. 157)

In illness, our bodies are therefore no longer able to pursue our projects as we did when healthy. Recognizing the body becomes a deliberate focal point of attention. The body, in the words of Merleau-Ponty, is an *expressive unity*, which we can learn to know only by actively taking it up. As we no longer can ignore or take the body for granted, it must explicitly be attended to in various ways:

> We shall need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body, and in so far as we perceive the world with our body. But by thus remarking contact with the body and the world, we shall also rediscover ourselves, since, perceiving as we do with our body is a natural self and, as it were, the subject of perception. (PP, p. 239)

When healthy, we act in the present in light of more or less specific goals, which relate to future possibilities. Everything that affects my body affects me and becomes bodily if-then experiences. Thus, the lived body takes on this attitude in order to make predictions about the world. The notion of purposiveness and intentionality are essential to embodiment. In illness, bodily intentionality is thwarted when the “I can” is experienced as “I cannot”. Because the taken-for-granted, if-then causality of the body is interrupted, the purposiveness is also disrupted. This interruption results in a focus on the present moment and we become unable to effectively project into the future. In illness, we experience the situation as radically changing and perhaps forcing the enactment of non-habituated action due to the experienced changed character of lived temporality. When being unable to act as before, the person may become aware of the need to modify his or her actions. The primary perceptual relation between the body and object is that of giving form:

> If my body can be a “form” and if there can be, in front of it, important figures against indifferent backgrounds, this occurs in virtue of its being polarised by its tasks, of its *existence towards* them, of its collecting together of itself in its pursuit of its aims; the body image is finally a way of stating that my body is in-the-world. As far as spatiality is concerned, and this alone interest us at the moment, one’s own body is the third term, always tacitly understood, in the figure-background structure, and every figure stands out against the double horizon of external and bodily space. (PP, p. 115)

Sensory perception is already charged with meaning in that the object is always grasped as a significant whole against a background of co-perceived things. Any change to the “figure” results in a change in the “background” of the field. The field is dynamically changing, and the person is constantly engaged in contact processes to adapt to those changes.

In burnout, one figure that is immediately present and stands out from the ground is the perception of fatigue. The symptoms are located in embodied, intersubjective relations with others; they are experiences that are subjectively perceived. In contrast, when feeling well, our sensation of the body is part of the background. To perceive and be aware of an emerging figure is the act of contact. Thus, perception is the realization of my access to the world via my perceiving and inter-relational body. Bodily alertness implies that reflection is involved in almost everything we do. The cognitive capacity of the lived body can be understood in terms of a bodily knowledge that allows us to perform everyday activities and engage with others in meaningful ways. In this co-existence, we both direct ourselves *towards* the world, our actual environment, as well as being directed *by* the world, the situation and context we at any time inhabit.

Merleau-Ponty’s description of the lived body and its *comportment* in the world and relation to others offer a rich account of bodily integration. Comportment is a notion that emphasises the directed bodily activity in the world, rather than merely directed consciousness, and thus facilitates further distancing from any notion of person as separate from world. Even if my bodily style of being makes certain choices and decisions more likely for me than others, there is room for creative adjustments. When Merleau-Ponty insists that to be born is both to be born *of* the world and *into* the world, he captures how human beings exist in a double way of being both already constituted with a certain meaning and at the same time, constituting meaning themselves. Through its intentionality, the lived body grasps and relates to the world as a world of meaning. In search of meaning, we are ourselves the meaning-maker of the field. Existing is being constantly confronted with choices and decisions. In illness, the sufferer of burnout comes face-to-face with the radical contingency of his or her existence and the inescapable limitations of their embodiment. Freedom to act is situated in such a way that there is no freedom without a field – and since we as embodied subjects are of the world with which we are in constitutive relation, it is not outside ourselves – but rather inside ourselves – that we are able to find a limit to our freedom.

Phenomenology accepts that the human being is an agent who is in constant interaction with his or her environment, aware of phenomena such as the experience of bodily sensations in response to internal and external interacting factors. Within the interconnection between the person and the phenomenal field, the person may become aware of sensations of illness and *live through* the experience. According to Merleau-Ponty, living through means that I allow my bodily self to be *affected* by the situation. To be affected further involves that I become consciously aware of the experienced sensations. These sensations are in turn mediated, preserved and integrated. On the other hand, I may suspend the awareness of reality by withdrawing my bodily self from the situation. Absorbed in thoughts to distract from my sensations, I am no longer in a world of space and time because “the world is not what I think but what I live through” (op. cit., PP, p. xviii).

3.0 RESEARCH APPROACH

In this chapter, I will describe the research process of my study, which is founded on the research design decisions presented in chapter 2. I will start by explaining the methodological choice of this thesis.

3.1 The qualitative research paradigm

The major research methods fall under two paradigms: the qualitative and the quantitative. In my research I employ a qualitative approach, which can be defined as an "inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (Creswell, 1998, pp 1-2). Creswell further expands his definition of qualitative research as providing "a complex, holistic picture, a reference to a complex narrative that takes the reader into the multiple dimensions of a problem or an issue and displays it in all of its complexity" (Creswell, 1998, pp 15-16). Thus, the qualitative research method, understood in this way, is based on an assumption that reality is not objective but rather subjective, and that individuals create meaning from their lived experiences. The logic of the procedures in qualitative research is characterised as inductive, emerging and shaped by the researcher's experience in collecting and analysing the data. The inductive approach related to data collection emphasises the human experience rather than the theoretical perspectives of the enquirer (Creswell, 1998). Accordingly, the wider term *methodology* refers to how we acquire knowledge (Moses & Knutsen, 2012).

Both Merleau-Ponty's (1945/2003) and van Manen's (van Manen, 1990, 2014) ideas form the theoretical basis for much of contemporary work in phenomenological psychology. Phenomenology as method is consistent with the qualitative, constructivist research paradigm in accepting that the subjective processes of human experience provide a source of explanation for human action. In addition, personal descriptions of experiences and opinions are a legitimate source of research data (Creswell, 1998). Phenomenology aims to study lived and existential meanings and to describe and interpret them in their essence. This method employs a naturalistic inquiry that attempts to inductively and holistically understand human experience in context-specific settings (Patton, 1990), generating data rich in detail and embedded in the context. In this thesis, these philosophical theories do not just inform the phenomenological strategies; the findings that these methods generate are analysed using these phenomenological concepts heuristically. Phenomenology can be defined as a method of exploring subjective human experience as a whole, and the interpretation of this sort of research lies in the premise that "what is - is". In this thesis, my aim is to understand the participants' lived experience inductively and holistically in their contextual setting.

Before I present the procedures for recruitment, data collection and data analysis, as well as ethical and quality implications, I will identify my interest in the project and state how I – the researcher – am in the field (Creswell, 1998), making provision for reflexivity.

3.2 Reflexivity and perspectives from professional and lived experience

Heidegger's understanding of the *hermeneutic circle* (van Manen, 1990) is that it represents *being in the world* (Dasein) as a circular being, already embedded in presuppositions (Heidegger, 1953/2010). In this context, the hermeneutic circle refers to the nature of burnout and my means of how I interpret burnout as a phenomenon. Accordingly, it is impossible for me as a researcher to understand and operate from a detached perspective. Being in the world allows for meaningful engagement with the participants in this dissertation, which leads me beyond everyday understandings. Interpretative processes consequently involve breaking into the hermeneutic circle of being in the world to see beyond what may appear to me as plainly a thematic understanding, towards a closer connection with how the participants themselves make meaning of their experiences. The hermeneutic inquiry can therefore be taken both as a feature of being in the world as well as a device for the interpretation of human experience.

My entry into the *hermeneutic circle* (Schwandt, 2001) of the burnout experience started as a mentor and supervisor in corporate business when encountering employees who had "hit the wall". This role precipitated my awareness of burnout as a condition mainly to be handled by the managers in the companies that I worked for, although I also supported these individuals to be able to get back to work full time. This insight into the burnout experience gradually developed through listening to accounts of their experiences. During this hectic period when I worked and travelled a lot, I gradually became aware of recognising, and being able to identify, bodily signals of burnout myself. This process led me to develop a pre-conscious understanding of what it must be like to experience work-overload and pressure to perform that could result in symptoms of burnout. After ten years, I eventually ended up being burned out myself. This fact came unexpectedly – I would never have dreamt of this happening to me. In the words of Linda Finlay, I decided to start anew:

> Phenomenology invites us to slow down, focus on, and dwell with the “phenomenon” – the specific qualities of the **lived world** being investigated. (Finlay, 2011, p 3)

Being back to work again and seeing several clients in my clinical practice over many years who experienced symptoms of burnout, I recognised being aware of the six phases Moustakas (Moustakas, 1994) incorporated in his heuristic methodology. My clients’ experiences affected me deeply and, during these years, my dedication to give voice to their experiences gradually emerged. In fact, the PhD research process started long before I wrote my proposal. In the terminology of Moustakas, it started with the initial engagement phase where I tried to define and clarify burnout as a phenomenon and the question to be researched. Throughout the entire process, I needed to exercise awareness and check my preunderstandings. In other words, I had to pay attention to how I understood and had experienced burnout.

Although aiming at being able to maintain an open and receptive attitude toward the burnout experience, I was aware that a starting point free from presuppositions was unachievable. In the *immersion* phase, I fully lived the research subject while awake, asleep and dreaming. In the *incubation* phase, I retreated from the research subject in order to facilitate tacit, intuitive and unconscious processes that would take the research subject forward. The *illumination* phase involved the emerging of new awareness and insights leading to a synthesis. The *explication* phase is where I gathered ideas, insights and data to fully understand what I wanted to explore and frame a research question. Finally, I experienced a *creative synthesis* phase as a tacit and intuitive process of how I wanted to tell the story. Through these phases, I can recognise how I prepared myself to be immersed in the research project and how this process enabled and guided me to frame the research question. I fully acknowledge how this process demands a passionate but disciplined approach and commitment.

In the PhD project, I have applied the phenomenological attitude, recognised by epoché as well as reflexivity (Finlay, 2011), and used phenomenological theory as outlined by (van Manen, 1990, 2014) to answer my research question.

3.3 Research design

3.3.1 Participants and recruitment procedure

I contacted my professional network for support to recruit interviewees shortly after having received the Norwegian Centre for Research (NSD) authentication for the project. During winter and spring 2015/2016, I conducted eight interviews and transcribed the interviews verbatim. The data analysis was my main focus during the months from autumn 2016 until summer 2017. Due to practical reasons, the project was carried out in the Oslo area (Norway). I contacted 10 psychotherapists and 10 general practitioners (GP) from this area. I also contacted a senior advisor at the NAV Employment Centre in Oslo and asked if he could help to recruit participants for the project. They were all given written information about the project and a handout for their patients/clients with contact information (Appendix 1). None of the GPs responded and the contact person at NAV dismissed the request because “it could lead to a conflict of confidentiality”.

Eleven individuals contacted me and were invited to a personal information meeting. The aim of this meeting was to present the project and give information related to the volunteers’ role as interviewees as well as making sure that they fulfilled the selection criteria. These criteria selected for individuals between 25 and 65 years who had been employed at least at an 80% position and had been on sick leave for more than 52 weeks prior to the interview. In addition, their burnout symptoms were consistent with Exhaustion Disorder according to ICD-10, F43.8A. Two men and six women fulfilled the criteria and agreed to participate as interviewees. In addition, they were invited to keep a personal diary during the fortnight prior to the interview. Keeping a diary was optional and was introduced as a tool for reflecting on the lived experiences of their situation. It was, however not intended to be part of the research material except for what they chose to share with me during the interview.

3.3.2 Short description of the participants

The participants were between the age of 36 and 65. They held working positions within IT, marketing/sales, healthcare, management and consultancy/freelance/art-design. All except for one were in a relationship with a partner. Four of them had experienced symptoms of burnout previously and been sick listed for shorter periods related to these symptoms. All of them had been sick listed between 1 to 6 years prior to the interview, and all the participants except for one had been in psychotherapy for a period.

3.3.3 The interview and data collection

The method for collection of research data was semi-structured interviews (N. Denzin & Lincoln, 2000) to uncover how the participants made meaning of their situation. Lived experience is mediated either by language, conversation or in writing (Van Manen, 1997b) . In seeking narratives and nuanced descriptions, interviews can put behaviours and feelings in context and provide me as researcher with alternative ways of understanding the meanings of the experience (Brinkmann & Kvale, 2015). Phenomenological interviewing assumes that human beings are naturally driven to make sense of their experiences and that their understanding is to be found in their narratives of experience (van Manen, 2014).

As addressed in the first meeting with the participants, the focus of the dissertation was to explore their lived experience of burnout. I informed them that I was interested in how they experienced the symptoms of burnout and what factors they experienced as enhancing or restricting their rehabilitation process. All of them mentioned the diary at the start of the interview and some referred to it during the interview. There are clearly some limitations associated with interviewing and, importantly, interviews may not reveal tacit or pre-reflective knowledge, even if probing can help bring hidden elements of experience to the surface (Brinkmann & Kvale, 2015).

Phenomenological research approaches and clinical gestalt psychotherapy share a common philosophy in attending to and acknowledging human experience. A common ground seems to be the “I-Thou” relationship (Buber, 1958/2000). During the interviews, an important consideration was to meet the participants in reciprocal humanity, while being aware that the interaction would influence the dialogue. To me, the importance of this meeting was to respect the participants as separate from myself and accept and confirm the other as he or she is now, rather than wanting the other to be different, or using the other as a means to an end. During the interviews, my awareness was of the "here and now" (Perls et al., 1951/1998) as a researcher – not as a psychotherapist. I was however aware that my practice as a gestalt psychotherapist could be utilised to enhance, support or facilitate a deeper meaning of what was happening in the “here and now” when exploring the participants’ lived experiences. This includes seeing the participants in the context of their entire "field"; behaviour is a function of the total field that includes both the participant and his or her environment. Additionally, a holistic approach is one of the cornerstones of my clinical practice. And I agree with Mackewn when saying: "you cannot divide a person into parts in order to study or treat that person without rendering meaningless the very entity you hope to get to know; for the whole is more than and different from the sum of its parts (Mackewn, 1997, p 43). In other words, the scrutiny of isolated parts of the organism leads only to an understanding of those parts in isolation.

During the interviews, which lasted between 90 and 180 minutes, and throughout the data analysis, the intention was to allow any emotions, patterns and themes related to the participants' experience to emerge naturally, rather than starting from a list of predefined themes. In this process, the aim was to open up for meaning, in addition to exploring, and to elaborate on the participants' pre-reflective lived experience. To capture the interviewees' experiences about the subject in question, I asked clarifying follow-up questions to check my understanding of what they were saying. I was aware of the importance of not imposing any a priori categorisation on them that could limit either the field of enquiry or their ability to choose whatever words they want, to make sense of their experiences.

An important consideration in this study was to give full attention to the meanings and values of those interviewed. Engaging empathetically with the participants offers the potential to reveal otherwise hidden aspects of experience through, for instance, sending my interpreted understanding back to the interviewee and thereby probing my understanding to make meaning more explicit (Brinkmann & Kvale, 2015). By remaining mindful of these very challenging aspects of interviewing associated with tacit and embodied knowledge, I aspired to represent the participants' experiences as faithfully and sensitively as possible. I achieved this partly by paying attention to what participants said and how they responded, including body language, and partly by considering my own bodily and cognitive reactions.

During the interviews, I was aware of feeling a deep emotional connection to each of the participants, feeling moved when they described how their experiences affected them. Their emotions and their tears touched me, and I was aware of how many of their experiences paralleled mine. This insight reminded me of holding back my own concerns, to be available for listening to how they made meaning of their experiences. As one of the main symptoms of burnout is fatigue, I encouraged the participants before embarking on the interviews to ask for breaks whenever they needed a timeout to relax.

Towards the end of the interview, I offered the participants the opportunity to draw a *rich picture* to metaphorically describe their lived experience related to their rehabilitation process. The question I raised was "How do you experience being yourself in the rehabilitation process just now?" Rich picture as technique is used in systems thinking and originated as a way of identifying multiple viewpoints of a situation (Berg & Pooley, 2013). From my own clinical practice, I have experienced that drawing opens up for intuitive consciousness, which is communicated more easily via impressions and symbols than in words. Six of the participants agreed to symbolise their experience by drawing in silence and then describe the drawing to me afterwards. The other two chose to portray the metaphor that emerged in words. Some of the participants provided sketchy descriptions that revealed little detail while others provided rich pictures that I directly experienced as a window into their lived world. Despite the lack of richness in some of the pictures, the reflection on what they had drawn provided information that could have been more difficult to obtain by interviews alone. Hence, on reflection, the combination of these distinct methods, the diary and the rich picture drawing, helped to meet variations in participants' personal style and seemed to offer a nice tool for expressing and reflecting on their own situation. The narratives provided by the images are part of the transcribed interviews.

Due to their illness, the participants were given the opportunity to choose the venue for our meeting. I conducted four interviews at my office and the other four at the participants' homes, and I transcribed the audio-recorded interviews verbatim directly after the interviews. The participants were issued with a copy of their transcript. They had the opportunity to not only read but also amend the transcript if they wanted to do so for whatever reason. Two of the participants took this opportunity to make parts of their narratives more explicit. The participants initiated these contributions by providing me with written material that we talked about on the phone. In total, I transcribed approximately 240 pages and spent a total of approximately 20 hours interviewing the participants.

3.4 The phenomenological method applied

There are several different ways of doing a phenomenological data analysis. In this dissertation, I am inspired by the interpretative phenomenological analysis (IPA) of Smith, Flowers & Larkin (2009) to structure the analytic process. My experience is that the inherent systematic approach allowed me to contribute with more confidence to the evidence base of my research. I have however, not applied the IPA as a prescriptive approach, but rather tried to be flexible and creative by drawing on van Manen's (van Manen, 1990, 2014) hermeneutic phenomenological reflection.

The typical feature of phenomenological analysis involves the researcher adopting a phenomenological attitude, reading the whole data for meaning and working closely with the details, and thus engaging with both the parts as well as the whole (van Manen, 2014). As an act of insightfully “seeing” meaning, rather than being a rule-bound process (van Manen, 1990), a deeper analysis of the individual lifeworld (Finlay, 2011; van Manen, 2014), and a move from description to interpretation are enabled. Typically, analysis has been described as an iterative and inductive cycle (J. A. Smith et al., 2009), which proceeds by drawing upon a set of strategies. Although the analytical process was experienced as far from linear or comprising such discrete stages as presented in the text below, I will in the following present it systematically. The following sub-sections are organised around some listed elements to show the development of understanding throughout the analytical process.

3.4.1 Reading and re-reading, and initial noting

There is generally not a precise point at which data reduction ends and analysis begins (Patton, 1990). Although interpretation began during the interviews with active attempts to make sense of participants’ responses, this discussion focuses on the subsequent immersion in the data and development of understanding. The process of reducing the volume of data is actually part of the process of making sense and forming ideas about the text. I see the transcription of the audiotaped interviews verbatim as an important part of this process, which helped me get closer to the content of what was being said. I started to read and re-read the transcribed text case by case. I immersed myself in the participant’s lived experience, while listening, reading and reflecting on the meaning of what he or she shared in the interview. My aim was to grasp the meaning behind the words in the text.

3.4.2 Descriptive comments

I highlighted particular sections of the text and made comments in the margin related to thoughts and questions that emerged. I used remarks mainly in the first sweep of analysis to summarise line-by-line what each statement revealed about the lived experience of burnout that could be conceptualised in a broader sense and ultimately to facilitate development of main themes. This applied to all the eight texts. I also added an extra column to record personal observations and comments on the interview process that occurred to me while working with the data. I also considered each individual interview in the initial stages of analysis. Through this initial noting, I explored the semantic content and surfaced my preunderstanding and potential prejudices. As I am part of the field, it is challenging to be able to set aside one's own presumptions about how this phenomenon could be understood. Therefore, my intention was to keep a stance of openness towards the participant's expressions of his or her experiences.

Because I had previously experienced excessive symptoms of burnout myself, I was especially aware of the need to take into account my own preunderstanding to be able to "hear" how the participants made meaning of their experiences. This process of re-living what the participants expressed affected me more profoundly than during the interviews. When re-living their words, their pitch of voice and their body language, I also recognised my own pain. When leaning back and just listening, I opened up for being able to take in their narratives in a new way. Reflecting on why this happened retrospectively, I became aware how profoundly their stories had touched me and how I had to hold back my own reactions during the interviews. During the process of analysis and writing, I felt vulnerable, experiencing feelings of frustration, anger and sadness. These emotions obviously paralleled the emotions experienced by the participants. During the research process, I was lucky to have the opportunity to vent my emotional reactions, having access to supportive colleagues in my supervision group. Being immersed in this activity was a very slow process in which I fully lived the research subject.

3.4.3 Developing emergent themes

In the non-linear process of analysis and interpretation, I was concerned with the multi-level, dynamic relationship between the part and the whole of the empirical material, while primarily emphasising the individual lifeworld (Finlay, 2011; van Manen, 2014). I used the data analysis as a process for uncovering meaning. As part of this process, I identified key phrases and meaning units and clustered them into themes. In doing so, I applied hermeneutic reflection as outlined by van Manen (1997), which involves practicing heuristic activities, including phenomenological reduction and reflection on the meaning of lifeworld experiences. The themes that emerged were listed separately in another document in a coherent order.

3.4.4 Searching for connections across emergent themes

I searched for connections across the emergent themes, attempting to identify common links between them to reorder and restructure them, while continually returning to the emergent themes to check consistency. The process of abstraction, synthesis and theme development helped me map how these themes fit together. Collective findings were synthesised through a process of writing and re-writing as insights and understandings developed and deepened. This writing process involved reducing the number and transforming the emergent themes into fewer, more super-ordinate themes. This reflects the creative role that writing played in the analytical process (van Manen, 2014). These super-ordinate themes exemplified the nature of the described lived experience and provided the lifeworld material for the phenomenological inquiry.

3.4.5 Moving to the next case and looking for patterns across cases

Moving between cases, I tried to bracket previous themes and stay open-minded. This was to ensure that I did justice to the individuality of each new case. I repeated this procedure for each case until I had produced a final table of themes. I then started to look for patterns across the eight cases capturing a suitable ordering of the key emergent themes for the group as a whole. In this process, I was surprised by the similarities among experiences and by how easily the themes across the eight transcripts fit together.

3.4.6 Taking it deeper: Interpretation and merging themes

Up to this point in the work with the empirical material, I have primarily been moving *from* the particular *to* the more holistic perspective. When digging deeper into the text, finding a particularly resonant part, I moved in the other direction to a more detailed reading to grasp meaning. In phenomenological writing, lifeworld experience descriptions are re-written and tightened to show, rather than tell, the meaning of the experience. Van Manen (2014) refers to this crafting process as writing anecdotes, which intends to speak to our imagination and give us a flavour of the phenomenon. “A phenomenological text is ultimately successful only to the extent that we, its readers, feel addressed by it… the text must reverberate with our ordinary experience of life as well as with our sense of life’s meaning” (Van Manen, 1997b, p 26). Although human experiences are always more complex than what is captured by words alone, the text as a whole is intended to represent the findings of a phenomenological exploration (Merleau-Ponty, 1945/2003; van Manen, 1997).

The writing process aided and deepened my understanding of how the participants made meaning of their experiences with burnout, which in turn led to four shared experiential themes across the cases. These themes were:

1. Unhomelike being in the world and being stuck in a black hole
2. The limit of diagnosis and the continuous battle in a limbo position
3. Naked in the eyes of the public and feeling of shame
4. Deciphering the future horizon via the path to hopelessness

These experiential themes are linked to the transcribed text through reference to specific page and line numbers. The result of the thematic reflection is an account of my interpretation of how the participants are thinking, which is referred to as the ‘double hermeneutic’ (J. A. Smith et al., 2009).

In the process of reflective writing, the *experiential* themes were interpreted further into textual descriptions. They were developed as a description of an aspect of the experiences, which were found in each cluster of meaning units. Accordingly, these *descriptions* embrace the *meaning structures* of the experience. These textual descriptions provide the evidence for the participants’ lived experiences and make the result of the analysis transparent. The content of the *textual descriptions* was checked against the transcripts before translating them into English. The textual descriptions were analysed further and discussed in three of the papers (no. 2, 3 & 4).

3.5 Ethics and other considerations

3.5.1 Ethics

The Norwegian Centre for Research (NSD no. p469) approved the project in May 2015 (Appendix 2). As a member of the European Association of Psychotherapy (EAP) and the Norwegian Gestalt Association (NGFO), I also adhere to the approved ethical guidelines related to clinical practice as well as when conducting research. Both the EAP and NGFO represent and sustain the highest professional standards for the free and independent practice of psychotherapy and uphold rigorous standards of competence and professionalism.

Prior to the interviews, both verbal and written information about the dissertation were given to the participants in separate meetings, and all of them in the first meeting signed written voluntary informed consent forms (Appendix 3). I informed the participants of the possibility of withdrawing if they wanted to discontinue for whatever reason. Clear boundaries were set about the context of the research project, the research process and how the findings would be reported. Confidentiality was considered at all times during the process. According to the standards set out by the Norwegian Centre for Research and the University of Oslo (UiO), all data were stored in TSD (services for sensitive data). I created a scrambling key, which is a list of names that makes identification of individuals possible in a data set. Creating a scrambling key entails removing names, social security number, email address or other directly identifiable information in a data set, and replacing them with a fictitious name, referring to a separate list where each code refers to a specific name. The scrambling key has been stored separately from the data material in order to keep outsiders from gaining access to link between names and codes.

In designing the study, the participants' vulnerable situation (being on long-term sick leave) was given special consideration. I acknowledged that the research process could cause painful awareness of their situation, and therefore the participants were informed about the opportunity to come back for a debriefing session if they experienced excessive emotions as a response to what was brought up during the interview. However, this situation did not occur.

I see ethics and credibility as interconnected: the way in which I encountered the participants was a critical aspect of data gathering that could potentially affect the quality of the research project. Therefore, it was important to ensure that the participants felt safe and comfortable about exploring their situation and that my conduct and engagement in the process was trustworthy. As a researcher, I need to be aware that the relationship between the participant and myself is one where complex ethical concern might arise. There seem to be some common ethical challenges in dealing with relationships in clinical practice and supervision, as well as when researching lived experience. For that reason, it takes special training and skills to understand the complex emotional and intellectual forces that influence the conduct of relationships, be it in research or in psychotherapy (G. Yontef, 1997, 2002). Here my professional background as a consultant and a psychotherapist gave me an advantage in the interview situation, since these ethical concerns are something I am trained to consider.

Interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives. Non-verbal cues may convey messages that can help in understanding the verbal response. To make constructive use of this flexibility calls for considerable skill and experience in the interviewer. Hence, the ethical challenge rests on my professional expertise and responsibility as I interact with the participant during the interview and with the data during the course of analysis.

3.5.2 Credibility and trustworthiness

The concept of validity has been controversial in qualitative research. Researcher bias and the effect of the researcher on the participants, also referred to as reflexivity, is mentioned as two main types of threats to validity (Maxwell, 2013). Hermeneutic phenomenology research aims to represent the experience under investigation as closely as possible to how the participants experience it, while recognising the interactions and overlapping perspectives between researcher and participant. The researcher as interviewer, analyser of data and author of the resulting narrative, purposely becomes a vital part of a study. Therefore, I paid attention to the need for increased awareness of integrity and accountability regarding the relational research process. To be able to manage the power imbalance and being aware of the subtle abuses that can occur is, in my opinion, the very critical hallmark of practical, ethical performance.

Another common problem for phenomenological researchers is to be challenged in defending that the conducted research project is based on phenomenological methodology (van Manen, 2014). This problem may be related to the critique raised against van Manen’s work (van Manen, 1990, 2017a, 2017b, 2018) as well as Smith’s work (J.A. Smith, 2018; J. A. Smith et al., 2009) for promoting confusions concerning the nature of phenomenology (Zahavi, 2019). In general, the critique has been raised that phenomenology as a qualitative research method is radically under-specified – lacking an implicit theory of “meaning” (Paley, 2017). This problem is related to the lack of standardisation, which might raise concerns about reliability. Consequently, concepts such as trustworthiness, authenticity and quality are often used as alternatives to validity and reliability, as they seem more appropriate for evaluating qualitative research. The credibility of qualitative research can be demonstrated by its persuasiveness and plausibility. In hermeneutic phenomenology, these qualities resonate within a phenomenological description that demands a phenomenological nod, affirming recognition of the interpretation (van Manen, 1997).

This section summarises my attempts to achieve credibility through ensuring the ethicality and trustworthiness of findings. For purposes of critical reflection, I have tried to make my subjective position transparent, including my pre-understanding and interpretative efforts. I have made my theoretical, methodological and analytical choices explicit, as well as offering the motivation behind these choices. With this, I hope to have demonstrated the project's coherence as a hermeneutic, phenomenological dissertation.

4.0 SUMMARIES OF THE PAPERS

The dissertation consists of five papers. The first was based on the empirical material of my MSc dissertation (Engebretsen, 2003). The data for this article was collected through six interviews with two men and four women who suffered from symptoms that could indicate burnout. The research question was "How do the experienced symptoms of burnout influence the process of burning out?" The interviews were carried out during the autumn in 2002. To explore the subjective experience of the participants' condition the data was analysed through an interpretative phenomenological analysis (IPA) and discussed in the context of existential phenomenology and gestalt theory. My intention behind including this article in the PhD thesis as a source of information was twofold. Firstly, the findings in the MSc dissertation provided new knowledge of burnout as an intersubjective, lived, contextual and temporal experience. Secondly, the gestalt therapeutic method was useful for gaining a deeper understanding of the causal mechanisms that seem to influence the temporal process of burnout. Additionally, the results from the MSc dissertation motivated the research question for the PhD project.

In articles two, three and four the meaning of the participants' lived experiences was explored using a life-world approach to existential phenomenological reflection and writing. I interviewed eight individuals who experienced burnout, two men and six women. They had all been on long-term sick leave (>1 year) due to symptoms of fatigue and pain and fulfilled the criteria for Exhaustion Disorder (ICD-10, F43.8A). Their symptoms were not medically explained and almost all the participants were labelled as depressed by their GP. The fifth contribution to the thesis is a book-chapter where I reflect on the clinician's role in the clinical encounter and the empirical data presented there is based on a case study from my clinical practice.

Summary of paper 1

Burned out or "just" depressed? An existential phenomenological exploration of Burnout

An increasing number of patients are on sick leave from work due to fatigue- and pain-related symptoms that could indicate burnout. The aetiology is unknown and recently it has been considered whether burnout should be a distinct medical diagnosis or "just" a form of depression. Little attention has been given to these individuals' experiences. Therefore, a phenomenological study was conducted to explore burnout from a first-person perspective.

The aim was to obtain a deeper understanding of the lived experience of burnout. Semi-structured interviews were chosen to uncover how the participants made meaning of their situation. An existential phenomenological method was applied because this approach is especially relevant when the aim is to explore burnout as an intersubjective, lived, contextual and temporal phenomenon. We are inspired by Merleau-Ponty's phenomenological approach and gestalt theory. The phenomenological focus is to attend to the embodied consciousness of the lived experience of being human. An interpretative phenomenological analysis (IPA) was utilised to uncover how the interviewees made meaning of their situation. Six individuals who had been on sick leave at 50-100% for at least three months due to fatigue- and pain-related symptoms were interviewed.

Four narrative phases mirroring burnout as a temporal sequence stood out: Achievement, Pressure, Psychosomatic Collapse, and Personal Meaning and Reorientation. During the transition from functioning well in society to becoming unable to meet society's expectations for achievement, several complex factors that seemed to boost the interviewees' ability to continue striving beyond their limits led to a fatigue reaction. During the Achievement phase, the participants experienced distress caused by a mixture of work overload and lack of support. The findings revealed how an absorbing commitment to achievement can be fuelled by a toxic introjection of not being "good enough". Subsequently this finding points to how performing well is related to an identification with their jobs and, in turn, became their identity as human beings as well. During the Pressure phase, they became more consciously aware of feeling exhausted. Although they felt distressed, they continuously made efforts to cope. They continued their frustrated strivings and "deflected" from their situation, which resulted in a lack of concern for taking care of themselves by desensitising their bodily needs. Experienced agency shifted during the transition from powerfulness to powerlessness that marked the Psychosomatic Collapse Phase. The interviewees described feeling guilt, frustration and self-directed aggression for being a burden to their families and to society. The association between shame and inferiority becomes particularly amplified in the context of our achievement-oriented society. When no longer able to perform and meet the conventions of the society, a negative self-esteem was confirmed. During this process, they felt worthless and angry towards themselves, which we argue can be interpreted as episodes of narcissistic depression. This finding describes self-hating depression, which is characterised by shame about the self and is distinctly different from depression caused by grief due to a loss.

Although the interviewees mentioned some episodes of feeling depressed, they did not see themselves as depressed, rather as frustrated and angry. Thus, based on the findings in this study, we question the claim that the focus of public health policies should just consider what is held to be the depressive core in burnout. The interviewees expressed concerns about being unable to justify their sensation of illness and the findings indicate that the dynamics of contact in the intersubjective field can have affected the participants' existence as bodily subjects. The lack of societal recognition of their condition seems to have seriously affected the process of contextualizing the illness and in turn negatively affected the healing process. Thus, the study contributes to a deeper understanding of how complex psychosocial factors can influence individual vulnerability and ultimately lead to a fatigue reaction.

Summary of paper 2

Suffering without a medical diagnosis. A critical view on the biomedical attitudes towards persons suffering from burnout and the implications for medical care.

A biomedical model encourages a reductionist diagnostic practice and a dualist split between physical and psychological symptoms. This fact can be the reason why the search for causal explanations in medically unexplained syndromes such as burnout has not been resolved by evidence-based medicine. The clinical guidelines mirror what counts as knowledge in medical inquiry, which in turn is mirrored in the attitudes towards individual patients. One challenge for understanding burnout is therefore related to the lack of clinical guidelines, due to its unknown aetiology. Thus, diagnosing and treating these syndromes is a challenge related to what counts as knowledge in medical inquiry and medical care. The Norwegian government expects medical efficiency to decrease long-term sick leaves. Treating depression medically has a documented effect. Depression is a common aspect in burnout and, as a result, clinicians often diagnose burnout patients as depressed. This practice may pose threats to the increasing number of individuals experiencing burnout.

The aim of this article is twofold: firstly, to assess how the values that accompany the biomedical paradigm affect clinical care, and secondly, to argue for a genuine person-centred approach to replace the biomedical model. In the study, which this article is based on, an existential phenomenological method was applied. Eight individuals, who experienced burnout, were interviewed. They had all been on long-term sick leave (>1 year) due to symptoms of fatigue and pain and they fulfilled the criteria for Exhaustion Disorder. Their symptoms were not medically explained and almost all the participants were labelled as depressed. In the article, I focus on two main problems; firstly, how the mismatch between the patient's experience of his or her illness and the doctor's interpretation of the condition can lead to ineffective treatment. Secondly, on how the interviewees struggled to be recognised as ill. I argue that the values that go along with the biomedical model and the accompanying reductionist and dualist ontology have implications for clinical care.

Within the framework of evidence-based medicine and the biomedical model there is a limited acceptance of heterogeneous, subjective health complaints with an unknown aetiology. As a result, the needs of the patients remain neglected. Accordingly, there seems to be a need to re-discover the perceived world to explore the burnout phenomenon further. Both mechanisms and the whole person should be understood as individual, relational, and contextual. A way forward for supporting persons that suffer from burnout is to move away from the biomedical framework and its underlying ontology and inherent values, and instead approach burnout from a phenomenological perspective. The implicit knowledge provided by phenomenology ought to be made explicit and taken into account.

There are several consequences of a phenomenological paradigm for how the person is perceived and how treatment is engaged. In a phenomenological framework, the owner of the subjective experience is recognized. The main point here is to take the subjective lived experience of the condition back to "the owner" and not classify the symptoms based solely on the view of a medical expert. When the patient's status as a knower is disregarded, the person may perceive him or herself as stigmatised. Existential phenomenology, as an approach to our humanness, offers in contrast a genuine person-centred approach to medical care. From that perspective, the health care providers' role is to provide support for what the person really needs and to help frame the person's situation.

Summary of paper 3

Naked in the eyes of the public: A phenomenological study of the lived experience of suffering from burnout while waiting for recognition to be ill

Although there has been a focus on problematic issues related to healthcare services and complaints made by patients, individuals who suffer from medically unexplained syndromes continue to report being epistemically marginalized or excluded by health professionals. The focus of this article was to explore how sufferers from burnout experienced being encountered by the healthcare system and NAV. The context within which these encounters took place is coloured by the social and political norms set by the biomedical model and evidence-based medicine. Due to the unknown aetiology of burnout, the clinical guidelines can provide no answer to their condition and their subjective health complaints were labelled as psychopathological.

The aim of the article was to uncover a deeper understanding of how the clinical encounter affected the lived experience of suffering from burnout. Therefore, a phenomenological approach was chosen to inductively and holistically understand the human experience in this context-specific setting. Semi structured interviews were conducted with two men and six women between 25 and 65 years of age, who had been on sick leave for more than 52 weeks. Their symptoms were consistent with Exhaustion Disorder. The meaning of the interviewees' lived experience was explored using a life-world approach to phenomenological reflection and writing.

The participants had experienced being ill for a long time. Feeling seriously ill without recognition of their situation triggered an existential anxiety. Their perception of pain was located in their embodied, intersubjective relations with others as much as the pain also occurred "in" their bodies. The participants described their experience of encountering the general practitioner as taking part in a battle. Feeling seriously distressed without recognition of their situation triggered an existential anxiety, frustration, despair and hopelessness. This fact seemed to result in a disconnection from their habitual lifeworld, which in turn triggered a shame reaction. Being transformed into persons that were unknown to themselves elicit a feeling of lost control and loss of agency. Additionally, the study showed a possible distrust related to several communication levels within the healthcare system, which influenced the recovery process negatively. Lack of experienced support can lead to exacerbated feelings of distress. Gradually the participants lost sight of a life worth living.

Although their basic need was to feel supported, shame could have hindered supportive interaction. The need to withdraw from interactions with others and themselves became acute. It was however not possible to escape, because perception via their perceiving inter-relational bodies could not be separated from their worlds without literally leaving the world. Three of them explicitly considered suicide as a way out. Accordingly, the psychosocial experience of being ill may be as important as its unknown aetiology. Therefore, in the context of these interpersonal relations both norms, values and attitudes as well as issues of power, need to be considered and addressed properly.

Summary of paper 4

Out of chaos – meaning arises. A phenomenological study of the lived experience of re-habituating the habitual body.

The starting point of this article is how the habitual body, as suggested by Merleau-Ponty, can be experienced quite differently when suffering from burnout than how it has been lived in the past. In illness, these two layers of the body become the temporal point where the past, the present and the future meet. The narratives show how the participants experience a sincere bonding to their lost lifeworld, which seemed to result in their holding on to their previous worlds while simultaneously trying to unleash themselves. The illness obstructs their ability to live assumptions about their bodily existence as well as being unable to free themselves from the facticity of their condition.

The aim was to explore how sufferers of burnout who have been on long term sick leave (>52 weeks) deal with the process of coming to terms with their present body – the lived body as ill. Therefore, a phenomenological approach was chosen to inductively and holistically understand the human experience in this context-specific setting. Semi structured interviews were conducted with two men and six women between 36 and 65 years of age, who had been on sick leave for more than 52 weeks. Their symptoms were consistent with Exhaustion Disorder (ICD-10, F43.8A). The meaning of the interviewees' lived experience was explored using a life-world approach to phenomenological reflection and writing.

Four experiential dimensions were discussed: "Trapped in the present body", "The balancing act", "Precious moments of joy" and "This is my Lifeworld now". When unable to fulfil the desire to enact habitual actions, loss of future possibilities was experienced as a constriction of their lifeworld. The narratives highlight how the very nature of the body as being in the world was transformed, and the fundamental unity between the body and themselves was experienced as disrupted. The disruption of the lived body is not merely experienced as a breakdown in the mechanical functioning of the biological body. As the participants' lived experiences show the significance of past, present, and future has changed, which seemed to be experienced as a chaotic disturbance in the participants' world. Our phenomenological analysis points to how the participants' situation was experienced as radically changing, which seemed to empower non-habituated action and movement. Even if their bodily style of being makes certain choices and decisions more likely for them than others, there seems to be room for creativity.

As our study indicates, the lived body possesses its own operative intentionality of habituated actions where the interaction between the participant and his or her environment-field is a contact process. Through this process, meaning emerges. We saw that the participants managed to engage with others despite struggling to survive. This is especially evident in the participants' experienced precious moments of joy where an awareness of well-being seems to become conscious over time. Their mode of being-with-others seems to form and constitute their lived experience positively. In search of meaning, the participants became aware that they themselves were the meaning-makers of their lives – and out of the existential chaos, new meaning appeared. Further, as our phenomenological analysis shows, the inherent human ability to adjust to the never-ending temporal processes of life seems to take place as the participants demonstrated deliberate choices and reflective self-cultivation to adjust to their present situation.

By being able to demonstrate new habitual actions, the participants may be able to constitute a "new" defined self, which in turn can result in a re-habituation of the lived body. For some of them it was still very difficult to accept that a chapter of their life had been terminated. The findings suggest that the biomedical understanding of burnout do not adequately capture the personal experience of the syndrome, which in turn restrains the participants' ability to integrate the bodily experience of burnout into their lives. They expressed hope, however, that they would be able to come to terms with their present situation. Thus, the existential breakdown seems to provide a starting point for rehabilitation and self-acceptance, which can enable return to work.

Summary of paper 5

Reflections on the Clinician's Role in the Clinical Encounter

How we as clinicians encounter our clients or patients is mirrored by the ontological stance we are taking and the epistemological question “how do we know”. Some years back in time, I started wondering about the underlying motivation for the ontological and epistemological choices I had made in my search for answers to how I practice gestalt psychotherapy. In this text, I address what I hold as the fundamentals of a genuine “person-centred” approach to the clinical encounter and address two pertinent questions; the first one is how important the clinicians’ role in the clinical encounter is, and the second is how the clinician can contribute to the encounter with the client in positive or negative ways. I start with the first one, which addresses how important the clinician’s role is within the clinical encounter.

Gestalt psychotherapy is rooted in an existential-phenomenological worldview where all events are a function of the relationships between multiple interacting forces where no event occurs in isolation (G. Yontef, 1993). If we apply this view to the clinical encounter, any therapeutic process is a function of the relationship between the interacting therapist/doctor, client/patient and the field as a whole. Thus, the field is co-constructed as an integral part of the therapist/client experience, which will have an impact on the possibilities for different outcomes of the process. Thus, the dialogic encounter can be seen as an emergent phenomenon where the client and the therapist are mutual manifestation partners for the outcome of the therapeutic process. Gestalt psychotherapy is based on the meeting between the therapist and the client as the central healing mode. This means a healing through meeting in reciprocal humanness. In this view, it is important to acknowledge the clinician as a person, with everything that he or she brings to the clinical encounter. Therefore, a relational approach requires careful and consistent observation of all the data in the field including my own processes, values and beliefs as a therapist. This leads us to the second question, which addresses how the clinician influence the encounter in positive or negative ways.

As part of the therapeutic process, I am not only engaged as a supportive ground, but as a co-participant as well. When “acting” as a tool in the therapy process, the client and the therapist are intertwined in each other’s worlds and actively co-create the shared perceptual field of the therapeutic relationship. Therefore, from a dialogic perspective, the client’s lifeworld processes cannot be interpreted as emanating from the client in isolation but must be seen as emerging as part of an inter-subjective relational system. In my experience, relating objectively to phenomenological data constitutes a major challenge, even for well-trained psychotherapists. When the therapist is unconsciously drawn into phenomena such as transference and countertransference the outcome of the therapeutic relationship can in best case be ruptured and in worst case be quite the opposite of therapeutic. Therefore, I see supervision as crucial when working dialogically. The case study I presented in the text shows how easily this can happen. Therefore, the attentive attitude requires humility and explicitly promotes respect and appreciation of differences.

5.0 DISCUSSION

In this chapter, I will summarise and discuss the findings of the thesis as a compilation of the main conclusions of the five papers. Thus, the discussion embraces the findings that I listed for each of the papers in chapter 1.

5.1 The importance of encounters

All the papers address different aspects of the burnout challenge specifically focusing on the importance of *encounters* when in a vulnerable situation, as is the case when suffering from burnout. The challenge is related to understanding burnout as an intersubjective, lived, contextual and temporal experience. Paper one explores the participants' experience of the transition from functioning well in society to becoming unable to master their life situation. The findings point to how lack of recognition of the participants' illness might seriously have affected their healing process. In paper two, I addressed how the burnout challenge is related to what counts as knowledge in evidence-based medicine and how attitudes, norms and values in turn might negatively affect the clinical encounter. Paper three and four explicitly explored the lived experiences of encounters. Paper three revealed that the participants felt that they were distrusted by the GP and NAV and that they spent much energy in these encounters trying to explain their condition without feeling seen or heard. Their stories show how they as "knowers" of their own bodies were ignored and distrusted, which seemed to worsen their condition. In contrast, in paper four, I showed how encounters where the participants experienced precious moments of joy from being-with-others had a positive influence by enhancing their experience of well-being and perceived control. In paper five, I focus on the clinicians' role and consider how values, methods and practices can affect the clinical encounter in positive or negative ways.

In chapter two, I outlined a common ground from which I would discuss the conclusions of this thesis. Accordingly, all the five papers point towards approaching burnout from a phenomenological perspective. In this chapter, I will examine further two challenges that are related to the participants' experiences of the clinical encounters. I will start with discussing the concept of causality and its implications for understanding the burnout phenomenon. Here I will introduce a dispositionalist view of causality (Mumford & Anjum, 2011), which can provide new understanding of causal mechanisms related to burnout. Then, I will address how the ontological and epistemological stances we take can influence the rehabilitation process in positive or negative ways.

5.2 Rethinking the notion of causation and causal evidence

Evidence-based medicine has a clear basis in the Humean regularity theory of causation and the positivist methodology that follows from the strict Humean empiricist agenda. Emphasis is placed on observable events and statistical approaches (RCTs, meta-studies, and other quantitative methods). Cartwright criticises that these statistical approaches, which she points out are seen as the gold standard for establishing causal conclusions in evidence-based medicine, might miss out important causal evidence (Deaton & Cartwright, 2018). Additionally, she points out a problematic gap between scientific models and social reality as a threat to medical effectiveness (Cartwright, 2016). Other critical voices targeting the positivist bias in evidence-based approaches are found both in social science, e.g. the critical realist movement, and in medicine, e.g. the EBM renaissance movement (Greenhalgh and colleagues, 2014). Recently, a global network of 42 clinicians and philosophers of science from various international research projects working specifically on causation in medicine, has challenged the evidence-based medicine framework. In an open letter to *BMJ Evidence Based Medicine*, we made a joint appeal that EBM ought to expand its understanding of 'evidence', in particular of 'causal evidence' (Anjum et al., 2018). The signatories include members of the CauseHealth group, including myself, and several renowned scholars of medicine. In the letter, we list eight policy recommendations for taking causation seriously in evidence-based approaches. The third of these policy recommendations addresses the importance of understanding the causal mechanisms underlying observable events, something that cannot come from statistical evidence alone:

> An understanding of causal mechanisms can help to determine *whether* an intervention works (i.e. its efficacy shown in experiment or effectiveness in clinical practice). In addition, we should strive to understand *how* an intervention works (i.e. its mechanism) and how it can be made to work (i.e. the conditions under which it works best). Understanding mechanisms is essential for both of these (Anjum et al., 2018, p 1).

From a biomedical perspective, medicine mainly focuses on what all human bodies have in common. The evidence-based medicine focus emphasises clear-cut one-to-one relations between cause and effect as well as promoting the ideal of statistically average patients who are expected to respond in the same way to a specific medical treatment. The reality is however quite different (Cartwright, 2016). In complex illnesses such as burnout, these relationships seem difficult to find. In this section, I will address how singular causal mechanisms can offer a valuable insight into the challenges that medicine is facing with medically unexplained symptoms. This insight will support the appeal to reconsider the concept of causality as well as what should count as evidence.

If we understand evidence as evidence of causation, as argued by Anjum and Mumford (Anjum & Mumford, 2018) and Anjum, Copeland and Rocca (2018), then what needs to be reconsidered is first of all the Humean regularity conception of causality on which EBM methodology is based. Causal dispositionalism, as developed by Mumford and Anjum (2011), is offered as an alternative ontological framework to the Humean empiricism and regularity theory in the CauseHealth project. Any such change in the ontology of causation will also have epistemological implications for how we study and establish causation (Anjum & Mumford, 2018). In a forthcoming book, *Rethinking Causality, Complexity and Evidence for the Unique Patient. A CauseHealth Resource for Healthcare Professionals and the Clinical Encounter* (Anjum et al., Forthcoming), written by philosophers and clinicians from the CauseHealth network, it is argued that the clinical encounter requires an evidential focus on understanding causal mechanisms, causal complexity and medical uniqueness. The conclusion of the book, 'CauseHealth recommendations for making causal evidence clinically relevant and informed', states that we then need to move away from purely quantitative and statistical methods and toward more qualitative, phenomenological and narrative approaches in our causal inquiry. Paper five is a chapter in that book and the methodological choices for my study were motivated by my involvement in the CauseHealth project. The dispositionalist approach establishes a fertile ground for highlighting which causal mechanisms and factors might influence, contribute to or counteract the symptoms of burnout, seen precisely from a qualitative, phenomenological and narrative approach.

In paper two, I addressed the challenge of diagnosing and treating medically unexplained syndromes such as burnout, pointing out that the challenge might be related to what counts as knowledge in medical inquiry and medical care. This problem seems related to the limited acceptance of heterogeneous, subjective health complaints with an unknown aetiology within the framework of evidence-based medicine and the biomedical model. Paper two points to a possible background of the problem being related to the numerous factors that seem to interact but cannot be traced back to a single common cause. As described by the participants in the study, when no biomarker was found, their subjective health complaints were labelled as depression. Medically unexplained symptoms might instead be seen as a reaction to complex causes and a broad contextual setup, but unfortunately, such point of view has only been marginal.

The dispositionalist understanding of causation and causal mechanisms, as developed by Anjum and Mumford in the book *Getting Causes from Powers* (Mumford & Anjum, 2011), takes causation to be singular, complex and context-sensitive. In this dissertation and in the following discussion, I rely on their theory of causation. In line with the CauseHealth project, I take the single case as a starting point for causal inquiry, emphasising the particular and unique situation of the individual client.

Mumford and Anjum (Mumford & Anjum, 2011) offer a tool for modelling causality in the single case by using a vector model. This tool has been developed into a clinical framework to help overcome some challenges that practitioners face in complex clinical presentations including those that are medically unexplained (Low, 2017). To illustrate briefly how we can use this tool to understand the causal complexity of burnout, I will show that the onset of burnout for one of the participants in the study did not just “come out of the blue”. The participant recurrently asked, “Why did this happen to me? I have done everything I could to avoid ending up here” and “Why just now - when I had got the dream job?” Using a vector model, we can see how different factors might have accumulated over several years and in turn may have influenced the participant’s well-being.

As we can see from the vector model in figure 2, causation typically involves multiple causes, where the effect is produced by more than one disposition (or causal power) interacting, as visualised by the arrows that are pointing in two opposite directions. The threshold in the vector model is a way of understanding the point in which a particular effect occurs, for instance the symptoms of burnout. Figure 2 shows a vulnerable situation, where the overall resultant situation R is close to the threshold effect (T) for burnout. In contrast, figure 3 shows a robust situation, where R is far from the threshold for burnout.

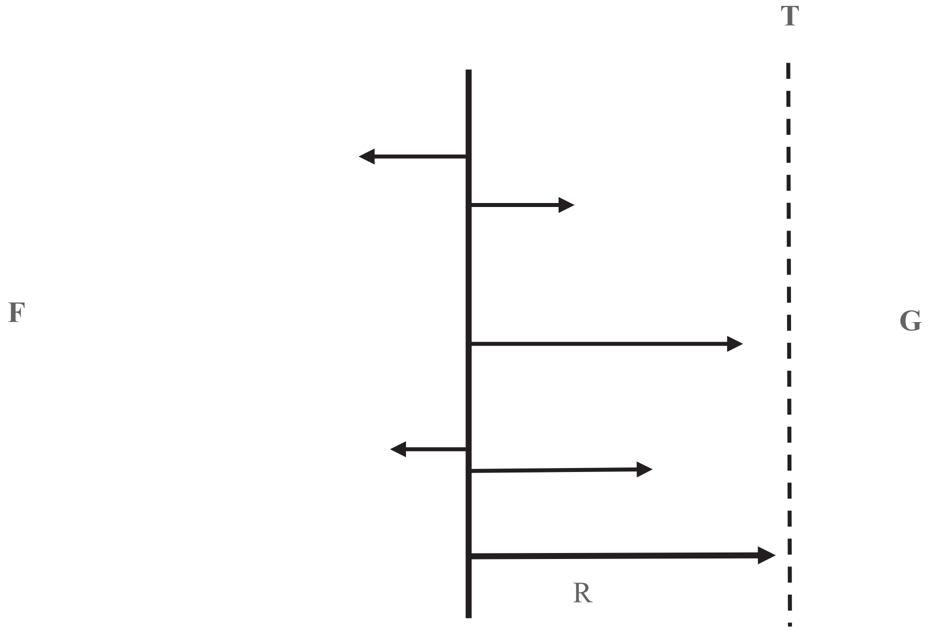

Figure 2: A Mumford-Anjum vector model of causation, showing a vulnerable situation where the resultant tendency R is at a tipping point for the given threshold effect T.

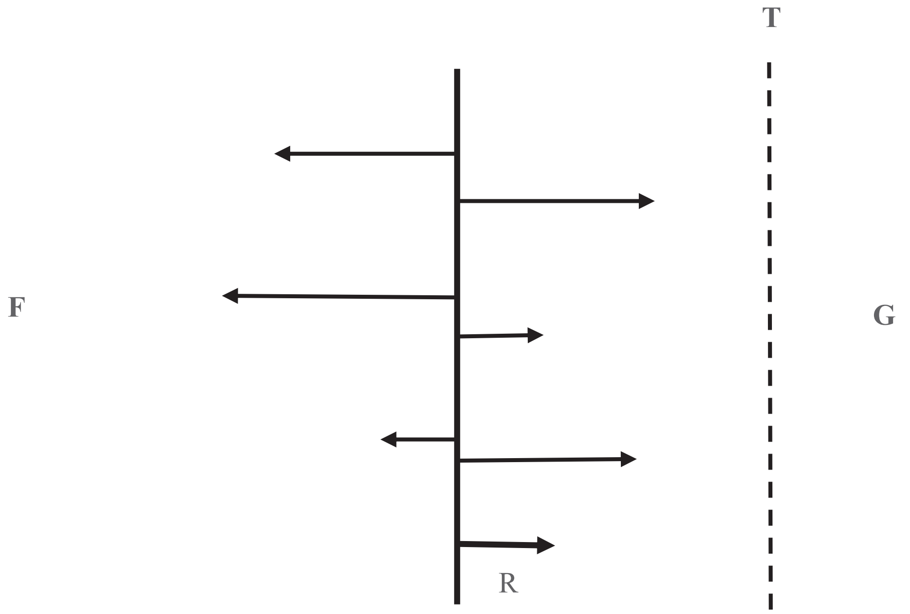

Figure 3: A vector model showing a robust situation, where the resultant tendency is far from the threshold effect T.

An implication of understanding causation in this dispositionalist sense is that there is a lot of causation happening beneath the surface, without an observable threshold effect being met. A person can be in a vulnerable situation, close to reaching the threshold of burnout, long before it manifests itself in an observable effect. Therefore, dispositions can exist without manifesting themselves and only through interaction with other dispositions will a causal process be initiated that could contribute to a number of effects. Also, a set of causes does not guarantee that the effect happens because the effect could have been counteracted by some additional power. Accumulation and subtraction are all in play regarding whether an effect is actually produced or not. According to dispositionalism, causes and effects come in qualitative degrees, where something can be more or less disposed in a certain way (e.g. more or less fragile, toxic, carcinogenic, fertile, vulnerable, robust, etc.).

This is what may have happened to the participant in my study. A minor causal factor such as a flu can, under the right circumstances, tip a causal situation over a threshold and manifest in burnout symptoms. This shows how context-sensitivity plays a significant role for causation. With this example as an ontological background, it appears to be an oversimplification to look for one single feature that is correlated to the overlapping, heterogeneous symptoms that are typical of medically unexplained syndromes. Paper two calls attention to how the ontological and epistemological stance taken by clinicians influences clinical practice. The norms, values and attitudes inherent in evidence-based medicine and the biomedical model could lead to a misunderstanding of subjective health complaints such as considering part-time return to work as part of the rehabilitation process, which might have serious implications for medical care.

In paper one, four narrative phases mirroring burnout as a temporal sequence stood out. Listening to narratives gives us an opportunity to detect factors that are relevant for the single case. From a dispositionalist understanding of causation, narratives applied as methodology for detecting relevant dispositions can provide a deeper insight into how dispositions interact in the specific context (Anjum et al., Forthcoming; Low, 2017). Hence, narratives accompanied by the vector model can provide the healthcare professional with more knowledge of what the unique sufferer needs. As such, narratives can reveal possible causal mechanisms for the multiple dispositions that are involved as well as how they contribute to the effect. I will return to how narratives can provide crucial information to be processed in the clinical encounter.

One aspect of the contemporary debate about the academic status of qualitative approaches is whether phenomenology, narrative research and case studies can properly be called ‘scientific’. In this regard it is worth noting that the German term for science

(Wissenschaft) has a much broader sense than that associated with the English use of the term science, which is typically restricted to those forms of science that employ the empirical methods of observation and experimentation (van Manen, 2014). From a dispositionalist perspective we see what we consider as causal evidence is much broader than what is suggested by the regularity theory and its corresponding methodology (Anjum et al., Forthcoming; Anjum & Mumford, 2018). Additionally, the German term for science includes both the empirical methods and the hermeneutic and phenomenological disciplines concerned with the interpretation of meaning and the description of experience, respectively (van Manen, 1990, 2014).

The phenomenological approach is beneficial when looking beyond symptoms and statistical outcomes as it can support us to detect the underlying causal mechanisms behind the observable events. This is why we need a plurality of methods and multiple types of evidence, and consequently to expand the current definition of what counts as evidence (Anjum et al., 2018; Anjum & Mumford, 2018). I will now turn to how the ontological stance taken by medical and societal professionals can influence the rehabilitation process.

5.3 Re-thinking emotional aspects in clinical encounters

In paper two, I addressed ontological and epistemological challenges related to the biomedical model and evidence-based medicine, pointing out how biomedicine seeks to frame health experiences in simple cause-effect terms. The values that go with the biomedical paradigm, and its inherently reductionist and dualist ontology, form the basis for what counts as knowledge in evidence-based medicine. As described by the participants in the study, when no biomarker was found, their subjective health complaints were labelled as depression. Amongst several symptoms, depression is just *one* of the symptoms in burnout; depression is also a *common* symptom related to several different diseases as recorded in the diagnostic and statistical manual of mental disorders (DSM IV-TR, 2000). Accordingly, burnout is reduced to one of the symptoms and is thereby attributed to the brain, which additionally reflects the dualist split of the body and mind. Reducing the human being into its bodily parts such as brain, heart, lungs, and limbs is one way of understanding reality. Another alternative is to see the human being as an irreducible whole.

In this section, I will elaborate on how the inherent norms, values and attitudes in these two ontologies, biomedical reductionism and phenomenological holism, might affect the care of individual patients. I will start by addressing the phenomenology of affect by drawing attention to how *self-affection*, *affective intentionality* and *inter-affectivity* might be understood as dispositional causal mechanisms that can play a vital role related to enhancing or restraining the rehabilitation process. However, before I explain these notions further in the text below, I will address how meaningless the world would have been without being able to experience affects. According to Tomkins, the affect system is the primary motivational system:

> Because without its amplification, nothing else matters–and with its amplification, anything else *can* matter. It thus combines *urgency* and *generality*. It lends its power to memory, to perceptions, to thought, and to action no less than to the drives. [..] A world experienced without any affect at all, due to a complete genetic defect in the whole spectrum of innate affects would be a pallid meaningless world. We would know that things happened, but we could not care whether they did or not. (Tomkins, 1991, pp 6-8)

Of the six affective responses, interest and enjoyment are positive; surprise is neutral, and fear, anger and distress are negative. Disgust and dis-smell act as modifiers of the negative affect, while shame acts as a modifier of the positive affect (Tomkins, 1991). In article three, we saw how shame affect might have restricted the participants' ability to accept support from others. The affective and bodily responses occur automatically and outside of conscious awareness. When becoming aware of being exposed as "naked in the eyes of the public", shame affect was provoked. Shame in particular as the basic regulator of contact in the social field has a modulating effect on the other affects, because of the way it takes us toward or away from the social field itself (Tomkins, 1991).

Cognitivist approaches as part of the biomedical model are not often concerned with affect and, when affect is accounted for, it is not related to interactional processes. Thus, cognitivist approaches have to a minor degree attended to inter-affectivity as an aspect of human interactions (De Jaegher, 2015). From a phenomenological perspective, interactions are not simply bits of information to be processed by the human brain. Two main themes of the enactive theory are autonomy and partaking in sense making processes (De Jaegher, 2015; Kyselo, 2014). The empirical material in this thesis shows how inter-subjective processes move the participants in their sense-making activities, enhancing or restraining their autonomy. In paper one and three, we saw how the participants' perceived distress seemed to influence their condition negatively when feeling overwhelmed by the outside world. Paper three and four specifically explore the participants' lived emotional experiences. The participants' feeling of distress as well as joy can be understood as emotions related to the concrete situation they lived through. During the interaction with others, the participants seemed to be consciously aware of specific features of feeling good or bad. In these interactions, their emotions seemed to be part of the bodily experience and therefore directly related to what was going on in the here and now. These experiences truly include *self-affection*, which can be defined as "the pure self-relational feeling and movement of every living being's own life, a feeling of oneself in the suffering and enjoyment of one's own life"(Henry, 1990/2008, p xii). Before I move on to discuss how inter-affectivity might influence the rehabilitation process, I will first turn to how self-affection as part of the bodily experience can influence *intentional affectivity*.

As paper four indicates, the lived body possesses its own operative intentionality of habituated actions. Through its intentionality, the lived body grasps and relates to the world as a world of meaning. Thus, the participants exist within the continuum of awareness and consciousness of constantly shifting experiences. The notion of purposiveness and intentionality is essential to embodiment (Merleau-Ponty, 1945/2003). Therefore, the lived body exhibits an if-then temporality of bodily action to predict contingency. Everything that affects my body affects me and becomes bodily if-then experiences. In illness, bodily intentionality is thwarted when the "I can" is experienced as "I cannot". Because the taken-for-granted, if-then causality of the body is interrupted, the purposiveness is also disrupted. As referred to in paper four, in illness it is the intentional arc that "goes limp" and this "intentional arc" can be understood as part of the participants' intentional affectivity. I will now turn to how inter-affectivity draws attention to how human beings are influenced by each other in social encounters. To understand the impact of inter-affection we need to combine insights into self-affection, affective intentionality, inter-subjectivity and embodiment (De Jaegher, 2015). In paper three, I addressed how the experienced lack of recognition of the participants' condition seemed to influence the process of contextualizing the illness and in turn had a negative effect on the rehabilitation process. Feeling seriously distressed without acknowledgement of their situation triggered an existential anxiety, frustration, despair and hopelessness. Hence, the experience of moving or being moved by another person is related to inter-affectivity. To illustrate this, I will quote Hans, one of the participants (paper three):

> *Dreading having to go to the doctor doesn't exactly help you get better. I felt like a little boy at school being told off. Going to see a doctor you know will tear at your soul isn't much good and you just cannot manage to do anything about it*…

In this quote, Hans seems to apprehend the badness of the experience. He expresses a feeling of being *teared at his soul*, which can metaphorically be understood as a bodily experience. Emotions are experiences of significance that are intentionally directed (De Jaegher, 2015). The dread Hans is aware of can be understood as his emotional affect related to seeing his doctor–and being unable to change the situation. Thus, the dread erodes his autonomy. As I particularly addressed in paper three, to be adversely affected is the very core of the painful emotional experience as the body is the vehicle for experiencing the world (Merleau-Ponty, 1945/2003).

The thesis' findings point to how complex relational mechanisms seem to influence the temporal process of burnout and affect the bodily fatigue reaction, which in turn seemed to culminate in a disconnection from the participants' habitual lifeworld. In light of the biomedical model, there seems to be a possibility that the GP and NAV might have underestimated or ignored the participants' emotional reactions. The problem is related to the fact that most theories of human emotions are deficient in terms of phenomenology. The consequence is that theorists of human emotions overlook the intentional feelings in human existence as essentially bodily feelings with a dimension of well-being or suffering (Slaby, 2008). Accordingly, the impact of encounters that might influence the lived experience of burnout in positive or negative ways are not taken into account.

In contrast to the established cognitive theories, a phenomenological approach assumes that feelings are emotional experiences and not just conscious states (Slaby, 2008). As such, emotions are evaluations of lived experience that contain intentional affectivity, which directly influence purposiveness, intentionality, autonomy and, in turn, our actions. As the participants' narratives show, the need to withdraw from others as well as from themselves became acute and three of them explicitly considered suicide as a way out. I will now address why inter-affectivity is crucial and how the dynamics of inter-affectivity might contribute to the rehabilitation process. I start by quoting how Merleau-Ponty describes how we can affect each other's self-affection:

> It suffices that I look at [it] that I speak of it with someone. Then through the concordant operation of his body and my own, what I see passes into him, this individual green of the meadow under my eyes invades his vision without quitting my own. It is not I who sees, not he who sees, because an anonymous visibility inhabits both of us, a vision in general, in virtue of that primordial property of the flesh, being here and now, of radiating everywhere and forever. (Merleau-Ponty, 1968, p 142)

From this quote, inter-affection seems to be recognised as a continuous, mutual exchange of perceptions between the person and his or her phenomenal field. When interacting, the process itself and aspects of timing are the ingredients for affecting each other (De Jaegher, 2015). Research has found that delayed responses of the mother increased their infants' distress in face-to-face interactions (Murray & Trevarthen, 1986). This finding might shed light on how encounters can influence our self-affection, which in turn might mean that others can modulate our painful experiences and co-author new meaning. This means that interaction enables mutual affection and plays a fundamental role for inter-affectivity. I will now turn to how we can provide better support in the rehabilitation process.

In a genuine person-centred perspective, the health care providers' role is helping to frame the person's situation and to offer support for what he or she really needs. Both the underlying mechanisms and the whole person should be understood as individual, relational, and contextual. Hence, to meet the challenges that sufferers of burnout face, it is essential to understand the person's context. Listening to the patient's story is therefore a good starting point for gathering information of how this particular person understands his or her situation (Broom, Forthcoming). A person's story is an important phenomenological account that can replace a categorical diagnosis for outlining a treatment plan (Low, Forthcoming). Moreover, a dispositionalist view of causality has the ability to develop a common understanding of the situation that can provide a much clearer perspective on the complexity of the situation. According to Low (Low, Forthcoming), drawing a mind-map to visualise the experienced context provides an opportunity for a dialogue between the clinician and the person. In this context, a mind-map can be seen as a tool to bridge the inter-subjective gap between the subjective worlds of the person and the clinician. In the encounter, the person and the clinician bring in their individual understanding where they each attempt to make sense of the situation. Through formulating a co-constructed narrative, the causal elements or dispositions can then be brought into the fore. Thus, this inter-subjective sense making process can ground a strong therapeutic alliance because we participate in each other's sense making through moving in the world and being moved by it (Merleau-Ponty, 1945/2003). Enactive theory establishes that we can literally participate in each other's sense making processes. The inter-subjective process, which enables insight and sense making as embodied and affective, makes it possible to understand how we move and affect each other (De Jaegher, 2015). I will now turn to how this process might affect our autonomy.

As we saw in paper three, the psychosocial experience of burnout might be as important as its unknown aetiology. One reason is that the participants' lifeworld processes cannot be interpreted as emanating from the participants in isolation but must be seen as emerging from an inter-subjective relational system. Since life manifests itself in each living being as self-affection, life is also the essence of community (De Jaegher, 2015). In some encounters, we might experience that our self-support is restrained, even if we hope for the opposite. When the feeling of being restrained becomes the figure against the background that we long for, we might become aware how the absence of interaction deeply affects us. So, if inter-affectivity can influence our affective intentionality, new possibilities that we previously were not aware of might be opened up by entering into and influencing one another's affect and co-author intentions as well as affects in positive and negative ways. In paper four, I highlighted how the experienced existential crisis seemed to enhance new habitual actions and that the most transformative changes in the participants' lives seemed to be the precious moments of joy. These encounters profoundly affected their self-affection in a positive way. To sum up, part of the answer to the question why inter-affectivity is crucial might be that inter-affectivity can mean the difference between life and death.

The intentionality of the lived body constitutes it as fundamentally open to new possibilities and to forming a new style of being in interconnection with its conditions (Merleau-Ponty, 1945/2003). During the experienced existential crisis, the inherent human ability to adjust to the never-ending temporal processes of life seems to take place. The participants demonstrated deliberate choices and reflective self-cultivation to adjust to their present situation. Although the participants in the study still were in a process of coming to terms with their habitual body, they seemed to demonstrate new habitual actions, which in turn might result in a re-habituation of the lived body. Although they might not have been consciously aware of what they needed, others might have perceived their intentions. Therefore, experiencing inter-subjectivity as part of the clinical encounter can provide the support we need to be able to see new meaning. Through our lived body, we express intentions and our bodies enable us to perceive intentions in others. This sharing in inter-affectivity comes through participating in a process that is not simply the summation of individual activities, but a jointly created and literally embodied pattern that affects each of our affections (De Jaegher, 2015). The encounter is not simply uncovering the person's experience of his or her situation but can be seen as a genuine interactive process where both the person and the clinician bring themselves in as human beings and thereby influence the encounter reciprocally. Thus, the encounter can be understood as an emergent phenomenon, as I pointed out in paper five, where the client and the therapist are reciprocal partners for the mutual manifestation of the outcome of the therapeutic process.

As clinicians, we are significant human beings to the persons who are suffering. We can provide the structure and therapeutic environment for supporting these people in their rehabilitation process – or risk doing the opposite. The ontological stance we take, either consciously or unconsciously, will influence our attitude and, in turn, the way we practice. As part of the therapeutic process, the client's lifeworld processes cannot be interpreted as emanating from the client in isolation but must be seen as emerging as part of an inter-subjective relational system. Therefore, in the context of these interpersonal relations, both norms, values and attitudes, as well as issues of power, need to be taken into consideration and addressed properly. As addressed in the previous section, the vector model offers a tool for modelling causal processes in the individual case. Additionally, using a mind-map in tandem with a vector model of causal powers, a dispositional perspective can ground a non-judgmental viewpoint of a person's lived experience (Low, Forthcoming). A way forward for supporting persons who suffer from burnout might be to see burnout from a phenomenological perspective and take the subjective lived experience of the condition back to the "owner". Therefore, we need a genuinely person-centred approach based on a phenomenological worldview for understanding and taking care of human needs.

6.0 CONCLUSION AND FUTURE RESEARCH

The title: “From dedicated to burned out – and back?” might indicate that I am reluctant to give a distinct answer to this question. As the participants’ narratives show, rehabilitation is time-consuming. In Western societies, the political health economic imperative is to reduce costs. In this view, patients are rational actors, who have the capacity and responsibility for self-care. Self-management of illness requires that the individual patient, guided by psychological interventions, will be provided the necessary self-confidence to produce the desired outcome (Coventry, Dickens, & Todd, 2014) . These interventions are often based on cognitive behavioural theory (Alderson, Foy, Glidewell, McLintock, & House, 2012). The effects of these interventions have, however, proved very small (Coventry et al., 2013; S. M. Smith, Soubhi, Fortin, Hudon, & O'Dowd, 2012). The reason for this fact might be the limited focus on the heterogeneity and complexity of syndromes such as burnout. Another important aspect is that autonomy often is something that is ascribed to a person from an outside perspective. Attributing a detached, disembodied autonomy without differentiating between the unique individuals may lead to the serious consequence that we expect that patients at any time might be able to change their situation (Kall & Zeiler, 2014). Social injustice might influence the patients’ choices and decision-making and inform his or her bodily way of being. In turn, this practice will form what he or she sees as choices in the first place. How, then, can the patient’s habituated modes of acting qualify as autonomous?

In contrast, I see the human being as an autonomous agent in suffering, who is aware of his or her bodily responses in relation to different ways of taking care of him or herself. According to a phenomenological worldview, autonomous decisions are made in the midst of social relations, as responses to others, whose perceptions and actions inform mine. To act autonomously, is not to presume that one acts independently of others. Bodily relational autonomy is situated and bound to facticity. The tendency to see these patients as rational actors might implicate that they are ascribed a non-situated rational autonomy, which in turn might hamper their autonomous choice (Kall & Zeiler, 2014).

As human beings, we have to deal with the physical limitations imposed upon us by illness whether we like it or not. In a critical way, we are forced to recognise our inherent vulnerability. The sense of inescapability and limitation is intrinsic to illness-as-lived. Sartre’s account (Sartre, 1958) of the contingent necessity of embodiment may however provide a possibility to take on responsibility for how we choose to react. But to be aware of this opportunity we first have to acknowledge the situation as it is, via the route of self-acceptance. When one fully becomes what one is, rather than trying to be what one is not, change seems to occur, paradoxically (Beisser, 1970). Phenomenology provides – through accounts of how we are born into a world already inhabited, shaped and made meaningful by others – a way of understanding how human existence is characterised by a basic openness to others and the world. Our very perception of something as a choice needs to be understood against our whole situation including our bodily capabilities, our goals and plans, as well as our perceptions of others, the world and ourselves. The recognition of those aspects over which it is possible to exercise some control may provide some kind of hope. Thus, Sartre's account of freedom (Sartre, 1958) emphasises that, although we may have little or no control over our illness, we always have freedom to choose how to respond to the difficulties within our lives, and how to constitute the likelihood of feeling better.

The knowledge contributed by the five papers is highly relevant to stakeholders who are concerned about the short- and long-time consequences of burnout. Burnout often indicates that systems are under stress, but it affects individuals. As I mentioned in the introduction to this thesis, the burnout phenomenon has been widely discussed as an epidemic that hits individuals in specific occupations. Suicide among doctors is one concern that has led to an increased interest in burnout as a societal problem. These suicides might as well be an indication of a stressful work situation for doctors who seem placed in the demanding middle-position to "adhere" to the medical policy set by the government. Moreover, this fact might in turn influence the clinical encounter negatively. To eradicate the underlying causes of burnout either the stressor or the individual, or both, need to change. Impossible work demands that might break anyone have to be challenged and ought to be changed. Waiting for this change to happen, however, might take years. Meanwhile, we all - including policymakers, clinicians and managers - share a responsibility to take symptoms of burnout seriously at an early stage to prevent symptoms of burnout becoming chronic.

Regarding further research on burnout, progress calls for a deeper exploration of causal mechanisms through which personal dispositions as well as inter-subjective relations influence each other. I think three major foci are needed. The first one is how burnout changes over time; the second is the role of inter-affectivity; the third concerns how a genuine person-centred rehabilitation can be provided. Finally, I hope this dissertation will stimulate the medical and political debate to expand evidence-based medicine’s understanding of ‘evidence’, and in particular of ‘causal evidence’, to also acknowledge the value of including perspectives from phenomenological and other qualitative research in order to fully understand a complex phenomenon such as burnout.

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APPENDIX 1

Til praktiserende terapeuter

Ås, 15. september 2015

Jeg henvender meg til deg for å be om hjelp til å komme i kontakt med personer som kunne tenke seg å delta i forskningsprosjektet " FRA HELTENT TIL UTBRENT – OG TILBAKE?". Prosjektet er en doktorgradsstudie og gjennomføres ved Norges Miljø- og Biovitenskapelige universitet. Det igangsettes et pilotprosjekt nå i høst, for å evaluere spørsmålstilling og bruk av metode. Pilotintervjuer gjennomføres i løpet av november 2015. Selve datainnsamlingen til studien pågår i løpet av mars og april 2016.
Jeg er praktiserende Gestalt psykoterapeut og tenker å gjennomføre en kvalitativ studie. Gestalt er en retning innen humanistisk og eksistensiell psykologi og terapi, som retter oppmerksomheten mot hele mennesket med tanker, kropp og følelser.

Bakgrunn

I Norge er ca. 15-20.000 personer langtidssykemeldt eller varig uføre på grunn av utmattelsessymptomer og/eller kroniske smerter. Dette gir store konsekvenser både på individ- og samfunnsnivå.

Det finnes i mange tilfeller ingen medisinsk forklaring på årsaken til disse lidelsene, og symptomene blir gjerne kategorisert som subjektive helseplager. Dette skaper alvorlige implikasjoner med hensyn til diagnostisering og behandling. Noen blir imidlertid så friske at de klarer å komme tilbake til arbeidslivet igjen.

Målsetting

Målet med prosjektet er å få mer kunnskap om hvordan denne pasientgruppen opplever sykdommen sin både kroppslig og mentalt og hvilken forståelse og mening som kan utledes av slike opplevelser. Hva oppleves som støttende i prosessen for å komme tilbake til arbeidslivet etter langtids sykemelding, og hva bidrar til å hemme prosessen? I tillegg er det ønskelig med mer kunnskap om hvilke erfaringer pasientgruppen har fra møter med helse- og sosialvesenet og samfunnet for øvrig.

Hvem kan delta?

Ti til femten menn og kvinner i alderen 25-60 år som er bosatt i Osloområdet, vil bli invitert til å delta i studien. Kriterier for deltakelse er symptomer på utbrenthet i henhold til den svenske diagnosen Utmattningssyndrom (ICD-10, F43.8A). Det vil si fysiske og/eller mentale symptomer på utmattelse som følge av opplevd stress. De som deltar skal være langtidssykemeldte (mer enn 52 uker) og tidligere ha vært i en 80-100% stilling.

De som melder sin interesse for å delta vil bli innkalt til et møte i forkant av selve studien for å avklare om de faller inn under utvalgskriteriene. I tillegg vil de da få nærmere informasjon om gjennomføringen av selve studien.

Hva innebærer deltakelse i studien?

Datainnsamlingen gjøres gjennom personlige samtaler og varer normalt i ca. 1-2 timer. Det er imidlertid ikke satt noen tidsbegrensning, slik at samtalen avsluttes når nye temaer ikke lenger dukker opp. De som deltar vil ca. to uker i forkant av samtalen bli bedt om å føre dagbok og notere hvordan aktiviteter, opplevelser og følelser påvirker dem gjennom perioden. Ett av temaene for samtalen vil være hvordan de opplever hverdagen basert på dagboknotatene. I tillegg vil spørsmål om hvordan de opplever prosessen med å bli frisk, samt tanker om hva som skal til for å påvirke og forbedre funksjonsevnen bli belyst.

Hva skjer med informasjonen om deltakerne?

Alle personopplysninger vil bli behandlet konfidensielt. Det er kun undertegnede og veileder som vil ha tilgang til dataene. Personopplysninger i form av navneliste, lydopptak og transkriberte samtaler, lagres separat for å ivareta konfidensialitet. Lydopptak og skriftlige samtaler er kun merket med en koblingsnøkkel som sikrer anonymitet. Deltakerne vil ikke kunne gjenkjennes i publikasjon.

Prosjektet skal etter planen avsluttes høsten 2018. Alle personopplysninger vil ved prosjektslutt anonymiseres.

Frivillig deltakelse

Det er frivillig å delta i studien, og deltakerne kan når som helst trekke sitt samtykke uten å oppgi noen grunn. Alle opplysninger om deltakeren vil da bli anonymisert.

Studien er anbefalt av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Dersom du har pasienter/klienter med utmattelsessymptomer og/eller kroniske smerter, som du mener faller inn under utvalgskriteriene, ville jeg være svært takknemlig om du kunne gi vedlagte informasjon til vedkommende.

Og om du har behov for ytterligere informasjon om studien, kan du ta kontakt med meg eller min veileder Ruth Kjærsti Raanaas.

Med vennlig hilsen

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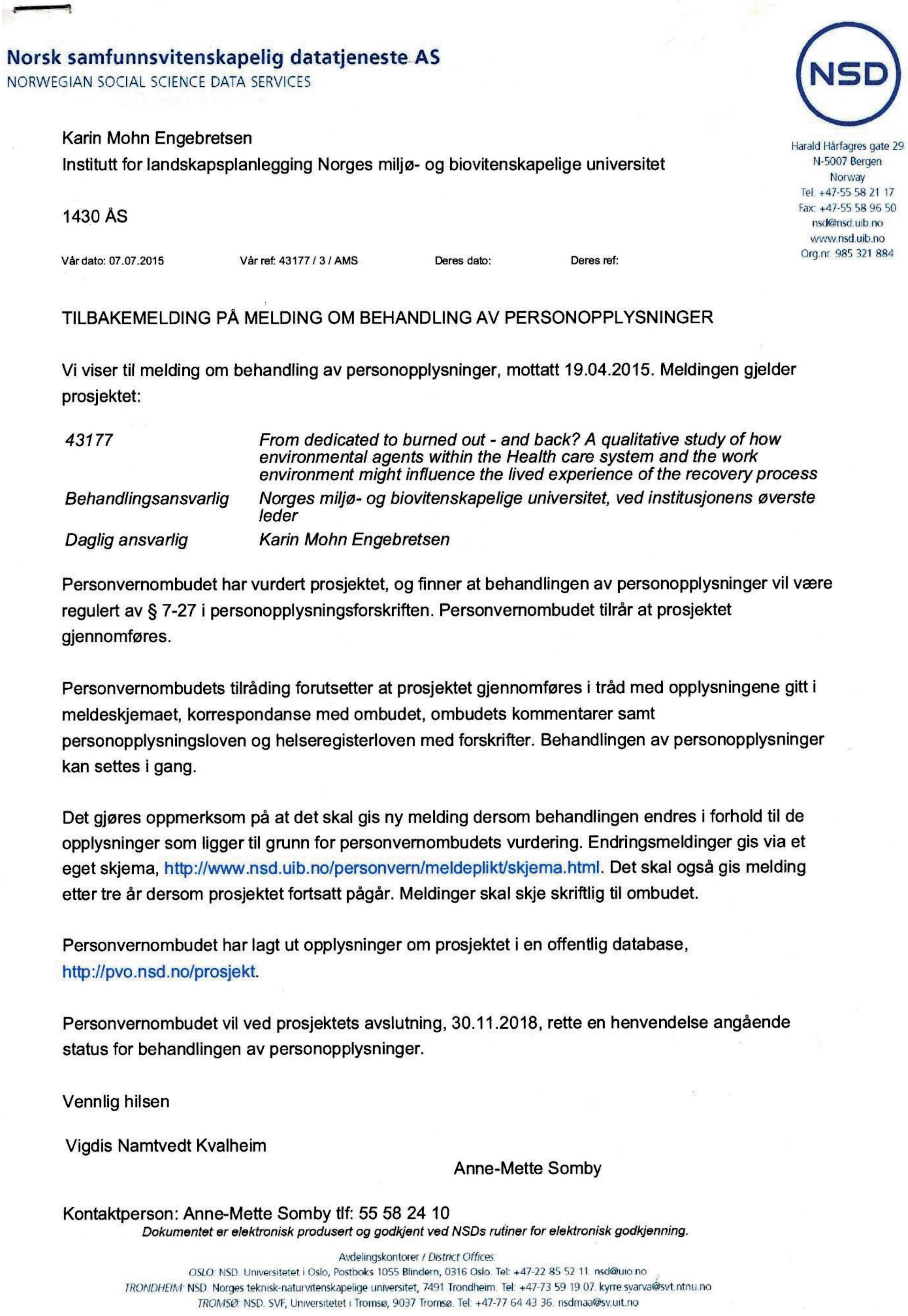
APPENDIX 2



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1430 ÅS

Vår dato: 07.07.2015 Vår ref: 43177 / 3 / AMS Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 19.04.2015. Meldingen gjelder prosjektet:

43177	*From dedicated to burned out - and back? A qualitative study of how environmental agents within the Health care system and the work environment might influence the lived experience of the recovery process*
Behandlingsansvarlig	*Norges miljø- og biovitenskapelige universitet, ved institusjonens øverste leder*
Daglig ansvarlig	*Karin Mohn Engebretsen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 30.11.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Anne-Mette Somby

Kontaktperson: Anne-Mette Somby tlf: 55 58 24 10

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

APPENDIX 3

Informasjon om deltakelse i studien

" FRA HELTENT TIL UTBRENT – OG TILBAKE?"

Datainnsamlingen gjennomføres i perioden november 2015 til april 2016 og gjøres gjennom personlige samtaler. Samtalene varer normalt i ca. 1-2 timer. Det er imidlertid ikke satt noen tidsbegrensning, slik at samtalen avsluttes når nye temaer ikke lenger dukker opp. Du vil ca. to uker i forkant av samtalen bli bedt om å føre dagbok og notere hvordan opplevelser har påvirket deg gjennom dagen. Tema for undersøkelsen vil være hvordan du opplever hverdagen din i tillegg til dine tanker om hvordan sykdommen og det å forsøke å bli frisk oppleves i hverdagen.

Instruksjon for dagboksnotater

Bakgrunnen for at jeg ber deg om å skrive «dagbok» er at det er veldig lett å glemme hva som egentlig skjedde for en dag eller for en uke siden. Dersom du noterer ned hvilke opplevelser du har hatt og hvordan du har følt deg vil det være lettere å huske hva du vil svare på spørsmålene jeg stiller under samtalen. Bruk gjerne litt tid før sengetid på å gjøre opp en status på hvordan du har opplevd dagen din. Å skrive ned det du har opplevd kan også gjøre deg oppmerksom på sammenhenger som du kanskje ikke har vært så oppmerksom på tidligere.

Jeg vil derfor be deg om kort å notere hva du har gjort i løpet av dagen.

- Hvordan har du opplevd det å være deg?
- Har ulike aktiviteter og hendelser gitt deg energi eller tappet deg for energi?
- Hvordan har ulike aktiviteter og hendelser påvirket dagsformen din?
- Har dagsformen variert i løpet av dagen eller har den vært stabil?

Du kan skrive så langt eller kort du vil – det viktigste er at du skriver noe hver dag!

Hva skjer med informasjonen om deg?

Alle samtalene vil bli tatt opp på lydbånd og skrives ut av meg i etterkant. Hver deltaker får en utskrift av sin samtale for gjennomlesning, og mulighet for å gi tilbakemelding på eventuelle kommentarer eller rettelser. Først når du har bekreftet at det ser greit ut, vil prosessen med å systematisere og analysere opplysningene starte.

Alle personopplysninger vil bli behandlet konfidensielt. Det er kun meg og min veileder som vil ha tilgang til dataene. Personopplysninger i form av navneliste, lydopptak og transkriberte samtaler, lagres separat for å ivareta konfidensialitet. Lydopptak og skriftlige samtaler er kun merket med en koblingsnøkkel som sikrer anonymitet. Deltakerne vil ikke kunne gjenkjennes i publikasjon. Prosjektet skal etter planen avsluttes høsten 2018. Alle personopplysninger vil ved prosjektslutt anonymiseres. Studien er anbefalt av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Din deltakelse i dette prosjektet er av stor verdi for meg, og jeg håper at du også vil oppleve den tiden du avsetter, som meningsfull. Jeg setter stor pris på at du er villig til å dele dine erfaringer med meg. Dersom det er noe du er usikker på, er det bare å ta kontakt med meg.

Med vennlig hilsen

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Samtykke til deltakelse i studien

” FRA HELTENT TIL UTBRENT – OG TILBAKE?”

Jeg har mottatt informasjon om studien, og er villig til å delta

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Dato og sted

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Navn skrevet med blokkbokstaver	Signatur prosjektdeltaker

Article 1

Received: 1 May 2019 | Accepted: 30 August 2019
DOI: 10.1111/jep.13288

ORIGINAL PAPER

WILEY Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

Burned out or "just" depressed? An existential phenomenological exploration of burnout

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Abstract

Rationale, aim, and objective: An increasing number of patients are on sick leave from work due to fatigue- and pain-related symptoms that could indicate burnout. The aetiology is unknown, and recently, it has been considered whether burnout should be a distinct medical diagnosis or "just" a form of depression. Little attention has been given to these individuals' experiences. Therefore, we conducted a phenomenological study to explore burnout from a first person perspective. The aim of the study was to obtain a deeper understanding of burnout as phenomenon.

Theoretical perspective and method: We are inspired by Merleau-Ponty's phenomenological approach and gestalt theory. The phenomenological focus is to attend to the embodied consciousness of the lived experience of being human. An interpretative phenomenological analysis (IPA) was chosen to uncover how the interviewees made meaning of their situation. Six individuals who had been on sick leave at 50% to 100% for at least 3 months due to fatigue- and pain-related symptoms were interviewed.

Results: Four narrative phases mirroring burnout as a temporal sequence stood out: achievement, pressure, psychosomatic collapse, and personal meaning and reorientation. We identified several interruptions to contact, which seemed to boost the interviewees' ability to continue striving beyond their limits. The results of this study contribute to a deeper understanding of how complex factors might influence individual vulnerability and lead to a fatigue reaction.

Conclusion: The findings indicate that lack of recognition of the interviewees' illness may have affected the healing process. When understanding burnout as an intersubjective, lived, contextual, and temporal experience, it is important to take the implications of such factors into consideration for both medical theory and clinical practice. On the basis of our findings, we argue that reducing burnout to a form of depression will neither solve the problem of its unknown aetiology nor provide for meaningful individual health care.

KEYWORDS

diagnosis, epistemology, evidence-based medicine, health policy, person-centred medicine, philosophy of medicine

1 | INTRODUCTION

An increasing number of individuals in the industrialized society of today experience long-term absenteeism from work due to fatigue- and pain-related symptoms that could indicate burnout. Burnout can be defined as a work-related chronic stress syndrome. It is a generic name for a state of physical fatigue, emotional exhaustion, and cognitive weariness, due to prolonged exposure to unavoidable stressors.[1] The aetiology of burnout is unknown, and it is often categorized as a medically unexplained syndrome. Burnout has received considerable attention from both scientists and clinicians, as well as from society in general for almost half a century.[2]

Most of the empirical research on the syndrome is conducted within a social-psychological framework where burnout is understood to relate to an individual's capacity to meet society's expectations about personal achievement.[3] There is a commonly felt “anticipation to achieve” in today's society. Failing to achieve what is “expected” within the social and cultural context of today can lead to feelings of distress and can influence the personal sense of self.[4] The relationship between expectations and the sense of self is supported by an extensive study by Hallstein,[5] wherein “scripts” such as “I am my achievements” are assumed to explain how motivation to achieve might result in absorbing commitment to work. Scripts can be seen as sets of ordering rules that provide for control of our social interactions.[6] Another study also highlights how absorbing commitment to achieve can influence the process leading to exhaustion.[7] This study showed that the participants ignored their stress symptoms and worked harder despite increasing illness.

Recently, some researchers have addressed whether burnout should be considered a distinct medical diagnosis or a form of depression.[8-10] Bianchi et al[2] suggested that public health policies should focus on what they hold as the core aspect of burnout, namely, depression. Further, they argue that the inclusion of burnout as a separate category in future disorder classifications is unwarranted. How burnout should be understood and categorized can be seen as a matter of ontology and aetiology. The values implicit in the biomedical paradigm motivate statistical and experimental designs, and inherent ontological assumptions are mirrored in how research is conducted and how data are assessed.[11] Research on medically unexplained conditions has pointed to several ontological and epistemological limitations related to understanding these syndromes properly.[12] Similarly, the biomedical approach mainly adopted in evidence-based medicine leads to illness being defined exclusively in terms of objective, quantifiable data, as states of diseases measured according to objective time.[13]

Little attention has been given to these individuals' experiences of suffering from burnout. As with other medically unexplained syndromes, there is a tendency to assume a narrow perspective to focus on problems related to either psyche or soma as pathologies located within the patient.[14] However, a medically unexplained syndrome could be seen as an adequate response to a subjective experience of the encounter with a demanding life situation.[15] As a psychotherapist and before that as an organizational consultant for corporate business, the first author has met an increasing number of individuals over the last 25 years who experience themselves as burned out. This fact has triggered her interest to explore the phenomenon further. The aim of the resulting study was to obtain a deeper understanding of the phenomena related to the experience of burnout.

In the remainder of this introductory section, we will discuss an alternative approach via existential phenomenology and gestalt theory that can provide for a deeper understanding of burnout. Then, we present and discuss the findings, which are summarized in the last section.

2 | THEORETICAL PERSPECTIVE

We are inspired by the philosopher Maurice Merleau-Ponty and his phenomenological approach, which especially emphasizes our bodily existence.[16] The phenomenological focus is to attend to the embodied consciousness of the lived experience of being human. The lifeworld[16] is phenomenologically both relational and personal in that the person and the world coexist. In this coexistence, we both direct ourselves towards the world, our actual environment, as well as being directed by the world, the situation, and context we at any time inhabit.[16]

Gestalt theory embraces Merleau-Ponty's holistic view of the human being, conceptualized as existing in continuing interplay in the “organism-environment field.”[17,18] The organism-environment field is defined as a systematic web of relationships, which Yontef describes as a totality of mutually influencing forces that together form a unified interactive whole.[18] Out of this intersubjective field, “figures” emerge. The configuration of a figure against a ground displays the meaning, and the meaning is achieved only through relations in the field. Thus, the relationship between the ground of the field and the figures that emerge is what gives meaning to the whole.[18] Burnout is lived in the context of family and society. In burnout, one figure that is immediately present and stands out from the ground is the perception of fatigue. The symptoms are located in embodied, intersubjective relations with others and are experiences that is perceived by the person who lives through this condition.[16] In contrast, when feeling well, our sensation of the body is part of the background.

To perceive and be aware of an emerging figure is the act of contact.[16,18] Thus, perception is the realization of my access to the world via my perceiving and interrelational body.[18] Further to Merleau-Ponty, "perception is inseparable from the consciousness it has or rather is of reaching the thing itself."[16 (p. 374)] Within the interconnection between the person and the phenomenal field, the person may become aware of sensations of fatigue and "live through" the experience. According to Merleau-Ponty, "living through" means that I allow my bodily self to be effected by the situation.[16] In a "healthy" contact process, the awareness of the sensations of fatigue evolves into consciousness. These sensations are in turn mediated, preserved, and integrated.[17] On the other hand, the contact process might be interrupted by a lack of awareness by a suspension of reality by withdrawing my bodily self from the situation. Absorbed in thoughts, I am no longer in a world of space and time because "the world is not what I think but what I live through."[16 (op.cit., p. xvii)]

3 | METHOD

3.1 | Participants

The inclusion criteria were individuals with symptoms of fatigue- and pain-related diseases, who were on sick leave of 50% to 100% for at least 3 months prior to the interview. The first author contacted some of her colleagues and asked if they knew of potential participants for the project. Six individuals (four women and two men) contacted her by phone to participate. They were between 35 and 50 years old. Four of them were married or cohabitants, one was single, and one lived with a teenager. The interviewees represented different work situations such as information technology (IT), sales, private health care, psychiatry, and production. The educational level among the participants was relatively high, and four of them held management positions. Two of them had experienced burnout previously. One had been on sick leave at 100% for 2 years, two for 1 year at 100%, and one for 1 year at 20% to 50%. The remaining two had been on sick leave for 3 years; one of them at 100%, and the other at 50% to 100%. The names given for the participants below are pseudonyms.

3.2 | Datageneration and analysis

An existential phenomenological method was chosen because this approach is especially relevant when the aim is to explore burnout as an intersubjective, lived, contextual, and temporal phenomenon.[19,20] Semistructured interviews were chosen to uncover how the participants made meaning of their situation.[19,20] The first author conducted the interviews and transcribed the audio-recorded interviews verbatim. During the interviews, the intention was to give full attention to the whole spectrum of themes, events, and emotions related to the interviewees' experience. We used interpretative phenomenological analysis (IPA) as described by Linda Finlay.[19] Due to its interpretative engagement with the data and a move away from the search for essence, IPA is simultaneously inductive and deductive. The method consists of several steps. The transcription of the audio-taped interviews verbatim is an important part of the process of getting closer to the data. Then, reading and rereading the text are part of the first step, commenting on particular sections of the transcript. In this process, emerging meaning units were coded manually and listed under descriptive themes. The second step was to identify main themes and subthemes and search for potential patterns of meaning related to the experience of burnout in each of the transcripts. The third step was to explore patterns of meaning related to the phenomenon that was experienced similarly and differently across the transcripts. A general meaning structure of the interviewees' experiences of burnout was developed. In the fourth step, the theoretical interpretation inspired by Merleau-Ponty's[16] embodied consciousness of being human gave meaning to the interviewees' narratives. In addition, the idea of interruptions to contact as described by gestalt theory was applied to understand mechanisms that might maintain the interviewees' frustrated strivings beyond their bodily limits. The phenomenological research approach emphasizes the individual lifeworld; however, as a method that contributes to explore human phenomena, it can be recognized as valid for human beings in general.

3.3 | Ethical considerations

Prior to the interviews, both verbal and written information about the study were given in separate meetings, and written informed consent was obtained from each of the participants. They were given a copy of their transcript and had the opportunity to read and amend the transcript. All data were made anonymous and stored in a secure manner according to the ethical principles stated by Derby University (UK) and the European Association for Psychotherapy (EAP). In designing the study, the participants' vulnerable situation, being on long-term sick leave, was given a special consideration. Clear boundaries were set, based on a written informed consent about the context of the research project, the research process, and how the findings would be reported. We acknowledged that the research process could cause painful awareness of their situation, and consequently, each participant was informed about the opportunity to come in for a debriefing session after the interview if they experienced excessive emotions as a response to what was brought up during the interview. However, this situation did not occur.

4 | FINDINGS

Through the analytical work, four temporal themes emerged, which described various aspects of the interviewees' experiences. These were "achievement," "pressure," "psychosomatic collapse," and "personal meaning and reorientation." To illuminate these themes, we will present selected excerpts from the empirical material, followed by our reflections and analysis.

4.1 | Achievement phase

This phase is distinguished by high levels of energy spent achieving their individual goals. All the interviewees seemed dedicated to the work they were doing.

Ann My career has meant everything to me. I have fulfilled myself and confirmed that I am worthy.

They all perceived themselves as resourceful individuals, enthusiastic, and positive. Moreover, they were willing to do even more than others seemed to expect of them.

Lill To contribute has always been a part of the work culture, and in particular, it has been an expectation for the managers. So first I was at the office for longer than I should have been, then I went home and tried to be a mother for a minimum of time, putting in a maximum of quality. When the kids were put to bed in the evenings I went back to do some more work.

Common focal points among the interviewees were their experience of being “intoxicated” by their work. Working seems to be at the forefront of priority for everything in their lives. Both their family lives and their own basic needs seemed to be pushed into the background.

Gro It starts as an intoxication, and then it becomes so much fun that you don't manage to say no. I also worked late. I took on another project in the evenings and graduated at the same time.

4.2 | Pressure phase

The interviewees described how they experienced the period just before they became ill where they became more consciously aware of not being able to cope with their work situation.

Jon You are supposed to be working. You sit looking at the PC and don't manage to open letters, unable to turn on the machine, unable to do anything, and you know that the work just piles up. I did not do my job. I understood that later. It became too much.

Some of the interviewees experienced traumatic events related to members in their close family before they became ill, such as separation, illness, and/or death.

Kari We nearly lost our son. Then my father-in-law lapsed into coma when he had surgery.

Three of them also described episodes at work that were difficult to deal with, which affected the enthusiasm and dedication they previously had experienced related to their work.

Ann I experienced being stabbed in my back. I felt really sad about that. Extremely disappointed. It really got to me.

All the interviewees described an increase in their perceived level of distress.

David For a period before I became ill, I often experienced being angry. I had a lot of aggression, frustration and uncontrolled fury.

They started to question their own capacity and the level of support available, but they were still driven by an obligation to carry on.

Lill I worked twenty-four hours a day and knew that I was tired, but it was so interesting. I wondered, however, if it cost more than it was worth. I wondered if I was able to make it.

According to their experiential descriptions, their attempts to meet their own expectation “I should be able to accomplish” seemed to have failed. In spite of this fact, they continuously pursued the strivings and made efforts to cope, because inactivity and being unable to do as much as they did before evoked fear.

David I ran away from myself by jogging. This used to be a safety valve for me. I was so drained that I wasn't able to think through my problems. When I ran, they were gone. This was when I had more energy. Perhaps I avoided to catch hold of myself. Now I don't have the energy to run anymore.

4.3 | Psychosomatic collapse phase

Slowly, the consequences of their life situation resulted in perceptions of lost control and powerlessness, increased fears of appearing weak and worthless, and the development of a more permanent somatic exhaustion.

Jon I was going to attend a meeting. Then I don't remember anything more. I passed out and woke up in the hospital with 30 heartbeats per minute. There was no reaction. It was just as if the brain was disconnected.

In this phase, they became more consciously aware of bodily sensations and limitations. This awareness seemingly caused raised levels of fear, which heightened their perception of being helpless and vulnerable.

Gro I was depressed because I was losing my identity. I used to be an active person. Who am I now when I cannot be that person?

The interviewees described their experience of burnout as being physically and mentally exhausted. In addition, they had several bodily symptoms, which persisted and fluctuated in intensity over several months. They described losing control over their lives feeling guilty, frustrated, and angry towards themselves. Feeling guilt and frustration seems to be an appropriate emotional reaction to the situation. The anger turned towards themselves however is more subtle. This is what three of the interviewees said:

Gro I felt very guilty. Gruesome. I judged myself to rack and ruin because I was so drained.

David I don't have the energy to be anything else than what I am—pretty disgusting.

Lill I worked myself to death and felt that I was worthless. I felt that I was unable to cope. I was unable to make decisions, and I felt angry with myself. I didn't want to accept that I was not able to keep on going. I yelled at myself, saying, don't be foolish! I felt completely drained.

Family roles and relationships were threatened due to their inability to interact with significant others as they once did.

Jon I think you have to do something with the genes to accept being 100% taken care of by your wife. It was hard.

One of the problems they all described was how difficult it was to relate to the illness and to accept and justify that they were ill. As Ann mentioned earlier, her career has confirmed that she is worthy. Might accepting that they were unable to perform be related to the opposite feeling—being unworthy?

Gro I realized that I was in a sense ill in the same way as if I had broken a leg. However, it wasn't the leg that was broken. It took some time to accept that.

Some of the participants explicitly mentioned not feeling taken seriously.

Jon I finally managed to get through in the system and got an opportunity to speak to a psychologist. After the five consultations they had given me, I was told that this was not a problem. I could just carry on, take some painkillers, keep on exercising and then start working again.

4.4 | Personal meaning and reorientation phase

All the interviewees had clearly reflected much on why they became ill and how to recover. Such reflection might represent the beginning of a gradual reorientation.

David I can see a pattern. It is clearly related to my way of being and my way of being treated. I can see that I am just about to take the wrong step again.

Two of the interviewees have previously experienced being burned out. They seemed, however, not to have learned how to avoid being ill from burnout.

Kari I committed myself to more assignments at work and let myself be fascinated by it. I pulled myself beyond my bodily limits. It all went well for some time during this interval between the first and second time I burned myself out.

The individual processing of their situation has contributed to varying degrees of how they experience themselves. This is how Ann puts it.

Ann I am not quite happy about being a new one. I have kind of not yet become. Call it a foetus. I am not completed as a new one. I just am.

5 | DISCUSSION

The four temporal phases of burning out show that the interviewees went through a process, from functioning well in society to becoming unable to master their life situation. Due to several circumstances, the pressure they experienced raised their level of distress. The findings indicate a lack of concern for taking care of themselves, ignoring the sensations of illness. Merleau-Ponty[16] identifies perception and awareness as the act of contact. Thus, when we consciously engage with a phenomenon, we are in contact with our real, emerging world. In this section, we will discuss how the dynamics of contact in the intersubjective field might have affected the participants' existence as bodily subjects.

5.1 | The act of contact during the transition from the achievement phase to the pressure phase

All the interviewees were dedicated to achieving their personal goals, and they were apparently successful and proud of themselves before they became ill. Although they seemed to be strong and self-confident, some of them expressed concerns about not being good enough. At some point, during the achievement phase, the interviewees perceived distress caused by a mixture of work overload and lack of support. Traumatic events related to their family lives or colleagues contributed to raise their level of distress, leading to an inability to cope with their situation. The experiential descriptions presented in the findings revealed some semiconscious expectations and values acting as “introjects.” These semiconscious expectations and values can be understood as accepted personal habits that are acquired without full awareness of their meaning and purpose.[18,21] This finding might shed light on how absorbing commitment to achieve might be fuelled by a toxic introject of not being “good enough.” To counteract this introject, the participants were driven by an obligation to carry on. Unhealthy or dysfunctional contact might involve chronic states of too much or too little contact with the environment. Absorbing commitment can be understood as too little contact causing a rupture in the fluid flow of contact. In gestalt theory terms, this interruption to contact is termed “egotism” and can be understood as the participants' unconscious attempts to bring an end to their uncontrollable life situation.[22]

Thunman[4] also refers to how important it was to her interviewees to perform well and that the identification with their jobs became their identity as human beings as well. This finding is in line with Hallstein's research,[10,23] where he refers to scripts such as "I am my achievements" that he assumed motivated an absorbing commitment to work. Moreover, he claims that the questioning and loss of these scripts gradually confirmed a negative self-image. Identity is undeniably part of sociality, and identity links the self to others and is developed in and through interactions with others. Related to the meaning of "selfhood," one of the parameters described by Merleau-Ponty,[16] the feeling of powerlessness, might be a feature of the psychological situation for the interviewees. They tried to establish the most effective balance between their bodily weakness and expectations of the social world. When they were no longer able to meet the conventions of the group and say "yes!" to fit in,[16] a negative self-esteem was confirmed. This finding highlights the lifeworld as phenomenologically both relational and personal in that the interviewees directed their behaviour towards what was expected, both within and outside themselves.

During the achievement phase, there also seemed to be a disruption in the awareness and flow of contact between "self" and "other." This interruption might have prevented the interviewees from being consciously aware of feeling overwhelmed by the inability to cope with their perceived demands. In turn, this interruption to contact might have resulted in a lack of concern for taking care of themselves. During the pressure phase, they became more consciously aware of being exhausted. Although they felt ill, they continuously made efforts to cope. This finding supports Jingrot and Rosberg's[7] finding that their participants ignored the stress symptoms and worked harder despite increasing illness.

They continued their frustrated strivings and deflected from their situation. One of the interviewees used to run before he became ill, to avoid being consciously aware of the problem, and to postpone dealing with it. This finding can be seen as a normal human ability, which allows us to put off dealing with an emotional situation until we feel able to address it.[24] As Merleau-Ponty puts it, "Each time I experience a sensation I feel it concerns not my own being, the one for which I make decisions, but another self, which has already sided with the world."[16 (p. 115)] Thus, both egotism and deflection, understood as interruptions to contact, contributed to the interviewees' ability to adjust creatively to their situation during the achievement phase. When mentally occupied, we may habitually interrupt bodily sensations and desensitize our bodily needs.

5.2 | The act of contact during the transition from the pressure phase to the psychosomatic collapse phase

During the pressure phase, the interviewees experienced having committed to demands that began to feel like a pressure. In addition, the perceived lack of recognition and disbelief from their communities also triggered an existential anxiety and feelings of shame. The association between shame and inferiority might become particularly amplified in the context of our achievement-oriented society, because the human being exists in a continuous interplay with the intersubjective field.[16,18] This is in line with Thunman's[4] suggestion that individuals suffering from burnout might be the victims of our achievement-oriented society.

The interviewees described a disruption in the roles that connect "self" with "other." Previously, they contributed well both to their family life and to society. Our study revealed how family roles and relationships were threatened due to their inability to interact with significant others as they once did. Experienced agency also shifted during the transition from powerfulness to powerlessness that marked the psychosomatic collapse phase. The interviewees described feeling guilt, frustration, and self-directed aggression for being a burden to their families and to society. As stated by Gro, she judged herself "to wrack and ruin," which demonstrates how introjection and "projection" operate simultaneously, resulting in retroflection or the punishment of the self. Here, projection can be seen as an attitude, which actually belongs to her own personality but is not experienced as such. Instead, it is attributed to persons in the environment.[17] Once Gro had projected her negative judgement she was making of herself (the introject) onto people in the environment, so that it seemed to her as though they were making the judgements, she could regard herself as a victim. This finding is in accordance with how such interruptions to contact might cause a shame reaction.[18] Shame is a severe rupture in the social field of belonging that shifts the emotional state from its functional organizing range to its dysfunctional, disorganizing extreme.[25] This rupture clearly illustrates how shame inhibits the individual from being able to take in support from others.

All the interviewees reported feeling worthless and angry towards themselves, which we argue can be interpreted as episodes of narcissistic depression. This finding describes self-hating depression, which is characterized by shame about the self and is distinctly different from depression caused by grief due to a loss.[26] Our study provides support for understanding burnout as an antecedent rather than a consequence of depressive symptoms and thus supports the findings in Ahola and Hakanen's study.[8] Thus, the option of considering burnout as a form of depression[9210] is not in line with the findings in this study.

The way the participants previously experienced themselves as being in the world felt altered and obstructed. This finding seems to be in line with Gingrot and Rosberg's findings[7] where the gradual detachment in their participants was interpreted as a process of losing one's homelikeness. Our participants' strivings seemed to have triggered perceptions of lost control and powerlessness along with several physical symptoms. When healthy, we can experience a familiarity with our lifeworld that is easily taken for granted. Merleau-Ponty speaks of our habitual body, which we sense is in habitual when we become ill.[16] On the basis of Heidegger's work,[27] Svenaeus[28] has developed an understanding of the essence of illness, which he refers to as unhomelike being in the world. Similarly, when the participants became ill, their bodies felt alien to them, influenced by processes beyond their control.

During the psychosomatic collapse phase, the interviewees became increasingly aware of their bodily sensations and symptoms of illness. Their physical symptoms became a "figure" against the background they knew: “One's own body is the third term, always tacitly understood, in the figure-background structure, and every figure stands out against the double horizon of external and bodily space.”[16 (p. 101)] Despite this fact, they still made efforts to cope, because inactivity due to the inability to perform as before evoked fear. This finding illustrates the act of contact where symptoms that are located in the participants' embodied, intersubjective relations with others emerge as experiences of burnout.[16]

In order to avoid being consciously aware of the evoked fear of appearing weak and worthless, there seemed to be a total “desensitization” of the interviewees' own bodily needs during the transition from the pressure to the psychosomatic collapse phase. This response prevented them from being able to sense, be aware, and mobilize energy to make contact to satisfy their basic needs. This interruption to contact might explain how the interviewees were able to ignore their bodily needs over a long period of stress. Desensitization can be understood as a response when sensations from the body such as pain or discomfort are ignored and information from the environment is also blocked out.[24] This “blocking out” can be seen as similar to how Merleau-Ponty[16] describes how the contact process might be interrupted by lack of awareness by a suspension of reality by withdrawing the bodily self from the situation. This brings the focus of the discussion to how the interviewees were put face to face with themselves. Previously, they were able to run away from themselves in several creative ways, such as deflecting the awareness of their own needs. When experiencing the psychosomatic collapse, the illness prevented them, however, from being able to flee. Thus, the inability to “live through” the experience of alienation from their lifeworld and interacting with significant others as they once did raised existential anxiety.[27] This confrontation can however open new ways of accepting the “new” lifeworld, as we will address below.

5.3 | The act of contact during the transition from the psychosomatic collapse phase to the meaning and reorientation phase

The interviewees expressed concerns about being unable to justify their sensation of illness. The lack of societal recognition of their condition might have seriously affected the process of contextualizing the illness and the ability to acknowledge the situation as it was. Two of the interviewees however seemed to have started to reorient themselves by accepting the sensation of fatigue and gradually started “living through” the experience. As previously pointed out in the first section, in a healthy contact process, the awareness of the fatigue sensations can evolve into consciousness that in turn is mediated, preserved, and integrated.[17] On the other hand, the contact process might be interrupted by lack of awareness by a suspension of reality by withdrawing the bodily self from the situation. According to Merleau-Ponty,[16] living through means that I allow my bodily self to be affected by the situation. This might be what Ann experienced when stating that she was not quite happy about being a new one. Thus, letting herself be affected by the process was seemingly experienced as demanding. Empowered to being able to “live through” the situation as it is and overcoming feelings of shame might facilitate personal growth. This is in line with the paradoxical theory of change[29] where change seems to occur paradoxically when one fully becomes what one is, rather than trying to be what one is not. This might be related to what Ann says, “I am not completed as a new one. I just am.” What she describes here might be understood as accepting the unfolding of herself as a “new” person. As she points out, this person is not complete yet, and in the process, she seems able to stay in contact with what she experiences here and now. Obviously, the interviewees struggled to establish a “new” lifeworld and to avoid pushing themselves beyond their bodily limits. To be able to contextualize the illness and take care of their basic needs seemed to be of utmost importance for rehabilitation.

6 | CONCLUDING REMARKS

By attending to the interviewees' subjective experience of burnout, meaning was explored.

During the transition from functioning well in society to becoming unable to master their life situation, complex contextual factors seemed to influence individual vulnerability. Thus, burnout might be understood as an intersubjective, lived, contextual, and temporal phenomenon. We discussed the findings in the context of existential phenomenology and gestalt theory. When living through burnout, the interviewees tried to establish the most effective balance between their bodily weakness and expectations of the social world. We identified several interruptions to contact, which seemed to boost their ability to continue their frustrated strivings. These interruptions to contact can be understood as creative adjustments in a survival process. Thus, the study contributes to a deeper understanding of how complex factors influence individual vulnerability that can lead to a fatigue reaction. Moreover, when no longer able to perform and meet the conventions of the society, experienced agency shifted, and a negative self-esteem was confirmed. Our personal identity is developed in and through interactions with others. When feeling unsupported by their communities, the interviewees struggled to justify their own sensations of illness. Therefore, the feeling of powerlessness experienced by the interviewees might be a feature of their psychological situation.

Although the interviewees mentioned some episodes of feeling depressed, they did not see themselves as depressed, rather frustrated and angry. Thus, based on the findings in this study, we question the view of Bianchi et al[2] that the focus of public health policies should just consider what they hold to be the depressive core in burnout. Research has shown that burnout and depression have similar symptoms as pointed out in this study. However, results gained in previous research have shown substantial differences—for instance, related to inflammation biomarkers.[30] Additionally, there also seems to be differences on a physiological level, associated with hypothalamic-pituitary-adrenal (HPA) axis functioning.[31] Thus, more research that explores burnout as a phenomenon is warranted.

Finally, the findings indicate that a lack of recognition of their illness may seriously have affected the healing process. Few studies have focussed on how clinical encounters might influence the return to work process experienced by the sufferers themselves. Therefore, further research seems warranted to provide more knowledge related to the needs of these individuals. Recognizing subjective health complaints at an early stage and supporting the awareness of basic, human needs, might hinder early symptoms of burnout from developing into a chronic condition.

ACKNOWLEDGEMENT

We acknowledge Samantha Copeland for her attentive advice on final revisions.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

FUNDING INFORMATION

The authors received no financial support for the research and/or authorship of this article.

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How to cite this article: Engebretsen KM, Bjorbækmo WS. Burned out or "just" depressed? An existential phenomenological exploration of burnout. *J Eval Clin Pract*. 2019;1–8. https://doi.org/10.1111/jep.13288

Article 2

Received: 27 February 2018 | Revised: 7 June 2018 | Accepted: 13 June 2018
DOI: 10.1111/jep.12986

ORIGINAL ARTICLE

WILEY Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

Suffering without a medical diagnosis. A critical view on the biomedical attitudes towards persons suffering from burnout and the implications for medical care

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Abstract

The search for causal explanations in medically unexplained syndromes such as burnout has not been resolved by evidence-based medicine. A biomedical model encourages a reductionist diagnostic practice and a dualist split between physical and psychological symptoms. Therefore, diagnosing and treating these syndromes remains a challenge. Depression is a common aspect in burnout and, as a result, clinicians often diagnose burnout patients as depressed. The Norwegian government expects medical efficiency to reduce sick leaves. Medically treating depression has a documented effect. This practice may pose threats to the increasing number of individuals experiencing burnout. The clinical guidelines in evidence-based medicine mirror what counts as knowledge in medical inquiry, which in turn shapes attitudes towards individual patients. The aim of this article is 2-fold: firstly, to assess how the values that accompany the biomedical paradigm affect clinical care, and secondly, to replace the biomedical model with a genuine person-centred approach.

In the study described, an existential phenomenological method was applied. Eight individuals, who experienced burnout, were included. They had been on long-term sick leave (>1 year) due to symptoms of fatigue and pain and fulfilled the criteria for Exhaustion Disorder (ICD-10, F43.8A). Their symptoms were not medically explained, and almost all the participants were labelled as depressed. Four themes emerged that described how they experienced living with burnout: “unhomelike being in the world,” “the limit of diagnosis,” “naked in the eyes of the public,” and “a path to hopelessness.” I identify 2 main problems; firstly, the mismatch between the patient's experience of his or her illness and the doctor's interpretation of the condition can lead to ineffective treatment. Secondly, the interviewees struggled to be recognized as ill. Thus, the inherent values in the biomedical paradigm might have serious implications for the medical care of patients with burnout.

KEYWORDS

diagnosis, evidence-based medicine, guidelines, multi-morbidity, person-centred health care

1 | THE CHALLENGE OF DIAGNOSING BURNOUT

The search for causal explanations for medically unexplained syndromes has not been resolved by statistical data because of the multiple heterogeneous factors involved.[1] These syndromes are to a minor degree seen as a reaction to complex causes and causal mechanisms, and are not understood in relation to the whole person. A biomedical model encourages a reductionist diagnostic practice with a dualist split between physical and psychological symptoms. Therefore, there is a need to re-discover the perceived world[2] to explore the burnout phenomenon further. The aetiology of burnout is unknown, and there is no clinical guideline available for practitioners with burnout patients. Therefore, diagnosing burnout remains a challenge because of this lack of knowledge. Burnout is a generic name for a state of physical fatigue, emotional exhaustion, and cognitive weariness, due to prolonged exposure to unavoidable stressors.[3] Such multi-morbidity is common—psychological and physical conditions often co-exist—but the evidence for recommendations in, for example, the NICE (National Institute for Health and Clinical Excellence) guidance[4] is generally derived from people with just one health condition. Moreover, the syndrome is characterized by several, severe subjective health complaints that often overlap with symptoms seen in other conditions such as fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, neurasthenia, or myalgic encephalopathies (ME).

In Norway, there is a focus on shortening the rehabilitation process and an expectation that clinicians will provide for an effective treatment to decrease long-term sick leaves. Depression is a common symptom in burnout, and since medical treatment of depression is documented as effective and might speed up the recovery process in burnout, this constitutes the guideline typically used by general practitioners.

In my work as a psychotherapist, and before that as an organizational consultant for corporate business, I have experienced burnout as an increasing individual and societal problem. Clients often present with stories of how they struggle to be recognized as ill and not just lazy. Due to this, the challenge related to diagnosing burnout includes 2 main problems. One is the mismatch between the patient's experience of his or her own illness and the doctor's interpretation of the condition. Consequently, there is a danger of ineffective treatment. Another problem is the experience of being misunderstood by the doctor, for instance, when the subjective symptoms are not taken seriously, which can worsen the symptoms. This also has a number of moral implications, which I will not address here.

The aim of this article is 2-fold; firstly, I will assess how the values that go with the biomedical framework affect medical inquiry and the attitudes of the medical profession related to how burnout is understood and treated. Secondly, I will challenge the biomedical model and recommend that we replace it with a genuine person-centred approach. In the next section, I present the findings of a qualitative study, illustrating how 8 interviewees experienced burnout. Then I discuss how ontological and epistemological assumptions and the values inherent in the biomedical model might obstruct the care of individual burnout patients.

2 | LIVING WITH BURNOUT

In the current study, 8 individuals on long-term sick leave (>1 year) due to symptoms of fatigue and pain were included. They fulfilled the criteria for Exhaustion Disorder (ICD-10, F43.8A). An existential phenomenological method was chosen because this approach is especially relevant when the aim is to explore burnout as an intersubjective, lived, contextual, and temporal phenomenon.[5,6] Accordingly, I conducted in-depth interviews to explore the interviewees' experience of being met by the health care system to regain well-being. The existential phenomenological research approach[2] emphasizes the individual lifeworld[7] and can be defined as a method that explores human phenomena that can, in turn, be recognized as valid for human beings in general. This approach reflects Merleau-Ponty's idea to understand the human being as a "body-subject" where the human consciousness always is embedded in the body. Phenomenology has been the guiding philosophy both during the generation of the empirical data and throughout the analysis and writing process. In the interpretation of the participants' stories, 4 themes emerged from the analysis of the empirical material that reflect the participants' lived structures of meaning. These themes were named "unhomelike being in the world," "the limit of diagnosis," "naked in the eyes of the public," and "the path to hopelessness."

I follow Svenaeus,[8] who has developed an understanding of the essence of illness based on Heidegger's work, Being and Time,[9] and refers to illness as "unhomelike" being-in-the-world. When we become ill the body feels alien, influenced by processes beyond our control. To feel your own body or yourself as alien is described philosophically as the feeling of not being at home, but rather as an unhomelike perception of your own being in the world.

To illustrate the interviewees' lived experience, I will present some snapshots of how they described their situation. The names given for the participants below are pseudonyms. Their stories point to some problematic implications for medical care of burnout. I have chosen to focus on the 4 themes previously mentioned.

2.1 | Unhomelike being in the world

Without exception, the participants were transformed by the illness into persons who were unknown to themselves.

> *"I'm in the middle of chaos. I don't understand myself, can't recognise myself. Cannot fathom why things are as they are. I hardly know who I am."* ***Emma***
>
> *"Reality has become lost to me. Not completely, but partly. My identity has also been shaken, quite a lot. Actually, a great deal, because I have had to handle reality – today's reality. Often I have not recognised myself. This is very frightening. I react in ways I don't recognise. Both contracting such a strange illness, but, also everything around it kind of makes me feel like I've been pushed out of my own skin."* ***Sonja***

The pain took over their lives, yet it was difficult to explain in words how they felt. It was a sensation of embodied, existential exhaustion that did not distinguish between "physical" or "psychological" aspects. The immune system seemed dysfunctional, resulting in recurrent infections, allergies, and food intolerances. Other symptoms were headache, dizziness, and nausea, problems with insomnia, sleeping, formulation, coordination, concentration, memory failures, anxiety, or depression. This condition persisted and fluctuated in intensity over several months.

> *"I have no clear recollection of the first doctor's appointment, but I tried to explain how things were. I felt absolutely awful. In fact completely horrible and almost shameful. Not at all well and it is hard to describe."* ***Toivo***

2.2 | The limit of diagnosis

By medical examination, no biomarkers were found that could explain their subjective health complaints. Nevertheless, a diagnosis is required for being granted sick-leave compensations in Norway.

> *"I felt that the doctor was real happy when I was sitting and crying in her office because at last she could prescribe Cipralex and call me depressed."* ***Tone***

Different diagnoses were given, such as neurasthenia, depression, or ME. These conditions are medically unexplained and, except for depression, there is no known effective medical treatment. According to public health policies, depression is considered the core aspect of burnout. Therefore, medically treating depression is thought to contribute to a shorter recovery process and was strongly recommended by their doctors.

> *"My doctor diagnosed ME, but this was not accepted by the Norwegian Labour and Welfare Organisation (NAV). The neurologist at the hospital wanted to know if I had been medicated for this condition, something I hadn't been. She told me to try Cipralex. But Cipralex is for depression. I am absolutely certain that I'm not depressed. She thought I should try Cipralex anyway, and if it didn't work I should just increase the dosage. I was completely shocked for ages. That this was supposed to be treatment, and from a senior consultant! Not to experience a grief reaction would be a total aberration. You are grieving for the loss of a function or whatever. It's normal, but it's not depression. Grieving is not a psychiatric diagnosis."* ***Sonja***

In many of the cases, however, being on a "selective serotonin reuptake inhibitor" (SSRI) medication had a counteractive effect, leaving them with even less energy. In some of the cases, the SSRI medication seemed to worsen their symptoms.

> *"He asks me if I'm suicidal. He is focused on depression and antidepressants came up quickly. The focus became wrong quite early on in relation to what my needs were or what I needed help with. I actually felt lobotomised, more or less in the middle of nothing. I went around like a zombie. I had to just stop taking the SSRI. Then the doctor swapped medication and gave me something totally the opposite. I exploded then. Went really manic. In actual fact I was hyperactive. Having burnout meant I didn't have much strength to cope so I lay there shaking and grabbing hold of the settee. I think that stuffing people with antidepressants and pharmaceuticals is completely bonkers when one doesn't really know what the problem is."* ***Toivo***

2.3 | Naked in the eyes of the public

The fact that their illness could not be medically explained made them feel stigmatized by not being recognized as ill.

> *"I am not being misunderstood, but I'm experiencing what it means not to be believed – actually a lack of trust."* ***Tone***
>
> *"People try to understand. And then you notice that they are a bit prejudiced. They're thinking `can't you just pull yourself together. How can that be so hard'? But they don't get it. I was embarrassed and felt awful – can't even manage that, you know."* ***Nina***
>
> *"It would have been easier to have a disease that had a status and was something you could actually see. I think the doctor felt uncomfortable with everyone nagging him and that it would have been good for him to be able to put down on paper that he had got me back to work again. I have dreaded going to the doctor."* ***Emma***
>
> *"With regard to my doctor it is a continuous battle. I don't feel that he respects me. Had the feeling he labelled me into a psychological pigeonhole. At first, I went there on my own, but now my husband comes along every time because I sense a big difference when he is there."* ***Gunn***

Being seriously ill without recognition of their situation triggered an existential anxiety and a need to withdraw from interactions with others. Moreover, being given a psychopathological diagnosis raised their fear of not being able to understand what was happening in their bodies and fuelled a shame reaction.

> *"When you experience hitting rock bottom like that, all your protective walls are knocked down and all your feelings lie exposed, leaving a lot of yourself seeping through."* ***Hans***
>
> *"The worst of it was handling the so-called reality, dealing with people and feeling so incredibly useless and shitty. I feel like it shows on the outside and that it's something everybody can point at and see. That's when anxiety and fear come thundering in all directions, shapes and variations, which is really, really shitty."* ***Toivo***

Their basic need was to re-orientate themselves to survive and learn how to cope with their transformed self in relation to others. It was however not possible to escape, as society required interaction in return for sick-leave compensation.

> *"I think the doctor has had a directive from NAV. The woman at NAV has in reality confirmed it. I felt real pressure to be at work. It went as far as my boss telling me to do something. You're walking around here like a corpse. People are wondering what's happening with you. Why the heck are you here so much. It's not good for you. Can't you just go on home and get well."* **Hans**
>
> *"As a matter of fact it was my doctor who seemed to think I could work. My boss and my clients were saying 'you look so tired and ill. Aren't you going home soon?' I became more and more ill and ended up at Aker Hospital with a possible heart attack. My pulse was sky high. But it wasn't a heart attack, and I was told I was just tired."* **Sonja**
>
> *"I didn't have any physical symptoms that showed. I was just terribly tired. She listens to me, a bit impatiently and says "Ok." I felt a strong scepticism emanating from her, with a very clear message about not wanting to put me on 100% sick leave. I started crying. It just felt so painful not to be met properly. It was a continuous struggle."* **Nina**
>
> *"I am not able to do anything. It's tiring. And scary. From being active and sociable to only wanting to pull away and be left in peace. Be alone. You imagine that this is laziness. Pull yourself together. And that's what happened. I started working a bit again in order to pull myself together and try."* **Emma**

2.4 | The path to hopelessness

When not being taken seriously by their doctors, their experience of being ill escalated. Two of them considered suicide as a way out. Progressively, the impact of their life-situation led to lost control, an increased fear of appearing weak and worthless, and they gradually experienced a more chronic exhaustion that might have prolonged their rehabilitation process.

> *"Dreading having to go to the doctor doesn't exactly help you get better. I felt like a little boy at school being told off. Going to see a doctor you know will tear at your soul isn't much good and you just cannot manage to do anything about it. The locum realized how poorly I was. I think he understood that I could do with some help and he got me an urgent appointment with a psychologist."* **Hans**
>
> *"I had cancer when I was in my thirties, and then I was received with open arms. Everyone does everything for you and gives you presents. However, when you get an illness like burnout there aren't many gifts around, that's for sure. You are just considered as a nobody. I was so distraught about everything that if I hadn't had children and grandchildren I would have killed myself. I thought about that a lot. During the worst period, I kept thinking about how I couldn't stand this. First of all feeling so ill and almost incapable of getting out of bed – and on top of that experiencing so much resistance. You are just a nobody then. There is nothing left."* **Sonja**

From what I have seen, both in the current study and in my clinical practice, the way in which burnout is treated in the health care system contributes to worsen their symptoms rather than promoting recovery. I now move to a more general discussion about the biomedical attitude towards burned out patients and the structural and ontological constraints that seem to motivate this attitude.

3 | INHERENT VALUES IN THE BIOMEDICAL FRAMEWORK AND IMPLICATIONS FOR UNDERSTANDING BURNOUT

In contrast to the interviewees' stories in the previous section, the biomedical paradigm paints a different picture of understanding syndromes like burnout where no biomarker is found. That there is no biomarker for burnout means that it falls under the category of medically unexplained symptoms. This problem is not unique for burnout. There is a range of other conditions, such as fibromyalgia and irritable bowel syndrome, which are also medically unexplained.

Diagnosing patients with several, severe subjective health complaints can be a challenge because of the lack of reference standards for the diagnosis.[10] This problem is linked to related issues, such as lack of a causal explanation, lack of diagnostic descriptions, and lack of a treatment or medical interventions.[11] In the cases described in the previous section, the interviewees' condition could not be explained in such terms—in other words, the criteria for ontological objectivity had not been met. This represents a problem for evidence-based medicine related to the biomedical approach and "bottom-up" thinking about causation.

Research on medically unexplained syndromes has pointed to several ontological and epistemological limitations related to evidence-based medicine for understanding these syndromes properly. One such limitation is that the evidence hierarchy shows a commitment to a Humean notion of causation in its prioritization of comparative studies and randomized controlled trials, based on regularity theory and difference making, respectively.[12] Evidence for causal claims are ranked according to the presumption that the relevant relations go in the direction from biological processes (causes) to mental and emotional processes, behaviour, and culture (effects). The ontological assumptions in this paradigm motivate statistical and experimental designs, and inherent ontological values are mirrored in how research is conducted and how data is assessed.[13]

These Humean commitments are thus reflected in the hierarchical ranking of evidence, and medical research methods such as randomized controlled trials and statistical inferential methods are the gold standard for creating new knowledge, particularly about causation.[14-16] The Humean notion of causation is strictly empiricist and defines causation as a form of correlation.[17] While causation does not automatically follow from correlation, such an inference is often made in clinical practice, for instance when labelling burnout as depression.

Consider that the correlation between burnout and depression might be because of a third unknown factor. Recently, it has become a matter for debate whether burnout should be considered a distinct medical diagnosis or a form of depression.[18] Amongst several symptoms, depression is just *one* of the symptoms in burnout and depression is a *common* symptom related to several different diseases as recorded in the diagnostic and statistical manual of mental disorders (DSM IV-TR, 2000). This kind of problem is related to the issue of confounding, or the possibility that unknown variables might influence the result (internal validity) of a study. This is only one type of case where correlation does not imply causation.[19] [15]

Medically unexplained syndromes are described as heterogeneous and multifactorial without a common cause.[11] The symptoms are often ambiguous and overlapping with no clear psyche/soma division. Moreover, there is no clear-cut one-to-one relation between the symptoms. However, biomedicine seeks to frame health experiences in simple cause-effect terms. Although this reductionist view is often helpful, it limits the usefulness of the approach when dealing with complex health conditions. Health is not a simple summation of causes and effects, because the cause can have multiple effects, and causes can interact to result in emergent properties of "disease." Accordingly, although there is a correlation between burnout and depression, it is quite another thing to draw conclusions from population level data that depression causes burnout or that they are the same condition. The epistemic consequence of taking a population or a sub-population approach and looking at average results in these populations is that this opens up a gap between the empirical evidence generated in the trials and the needs of individual patients.[20] Evidence-based medicine is criticized for systematically overlooking this gap between the statistical average and the needs of the individual patient. [13, 20]

In the biomedical framework, the statistical average of the relevant subgroup is supposed to apply to any individual case, although there is always a possible variation in the causal context within the population. [11,21,22] This problem is related to the question of external validity, ie the extrapolation of results in one population onto another population. This problem is because of the different contexts of the populations.[16,22] However, as seen in the current study, burnout symptoms manifested differently in the interviewees. Further, their individual needs were not recognized. Another problem related to external validity is the problem of recognizing who the patients are among that distribution. Burnout can be associated with being exposed to a stressful life-situation, but we do not know if a particular person is one who will experience burnout, because not everybody that experiences stress will suffer from burnout. The findings in the current study thus offer no support to Bianchi et al's[23] view that the focus of public health policies should just consider the depressive core in the burnout syndrome, nor that the inclusion of burnout in future disorder classification is unwarranted.

When ignoring the possible change in the causal context and thus failing to distinguish between, as it were, the "internal validity" of the general causal claims and their "external validity," mistakes can easily be made in causal reasoning.[16] One such mistake can be related to public health policies that consider burnout and depression as the same condition. Although burnout and depression have similar symptoms, there are physiological differences, as pointed out by the interviewees. It is reasonable to suspect that an effective treatment for one individual will not be an effective treatment for some or all of the others. Uncritically diagnosing and treating burnout medically as depression, due to one of the symptoms, raises serious concerns. As seen in the current study, medical treatment (with SSRI) had an unintended effect and worsened the symptoms for some of the interviewees. That this is a general problem is supported by recent research results. Antidepressants can lower the cortisol levels in burnout patients even more, and thereby potentially worsen their symptoms of burnout.[24]

The interviewees' experiences of "unhomelike being in the world" are related to how the biomedical model defines disease. There is a relationship between how fit for purpose the biomedical model and the clinical guidelines are to capture the diverse aspects of subjective health complaints and the quality of medical care.[25] The values that go with the biomedical paradigm, and the inherent reductionist and dualist ontology, form the basis for what counts as knowledge in evidence-based medicine. This fact has unfortunate and wide-ranging consequences, because these inherent values also affect the attitudes of the medical profession, affecting how patients are met and how illness is understood and treated. Being diagnosed as depressed was experienced as stigmatizing, and the interviewees expressed frustration with not being recognized as ill by their doctors. As expressed by the interviewees, not being believed might have severe consequences for their situation.

In this section, I have tried to show how the inherent values in the biomedical framework have stood in the way of diagnosing and treating burned out individuals for several decades. I will now offer an alternative approach that might help us understand the underlying mechanisms of this medically unexplained syndrome.

4 | A PHENOMENOLOGICAL TURN

4.1 | An existential phenomenological approach to illness

Phenomenology emerged as a philosophical movement and an epistemological idea, founded by Husserl in the middle of the 19th century. It has since developed into a range of research methods[26] including the existential phenomenological approach.[2] Phenomenology could be described as perception-based empiricism, in that we cannot conceive anything that is not perceived or perceptible. This approach differs radically from Hume's classical empiricism when it comes to what counts as data and the method of verification of observations.

One important difference between the phenomenological model and the biomedical model is that in a phenomenological framework, everything exists in connection with everything else, so that any change in any part affects all other parts of the phenomenal field. This means that each part is always seen in its role within the "whole," and the "whole" changes as the parts interact in fluid relation to one another. In the biomedical framework, however, the parts can be isolated and affected without necessarily changing the whole. The phenomenal field is "the lived world" as I allow my bodily self to be affected by the situation. To illustrate this point, consider the often-used metaphor that the biomedical model construes the human being as a complex machine. In this machine, dysfunctions might be caused by internal or external damaging factors and it is unable to re-establish well-functioning on its own. On this view, the human being is a passive "victim" subjected to external agents' active repair-work. The person as an agent is "gone," and thus, the person becomes the passive victim of the diseased part.[27] In contrast, phenomenology accepts the human being as an agent who is in constant interaction with his or her environment, aware of phenomena such as the experience of bodily sensations in response to internal and external interacting factors.

In phenomenological terms, the interaction between the person and his or her phenomenal field is a contact process.[2,28] In this process, the awareness of sensations evolves into consciousness that in turn is mediated, preserved, and integrated and results in a "new" organization of phenomena. That new organization, because of this process, is always and fundamentally an emergent phenomenon. The complexity of factors within the human body that influence each other always causes unforeseen effects in ways that are different from the mere sum of the factors. Therefore, we can never predict, dictate, or control the shape of this new organization.[29] Thus, phenomenological thinking may be a better approach to this kind of organization, one that emerges out of a multifactorial context.

According to Husserl,[30] consciousness is inextricably part of the bodily entity. Heidegger takes this view further by claiming that we always find ourselves in relation to something else and that I-myself is this relationship.[9] Ontological rethinking can support and open up for a re-interpretation of what is lost in how we consider human nature in biomedical medicine. One important rethinking is seeing the human being as an entity that can neither be reduced to a passive sufferer nor split into a brain and a body. Thus, existential phenomenology describes not just our way of being in the world but also our humanness. Symptoms such as depression, anxiety, grief, and fatigue are phenomena that express our humanness and emerge in relation to existential challenges.

4.2 | Phenomenology applied

The existential phenomenology as an approach to our humanness offers a genuine person centred approach to medical care. Evidence-based medicine has been criticized for lack of attention to subjective experiences with medically unexplained syndromes.[31] In contrast, the phenomenological focus attends to the embodied consciousness while being aware that the person and the world co-exist.[2] The clinical aim in a genuine person-centred approach is to explore what the individual, bodily experienced sensations are.

There are several consequences of a phenomenological paradigm for how the person is perceived and how treatment is engaged. Holistic relational values focus on the unique needs and nature of the person who experiences the illness rather than focusing on the illness itself.[32] A sensation of illness is a felt, embodied experience and thus part of the basic human condition. By contrast, a symptom is a constructed and socially informed cognitive interpretation.[1] In a phenomenological framework, the owner of the subjective experience is recognized. The main point here is to take the subjective lived experience of the condition back to "the owner" and not classify the symptoms based solely on the view of a medical expert.[29] A symptom is always an embodied experience before it becomes a symptom, that "indexes but is not itself an embodied sensation."[33] If the patient's status as a knower is disregarded, the person is also more likely to perceive themselves as stigmatized.

Moreover, lack of respect can destroy a possible trusting relationship.[34] The phenomenological view readily acknowledges the patient as a knower, which is critical to patient engagement, as illustrated in the case of burnout. Symptoms express our humanness. Therefore, health care providers need to meet the patient in reciprocal humanity that will ground a trusting relationship. To engage in a respectful dialogue can support the person to recognize the uncertainty that goes with the "unhomelike" being the world[8] and to be able to restore his or her confidence in the body.[35] Thus, the health care providers' role is to provide support for what the person really needs and to help frame the person's situation.[36]

5 | CONCLUSION

5.1 | Why we need a new framework for medical care

The search for causal explanations for medically unexplained syndromes has not been resolved by statistical data because of the multiple heterogeneous factors involved.[1] The search for causal explanations for burnout has involved a clear focus on why some people are burned out and why others are still healthy instead of asking what mechanisms are involved in manifesting the syndrome and how the symptoms may appear in the life of the single individual.

The burnout syndrome is, to a minor degree, seen as a reaction to complex causes and causal mechanisms, and is not normally understood in relation to the whole person. A biomedical model encourages a reductionist diagnostic practice with a dualist split between physical and psychological symptoms. Therefore, there is a need to re-discover the perceived world[2] to explore the burnout phenomenon further. Both mechanisms and the whole person should in turn be understood within his or her environment as individual, relational, and contextual.

The burnout challenge is related to what counts as knowledge. In turn, this affects the attitudes of the medical profession. One of the burnout symptoms is depression. The fallacy of constitutive reasoning can result in the mistake of thinking that depression, which describes one part of the syndrome, describes the whole syndrome as such, because both depression and burnout necessarily share some common features. The values that go with the biomedical model and the reductionist and dualist ontology inherently are the basis for what counts as knowledge in medical inquiry and medical care. Thus, the values inherent in the biomedical paradigm have implications for clinical care.

As burnout is based on subjective health complaints, important implications concerning diagnosis might arise because a diagnosis is not just the key to various social privileges but also to being recognized as ill. This fact has been shown to cause severe problems for the interviewees in the current study and to have worsened their well-being. Both depression and anxiety influence well-being and the immune system[37] and may inhibit one's rehabilitation efforts. Thus, being criticized by significant others is associated with symptom maintenance and poorer recovery outcomes and may lead to negative emotions.[38]

If we just bring more person-centred health care into medical care[39] as an ethical supplement, the biomedical focus remains the same because the inherent values are still governed by reductionism and dualism. As a result, the needs of the patients remain neglected.[40] We need a new framework for a genuine person-centred health care where the person is understood as an embodied agent. Both body and mind should be at the core and the empirical evidence should consist of both qualitative and quantitative data.

Lack of philosophical reflection may be the reason for seeing the biomedical framework as more scientific than a phenomenological framework. A way forward for supporting persons that suffer from burnout is to move away from the biomedical framework and its underlying ontology and inherent attitudes, and instead treat burnout from a phenomenological perspective. The implicit knowledge provided by phenomenology ought to be made explicit and taken into account. The time is now come to re-think what ontology we need for our medical model and for medical care.

CONFLICT OF INTERESTS

The authors declare no conflict of interest.

FUNDING

The author received no financial support for the research and/or authorship of this article.

ACKNOWLEDGEMENTS

I acknowledge Rani Lill Anjum for valuable philosophical discussions and Samantha Copeland for her attentive advice on final revisions.

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How to cite this article: Engebretsen KM. Suffering without a medical diagnosis. A critical view on the biomedical attitudes towards persons suffering from burnout and the implications for medical care. *J Eval Clin Pract*. 2018;24:1150–1157. https://doi.org/10.1111/jep.12986

Article 3

Received: 28 June 2019 | Accepted: 14 July 2019
DOI: 10.1111/jep.13244

ORIGINAL PAPER

WILEY Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

Naked in the eyes of the public: A phenomenological study of the lived experience of suffering from burnout while waiting for recognition to be ill

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Abstract

Although there has been a focus on problematic issues related to health care services and complaints made by patients, individuals who suffer from medically unexplained syndromes continue to report being epistemically marginalized or excluded by health professionals. The aim of this article is to uncover a deeper understanding of the what-ness of experiencing being naked in the eyes of the public while waiting to be recognized as ill. Therefore, a phenomenological approach was chosen to inductively and holistically understand the human experience in this context-specific setting. Semi-structured interviews were conducted with two men and six women between 25 and 65 years of age, who had been on sick leave for more than 52 weeks. Their symptoms were consistent with Exhaustion Disorder (ICD-10, F43.8A). The meaning of the interviewees' lived experience was explored using a life-world approach to phenomenological reflection and writing. The participants described their experience of encountering the general practitioner as taking part in a battle. Feeling distrusted by others seemed to result in disconnection from their habitual lifeworld, which in turn triggered a shame reaction. Additionally, the study showed a possible distrust related to several communication levels within the health care system, which influenced the recovery process negatively. Lack of experienced support can lead to exacerbated feelings of distress. Accordingly, the psychosocial experience of being ill might be as important as its unknown aetiology. Therefore, in the context of these interpersonal relations, both norms, values, and attitudes, and issues of power need to be considered and addressed properly.

KEYWORDS
burnout, epistemic marginalization, experience, health care, shame

1 | CONTEXTUAL SETTING

> *I'm in the middle of chaos. I don't understand myself, can't recognise myself. Cannot fathom why things are as they are. I hardly know who I am. I just want to sit here and be left alone. It's a bit scary. And when my husband gives me a compliment I'm unable to accept it. I hear what he's saying, but it doesn't register because of my own self-*

> *image. In a process like this, everything just disappears. That's why the little girl starts to appear, when I'm standing there completely naked. There is no way I can beat it. Everything just caves in. (Emma)*

Emma (fictive name) is one of the participants in the study. Her story is not unique. She is experiencing "burnout" and has been on sick leave for more than 1 year. Burnout is a generic name for a state of physical fatigue, emotional exhaustion, and cognitive weariness because of prolonged exposure to unavoidable stressors.[1] During the sick-leave period (52 weeks) the Norwegian Labour and Welfare Organisation (NAV), the employer and the general practitioner (GP) are supposed to cooperate to provide for a time-efficient recovery process while the patient is granted sick-leave compensations. After the sick-leave period, the patient can apply for work assessment allowance (AAP), which is paid by NAV. From what the first author has seen in her clinical practice as a psychotherapist, there seems to be a mismatch between the needs of the patients who experience burnout or other medically unexplained syndromes and what the health care system provides. In the following, we will first address the context in which the encounters between patients and their communities take place.

In the West, this context is coloured by the social and political norms set by the biomedical model and evidence-based medicine (EBM). The biomedical model and EBM are rooted in the positivist paradigm. Within this paradigm, knowledge is achieved exclusively by what is objectively measurable and directly observable, and little space is left for reflections about subjective factors and underlying mechanisms. "Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[2] Recommendations made within clinical guidelines are graded according to the strength of the evidence on which they are based. Clinical guidelines are thus presented as practical tools, in which the available evidence is synthesized and interpreted to guide choice of diagnosis and medical treatment. In the industrialized society of today, an increasing number of individuals experience long-term absenteeism from work because of fatigue- and pain-related diseases that are not yet medically explained.[3] This fact might challenge the care for these patients because of the lack of medical explanations and thereby lack of clinical guidelines.

In Norway, medically unexplained syndromes are placed in a "grey zone," which can result in a delay in receiving a diagnosis. Since a diagnosis is the key to various social privileges, important implications related to these syndromes might arise. A diagnosis is also a recognition of being ill. In encounters between doctor and patient, the evidence-based norms might influence the relationship negatively. Research has shown that individuals suffering from medically unexplained syndromes experience not being taken seriously within the health care system and often report disbelief and lack of support from their communities.[4] This fact may cause severe problems for individuals with these syndromes because APP and social security benefits are not readily granted without a known biomedical diagnosis.[5] Issues of legitimacy may in turn contribute to elevated distress and suffering and an aggravation of the physical symptoms.[6] However, often, the experienced symptoms are attributed to psychological factors leaving these individuals to cope with their situation on their own.[4,5,7]

Although some authors have focused on problematic issues related to health care services and complaints made by patients[8,9] and others have drawn attention to the epistemic aspects of these complaints,[10,11] patients continue to report being "epistemically marginalized" or excluded by health professionals.[12,13] Epistemic marginalization may be understood as under-inclusion of the first-hand experiences and perspectives of those who suffer from medically unexplained syndromes because of the ontological stance taken by health care providers. Unsupportive encounters may seriously affect the way in which the individual attributes value to himself or herself as a human being with subsequent increased distress. The lack of societal recognition may in turn threaten vulnerable individuals' sense of self and social identity and elevate vulnerability.[14,15] These patients have articulated feelings of shame and guilt associated with their pain.[16,17] Shame is a feeling of worthlessness and involves self-blaming and criticism in a stable and maladaptive manner.[14,18] To summarize, lack of support from society and medical professionals may lead to exacerbated feelings of distress. Shame has, in a cross-sectional study among people on sick leave, been found to be related to prolonged sickness absence[19] and thus might contribute to restrain the recovery process. So far, we have focused on the term medically unexplained syndrome. In what follows, burnout will be used to represent medically unexplained syndromes in general.

Most of the empirical work on burnout is conducted within a social psychological framework where burnout is thought to relate to an individual's capacity to meet society's expectations about personal achievement.[20] The majority of the empirical work consists of cross-sectional designs and randomized controlled trials.[21] These studies tend to miss much of the complexity, ambiguity, and ambivalence of the burned-out individuals' lived experience and to a minor degree appreciate that these individuals are coping with more existential changes in their lives.[22] The present study will contribute to fill this gap by starting to uncover what it is like to suffer from burnout while waiting to be recognized as ill. From what Emma in the initial quotation said, she "lost herself," and everything that she knew about herself felt changed. The little girl inside her was stuck in chaos, feeling terribly scared and naked. By conducting a phenomenological study, we will enhance the work of previous researchers by inductively and holistically exploring the interviewees' experience in their context-specific settings. The aim is to uncover a deeper understanding of the what-ness of experiencing being naked in the eyes of the public while waiting to be recognized as ill.

2 | THEORETICAL PERSPECTIVE

We are inspired by the philosopher Maurice Merleau-Ponty's phenomenological approach and his theory of human existence as basically a bodily, intersubjective, and situated existence.[23] When we experience burnout, one immediately present sensation can for instance be the perception of fatigue and pain. The experience is located in the person's embodied, intersubjective relations with others as much as it also occurs "in" the body.[23] The unity of the mind and the body is paramount; to be is to have a body that constantly perceives the situation we are part of.

Further to Merleau-Ponty, our consciousness is underpinned by an "intentional arc" that projects around us our past, our future, and our human milieu.[23] The intentional arc describes our relation to the world and focuses on the unity of the interaction between the individuals and their worlds. Out of this intersubjective field, "figures" emerge. The configuration of a figure against a ground displays the meaning, and meaning is achieved only through relations in the field. Thus, the relationship between the ground of the field and the figures that emerge is what gives meaning to the whole.[24] Thus, what we perceive is at any given time perceived from the specific point of view of a perceiving and situated individual. As perceiving subjects, we are always in a reciprocal connection to the context we, at any time, are engaged in. Perception is intimately linked to possibilities for action and is inseparable from the consciousness it has—or rather that it is—of reaching the thing itself.[23 p.374] As such, the body is situated and intends towards emerging figures that stand out from the ground in its environment. Thus, perception is the realization of my access to the world via my perceiving and interrelational body that cannot be separated from my world. This unity can be seen as the seat of personhood. In illness, it is the intentional arc that "goes limp" because in illness, our bodies are no longer able to pursue our projects as we did when healthy.[23 p. 136]

The person's world is phenomenologically both relational and personal in that the person and the world coexist. In this coexistence, we direct ourselves towards anything, in or outside ourselves, and display a behaviour in relation to that object and thus are self and world coconstituted.[23] Burnout is lived in the context of family and society and the perception of burnout is encountered in the intersubjective and social realms of the participants' lives. When something is perceived, it cannot be experienced without it being apprehended in terms of a meaningful world. For Heidegger, "world" and "lifeworld" are synonyms.[25] The person's lifeworld is their experience of being human.[26,27] Ashworth has described this notion further to encompass several parameters, including a sense of self, embodiment, relations to others, spatiality, temporality, projects, discourse, and mood as atmosphere. These parameters constitute a whole and are to be taken as parts of a lifeworld, which are not separable into rationally distinctive bits; the lifeworld is therefore indivisible.[26] Thus, all experience is within the lifeworld, and this is for each of us "my real, subjective world."[23,28,29]

3 | METHOD AND DESIGN

3.1 | Recruitment procedure and interviewees

The first author contacted 10 colleagues from the Oslo area (Norway) and asked if they could help to recruit participants for the project. They were given written information about the project and a handout for their clients with contact information. Eight volunteers, two men, and four women made contact. They were invited to a personal information meeting. The aim of this meeting was to present the project and make sure that they fulfilled the selection criteria. These criteria were individuals between 25 and 65 years who had been employed at least at an 80% position and had been on sick leave for more than 52 weeks prior to the interview. In addition, their burnout symptoms should be consistent with exhaustion disorder according to ICD-10, F43.8A. All the volunteers fulfilled the selection criteria and agreed to participate in the project. They were informed about the further process and their role as interviewees. In addition, they were invited to keep a personal diary during the fortnight prior to the interview, which they were free to refer to during the interview.

3.2 | Data generation and analysis

The focus of the interviews was the participants' lived experience of their encounters with their GP and NAV. We applied a phenomenological research method. This approach is especially relevant when the aim is to explore burnout as a lived phenomenon.[30,31] The existential phenomenological research approach emphasizes the individual lifeworld. This approach can be seen as a method to explore human phenomena that can, in turn, be recognized as true for all humans. During the interviews, an important consideration was to meet the participants in reciprocal humanity, while being aware that the interaction would influence the dialogue.

The first author conducted the interviews and transcribed the audio-recorded interviews verbatim. Then, the transcriptions were analysed. The intention was to allow any emotions, patterns, and themes related to the interviewees' experience to emerge from their descriptions of the situation, rather than being based on predefined themes. In this process, our aim was to explore and elaborate on the participants' pre-reflective and lived experience of burnout. As the interviewer and first author is part of the field, it is challenging to be able to set aside one's own presumptions of how this phenomenon could be understood. When analysing the data, we, as a collaborative research team, intended to keep a stance of openness towards the participants' expressions of their experiences. Thus, the process of analysis and interpretation as a nonlinear style was concerned with the dynamic relationship between the part and the whole of the empirical material at multiple levels.[30]

4 | ETHICAL CONSIDERATIONS

The project was approved by the Norwegian Centre for Research (NSD no. p469). Prior to the interviews both verbal and written information about the study were given to the participants in separate meetings and written informed consent forms were signed by all of them. They were given a copy of their transcript and had the opportunity to read and amend the transcript. All data were de-identified and stored in a secure manner according to the ethical principles required by the University of Oslo (UiO). In designing the study, the participants' vulnerable situation, being on long-term sick leave, was given special consideration. Clear boundaries were set, based on a written informed consent about the context of the research project, the research process, and how the findings would be reported. We acknowledged that the research process could cause painful awareness of their situation, and consequently, each participant was informed about the opportunity to come in for a debriefing session after the interview if they experienced excessive emotions as a response to what was brought up during the interview. However, this situation did not occur.

In the next section, we will present some selected excerpts from the empirical material. When working through and analysing the transcribed material, some parts of the participants' experiences stood out —parts that touched us and awakened us. For us, it was important to try to understand the meaning inherent in the words used to describe these experiences. From there, we chose excerpts from the transcribed material that could illustrate our analysis. Our focus was to be transparent as researchers about the nature of the experiences or phenomena we were analysing that we finally ended up with discussing. All the names are fictive.

5 | DISCONNECTION AND A SENSE OF SHAME

5.1 | The “battlefield”

Through our analysis, the participants' experiences related to encountering their GP and the NAV stood out as especially vital to explore further. The participants told about spending a lot of energy trying to explain their condition without feeling heard. As Gunn, one of the participants explained:

> *With regard to my doctor it is a continuous battle. I don't feel that he respects me. Had the feeling he labelled me into a psychological pigeonhole. At first, I went there on my own, but now my husband comes along every time because I sense a big difference when he is there. (Gunn)*

In this quotation, we were struck by how Gunn described her experience of encountering the GP as taking part in a battle. Health care is usually understood as a place where people can expect to get help, care, and comfort related to their illness and health condition. From what Gunn says, the battle seems related to her feeling of not being respected. The battle might, therefore, be understood as a disagreement with her GP related to what she terms psychological. Thus, the battle concerns an opposition between the GP's and Gunn's understanding of her illness. When the lived experience and understanding of one's own situation differs from the GP's understanding to such a degree as in this case, the GP's diagnosis is difficult to accept. Then, Gunn got the feeling of neither being seen or heard nor respected or understood. The kind of difference she is sensing when her husband joins her in the appointments is not described other than as “a big difference.” The difference made when bringing him along could be described as added supportiveness to counteract the feeling of being epistemically excluded. The husband's presence might be understood as “forcing” the GP to listen to how she understands her own situation and accepting that she has knowledge about her illness and the health challenges she experiences. Yet another participant describes his experience when encountering the GP this way:

> *He asks me if I'm suicidal. He is focused on depression and antidepressants came up quickly. The focus became wrong quite early on in relation to what my needs were or what I needed help with. I'm sort of in limbo; a place in between where I am neither nor. What I define as important to discuss with the doctor somehow disappears. It seems as if there are happy pills outside in the waiting room. I became passive and indifferent almost. (Toivo)*

Just like Gunn, Toivo also seems to disagree with the GP regarding diagnosis and medical treatment. In this situation, Toivo seems to experience being labelled with a diagnosis that he felt was the wrong one. Although he tried to explain how he experienced the situation, he seemed to feel abandoned by the GP. The doctor's strong opinion about what Toivo's needs were seemed to put him into a sort of middle position where he experiences being neither nor. This could be understood as the experience of feeling disempowered. Toivo seems to associate feeling passive and indifferent as a reaction to the GP's attitude that happy pills seem to be the solution to everything—and definitely to such problems that he himself presents with. In this situation, he might have felt unable to escape the neither-nor position. This experience might be interpreted as being neither able to recognize himself as depressed nor being able to influence the GP's opinion—in other words feeling helpless. Another participant tells about her experience of feeling “not being met” in the encounter with her GP.

> *People try to understand. And then you notice that they are a bit prejudiced. They're thinking ‘can't you just pull yourself together. How can that be so hard’? But they don't get it. I was embarrassed and felt awful—can't even manage that, you know. I didn't have any physical symptoms that showed. I was just terribly tired. The GP listens to me, a bit impatiently and says “Ok.” I felt a strong scepticism emanating from her, with a very clear message about not wanting to put me on 100% sick leave. I started crying. It just felt so painful not to be met properly. It was a continuous struggle. (Nina)*

Nina experienced the encounters with the GP as “a continuous struggle” that seems to be similar to what Gunn said and thus might touch upon each other in meaning. For Nina, the struggle seems to be related to feeling distrusted by the GP, when asking for permission to stay at home. Although Nina believes that people try to understand how it is for her, she seems to sense being prejudiced. When she became aware of the GP's scepticism, she might have felt pushed by the GP to stay at work, which she might have understood as an expression of “just pull yourself together.” When feeling seen as weak and unable to meet what she imagined that others expected of her, thoughts about herself such as being worth less than others might have come to the fore. When stating that it felt so painful not to be met properly, it is nearby to understand this experience as feeling judged and evaluated as unable to cope with what "everyone" has to handle in their lives. The painfulness might then be related to feeling degraded as a person. The participants' experience of being part of a battlefield points out a possible disagreement over whether it is the patient who has the right understanding of how it is like to suffer from burnout, or if it is the GP.

5.2 | The "NAV directive"

As we will see, the battle continues. In the next excerpt, another participant emphasizes how her GP also provided an explanation to her suffering that she could not recognize as the right one. She says:

> *I felt that the doctor was really happy when I was sitting and crying in her office because at last she could prescribe Cipralex and call me depressed. I feel like I'm very stuck. I have called it indifference. But for how long can I stand feeling like this? (Tone)*

Tone experienced her GP's reaction to her tears as like that of "being happy." This happiness might be understood as a reaction of observing some symptoms that fit with an accepted medical diagnosis. At last, when her patient was sitting there crying, an obvious symptom of depression manifested, and the GP could not only relate to a diagnosis but also prescribe medication to help her. Alternatively, perhaps the happiness Tone sensed in the GP when crying could have been a feeling of relief when finally, being able to give her patient a "legal" diagnosis. In this case, a legal diagnosis might be understood as a diagnosis that would be accepted by NAV. Thus, diagnosing her patient as depressed would "cover" her back by being able to justify her patient's sick leave in front of the NAV system. Just like Gunn and Tiovo, Tone seems to disagree with the doctor regarding how her illness should be understood and diagnosed. When being diagnosed as depressed, Tone says that she feels stuck. In this situation when not feeling heard or supported by her GP, it is easy to relate the feeling of indifference to a sensation of helplessness. In respect to the sensed disagreement between herself and the GP, Tone further explains:

> *I am not being misunderstood, but I'm experiencing what it means not to be believed—actually a lack of trust. Three times, I have experienced refusals in decisions from NAV. And there I am, so sure I'm entitled to the benefits, but instead I'm given an account where everything seems a bit turned on its head. Feeling that everything is twisted and turned so they can refuse me AAP (Work Assessment Allowance). And it is tough to read what they write about me as well. (Tone)*

Related to her applications for support from NAV, Tone says she is "not misunderstood" but knows "what it means not to be believed." She seems to experience that NAV do understand her version of the situation. She recognizes however what she sees as a distorted description of her suffering in the written rejections from NAV. Therefore, she interprets that they do not believe her. Thus, her experience of what it means not to be believed is not only a result of the rejections of the applications but is also related to how NAV confronts her with what she perceives as a twisted description of the situation she lives. Again, disagreement seems to be at the forefront. This time the disagreement is related to whether it is the patient or NAV that posits the "right" understanding and description of the situation. One of the other participants also described her experience of encountering NAV. She tells:

> *My doctor diagnosed ME, but this was not accepted by NAV. It was awfully frustrating and hurtful to experience such unprofessional treatment of my case from NAV. It felt degrading to be treated like that. As if I was a scoundrel. It is clear that when I am not seen or heard I almost give up. (Sonja)*

Sonja's GP diagnosed her with ME. When NAV refused to accept Sonja's diagnosis, she experienced that not only her GP was refused by NAV but also herself was seen as trying to claim rights she did not have. It hurts when feeling distrusted—and seen as if she tried to deceive undeserved rights. Disagreement and distrust seem to be prominent in the participants' experiences encountering both GP and NAV. Instead of feeling supported the participants described feeling left alone, distrusted, degraded, and helpless. A pertinent question related to what seems to happen in encounters between patients and those who are supposed to help is how then to act when you need help? In the next excerpt, one of the participants shares his experiences related to this:

> *I think the doctor has had a directive from NAV. The woman at NAV has in reality confirmed it. I felt real pressure to be at work. It went as far as my boss telling me to do something. You're walking around here like a corpse. People are wondering what's happening with you. Why the heck are you here so much? It's not good for you. Can't you just go on home and get well. Dreading having to go to the doctor doesn't exactly help you get better. I felt like a little boy at school being told off. Going to see a doctor you know will tear at your soul isn't much good and you just cannot manage to do anything about it. (Hans)*

Although Hans does not feel well, he still goes to work. Even when he experienced being seen as ill by both his colleagues and his boss, he cannot just take it as support because he needs to have the GP's "permission" to stay home and "get well." He dreads going to see his GP, as he knows that it will "tear at" his soul. What he believes is that NAV and the GP have a sort of agreement, which he experiences as not supportive for handling his situation. When the GP and NAV agree that you are not entitled to being sick listed, you have to go to work to earn money for living. In this situation, Hans experienced that his boss and colleagues almost "forced" him to stay home to recover. When being exposed to these radically different opinions related to his condition and literally being in the position of being disqualified and disempowered, it is understandable that it felt like being a little boy in the meaning of being without any authority related to his own experienced life situation.

The participants' stories seem to highlight possible distrust at several levels: between the patient and the GP, between the patient and NAV, and between NAV and the GP. The result seems to be that the participants feel neither seen or heard nor respected or understood. On the contrary, they seem to feel distrusted and disempowered. Such feelings are appropriate in response to how the lifeworld speaks to them in terms of being disqualified by others.

5.3 | Being a “no-body”

We shall now see how another participant describes her experience of struggling to cope with living the situation of being burned out.

> *Reality has become lost to me. This is very frightening. All the time there are things to relate to from outside. It is exhausting. There is no space for what is me. That's why it seems like I am shrinking into a reality that doesn't exist. I just can't cope with that part. I withdraw. (Sonja)*

When Sonja says that reality has become lost to her, this might be understood as she experiences her being in the world as radically changed. Such a big change of being in the world is frightening as the life and living situation she was familiar with and once knew seems to have disappeared. In this situation with all impressions and expressions from what she names “outside”—an outside that might be related to others—the GP, NAV, and society as such, she experiences there is “no space for what is her,” and she feels to shrink. One way of understanding this is that the outside does not see her as she experiences herself to be and, by this, shrinks her into a feeling of disappearing as there is no space for being who and what she is. Being put into such a situation, she sees the best alternative as to withdraw. To withdraw might be her way to protect herself and taking care of herself. In the next excerpt, Nina expresses how she felt “forced” to go underground when not able to meet what she sensed others expected of her. As she has previously mentioned, she felt being pushed by her GP to stay at work and she felt forced to “pull herself together.” When feeling unable to do so, she seemed to feel negatively judged by others.

> *I was invited to lunch with a possible employer. It was a wonderful occasion on which to present myself in a good light for possible new commissions. There were around 20 people present. Very important people. At the beginning of my presentation, I had to start by saying what an uncomfortable situation this was for me. I didn't know why I was there. I was extremely tired and felt pretty awful actually. I sensed how the audience lost respect for me. I could have died on the spot. I was so exhausted. I wasn't able to defend myself. That's how I seemed to finish, and then I was put on sick leave. That's when I went underground. That's what I've felt I did. So now I don't know how to get back. (Nina)*

At the beginning of her presentation, Nina started with disclosing to the audience how uncomfortable the situation was to her. This might be an expression of her understanding that she wanted to be there but because of feeling extremely exhausted, she knew that she was not able to handle the situation as she wanted to. When disclosing how she felt, she might have become aware that the audience could see her as not good enough, which might be the reason why she sensed that they lost respect for her. It is nearby to understand that losing the audience's respect could have triggered Nina to feel embarrassed and unable to hide from the gaze of others. Thus, she seems to relate the sensation of losing the audience's respect to feeling that she could have died on the spot. In this uncomfortable situation, she might have wished to flee but felt stuck in front of the audience. Then, “dying” could be understood as a metaphor for wishing to disappear, and this was exactly what happened when she went underground. Nina is not the only one who wants to hide from the gaze of others. Here is how one of the other participants puts it:

> *When you experience hitting rock bottom like that, all your protective walls are knocked down and all your feelings lie exposed, leaving a lot of yourself seeping through. (Hans)*

In this excerpt, Hans refers to what it was like when hitting “rock bottom.” His experience seems similar to how Nina described her need to protect herself by going underground. As Hans puts it, the protective walls he had built to hide his vulnerable self were no longer intact. In this situation, he seems to imagine being transparent to everyone and not being able to hide. Feeling vulnerable in this situation might be related to be seen as weak and helpless—in fact being exposed as unprotected and transparent. Thus, feeling “naked” seems to provoke an existential anxiety, as we shall see in the next excerpt.

> *During the first year on sick leave the GP proposed that I should join a project called “Quicker recovery” sponsored by NAV. The long bus fare and the treatment—it felt so shitty that I dropped out after just a few sessions. At this time, the worst of it was handling the so-called reality, dealing with people and feeling so incredibly useless and shitty. I feel like it shows on the outside and that it's something everybody can point at and see. That's when anxiety and fear come thundering in all directions, shapes, and variations, which is really, really shitty. I was at the point of despair. It was my whole life—all of me that I couldn't stand. And I am not able to do anything about it. My need to escape reality suddenly becomes acute. I am not able to stand how I am - and what I might do to myself. (Toivo)*

Toivo tells that he was at the point of despair. When attending the treatment project, he was forced to be part of what he terms the so-called reality. In this situation, Toivo felt "incredibly useless and shitty." Therefore, he seemed to drop out. His experience seems to touch upon Sonja's experience. She felt unable to interact with anyone when she experienced that reality had become lost to her. Additionally, it is possible to understand the despair Toivo experienced as a reaction to how he imagined others could see how he felt. This experience seems related to how Nina might have experienced being unable to hide from the judging gaze of others.

When living through burnout Toivo's Lifeworld is changed. He seems unable to recognize himself and does no longer fit into the "so-called" reality. Toivo, just like Nina, felt unable to change the situation. Seeing himself as a useless and "shitty" person, Toivo was desperate to escape his life. This situation seemed to have elicited an existential crisis where he realized that he could harm himself. Finally, here is how another participant experiences her desperate situation.

> *I had cancer when I was in my thirties, and then I was received with open arms. Everyone does everything for you and gives you presents. However, when you get an illness like burnout there aren't many gifts around, that's for sure. You are just "a no-body" then. There is nothing left. I was so distraught about everything that if I hadn't had children and grandchildren I would have killed myself. I thought about that a lot. During the worst period, I kept thinking about how I couldn't stand this. First of all, feeling so ill and almost incapable of getting out of bed—and on top of that experiencing so much resistance. (Sonja)*

In this excerpt, Sonja describes how she experienced the difference between suffering from cancer and suffering from burnout. When she had cancer, she felt like a "some-body"—a person who deserved presents. Suffering from burnout, she experienced quite differently—like being just a "no-body". Being a "no-body" can be understood as feeling unsupported and left alone. Moreover, by being a no-body, no one cared for her as it is not possible to care for a "no-body". As she puts it "there is nothing left," which might be understood as there is nothing left of her life as she knew it and how she wants to live it.

To summarize, the participants experienced feeling rejected in encounters with the health care system and NAV. None of them saw themselves as being depressed and being diagnosed as depressed made them feel neither seen or heard nor understood or respected. Additionally, having to struggle to convince others that they were entitled to social benefits, they experienced themselves as distrusted and without any status or legitimacy, which seems to be related to the experience of being disconnected from their worlds. The disconnection might create an awareness of feeling seen by others as worth nothing and, then turning the gaze of others towards themselves, seeing themselves as a "nobody." Seen as a nobody in the eyes of others seems to elicit a sense of embarrassment connected to themselves as persons. In the next section, we will discuss how the participants' experience of feeling undressed publicly and unable to hide their nakedness from the gaze of others can be phenomenologically understood.

6 | NAKED IN THE EYES OF THE PUBLIC

Without a known biomedical diagnosis, the participants' subjective health complaints were labelled and treated as psychopathological. This duality, related to understanding human beings as either mind or body, is due to the inherent norms, values, and attitudes that are coloured by the biomedical stance taken within EBM. Phenomenology understands human suffering differently. Merleau-Ponty points out that "there is no inner man (sic) … Man is in the world, and only in the world does he know himself."[23, xi] Thus, the experience of burnout symptoms cannot be separated from the participants' world as it is encountered in the context of family as well as communities. This context is the intersubjective and social realms of the participants' lives. Their perception of pain is located in their embodied, intersubjective relations with others as much as it also occurs in their bodies. Thus, there is no access to any inner selves except through living in the social and cultural surroundings we at any time in life inhabit, ie, our lifeworld. Therefore, the psychosocial experience of being ill is even more important than the unknown aetiology of burnout.

The participants had experienced being ill for a long time. Feeling seriously ill without recognition of their situation triggered an existential anxiety. All except for one described the encounters with the GP as a continuous struggle, which triggered feelings of frustration, despair, and hopelessness. Seven of them felt pushed to go back to work either during the period of sick leave or after having been granted AAP. The world seems to say: "Can't you just pull yourself together? How can that be so hard?" The interviewees' subjective knowledge, however, is their bodily perception of being ill. Being aware of what they sensed in their bodies, they knew that they were not able to perform what was expected of them. Moreover, when feeling distrusted the participants' distress escalated and turned their experience of being in the world upside down. As the empirical material and the phenomenological analysis has shown, the participants experienced being disconnected from their lifeworld. This theme highlights how the participants' relation with both others and themselves felt disconnected. Without exception, they were transformed by the illness into persons who were unknown to themselves. They were not able to recognize themselves and hardly knew who they were anymore. At the same time, being fearful of their own alienness, seemed to elicit a feeling of losing control. Others also seemed alien to them. When sensing the strangeness and weirdness of both themselves and others, anxiety raised. When healthy, they had experienced the epistemological progression referred to by Husserl; I express myself, then others listen to me and then I am able to influence the situation.[29] Although the participants tried to voice their experience of being ill, they felt distrusted and no one seemed to care. Thus, they no longer experienced themselves as agents in their own lives. This experience seemingly triggered a need to withdraw from interactions with others to survive. The participants were, however, not able to protect themselves from feeling intruded and overwhelmed by the outside world. The distress they experienced in this situation seemed to result in a feeling of powerlessness, which can be understood as the psychological situation, wherein the lifeworld speaks to them of social identity, their feelings of presence, their sense of agency, and inability to voice their experience. Thus, selfhood is a continuous background meaning of my feelings, thoughts, and behaviour, and the self as a fraction of the lifeworld is the way in which my actions and their effects are open to my awareness.

When we experience the inability to recognize ourselves as the person we used to be when healthy and to pursue our projects as we once did, the sharp awareness of "how do I appear" comes to the fore. In such situations, we suddenly become aware that others can see us as inadequate. Emma, in the introduction, described the disconnection with her world as feeling naked. Hans did not use the word naked in his description of how it felt like for him when all his protective walls had been knocked down, leaving a lot of himself seeping through. Thus, feeling disconnected from their world seems to elicit a loss of agency, which in turn leads to a loss of self-esteem.

Much of the literature on burnout recognizes that the sense of diminished self-esteem experienced is often accompanied by a sense of shame. While irrational, this sense reflects the persons' feeling of being "damaged" when not being met by others. It is the experience of feeling rejected and separated from others that triggers shame.[32] Moreover, when seen by another person, we are intertwined into that person's world. In this situation, we may feel either affirmed or undermined by others. Thus, other human beings are a central part of our lifeworld because of their impact on our selfhood. This means that we can feel judged, which elicits an awareness of either shame or pride. The person who experiences burnout perceives her own difficulties in the first person. Others also perceive her as a physical entity with particular features, which in this case may be faking illness—in other words, acting as a scoundrel. She is then perceived by herself as seen through the eyes of others. The moment we become aware of the mere look cast by another that we interpret as alienating and uncomfortable is the moment we want to escape it. It is through the look of the other that we feel objectified and judged as "cheating." Thus, shame might be triggered when we become aware of ourselves as objects seen through the eyes of the other.[33]

Gradually the participants lost sight of a life worth living. As Sonja puts it, "you are just a no-body then. There is nothing left." Although their basic need was to feel supported, shame might have hindered a supportive interaction with others. The feeling of being vulnerable and unprotected—in fact caught off guard in the eyes of the public—was not conjunctive with being able to take support from anyone. This fact might have counteracted resolving the existential crisis in which they felt stuck. Shame brings them face to face with themselves. This is what Sartre pointed out when discussing what he calls "bad faith"—the effort to flee from oneself.[33] The participants seemed to struggle to accept themselves as seen in the eyes of the others while simultaneously seeking to hide from themselves as well as the world. The need to withdraw from interactions with others and themselves became acute. It was however not possible to escape because perception via their perceiving interrelational bodies could not be separated from their worlds without literally leaving the world. As Toivo said, he felt neither able to stand the person he had become—nor what he might do to himself. Three of them explicitly considered suicide as a way out when being aware that there was nothing left worthwhile living for.

7 | THE EPISTEMIC INJUSTICE

The study uncovered that the participants sensed being distrusted by the GP when labelled as depressed. This fact seemed to worsen the participants' situation. The GP's mission is to take care of the patient and cause no harm. Therefore, we were struck by how the participants experienced the encounters with the GP using terms as a continuous battle or struggle. The interviewees expected support and being taken care of by their GP. These expectations were obviously not met, neither in the relation between the GP and patient nor between the patient and the NAV system.

In the encounter with the GP and NAV, all the participants spent a lot of energy trying to explain their condition without feeling seen or heard. Their stories show how they as "knowers" of their own bodies were ignored and distrusted. As previously mentioned in the introduction, this set of reaction to illness constitutes a form of injustice that is uniquely epistemic and is done to the patient in their capacity as knowers. Often such injustice is caused by biases and negative stereotypes[34]—in this case about burnout as a medically unexplained syndrome. From what the participants have shared in this study, we have seen how incommunicable the syndrome is and how invisibly fatigued the participants are. The discrepancy between the perceived ease of a task and the great challenge it poses for the person who experiences burnout creates doubt in the mind of the observer. An observer often sees the person when she is at her best because when the symptoms are bad, she is in bed. This fact does not really convey the subjective sensation of severe illness. The complete certainty of the lived experience of burnout and the complete doubt it generates when viewed from the outside makes it similar to distress. The distress and sense of loss of control in addition to the panic of dreading living with burnout for the rest of one's life are internal and invisible. The outsider, in this case the GP and NAV, can never know if the patient is really feeling the pain or merely behaving as if she does.

In illness, the norms of feeling and action shift considerably and are quite different to the norms when healthy. Persons who have not experienced burnout themselves have no reference parameters. Therefore, the ability of a healthy person to understand the constricted experiential space of the person who experiences burnout is limited because of the lack of a shared experiential background. The shared norms of normal functionality disappear. Thus, when normal and pathological experiences diverge, communication suffers, which is clearly highlighted in this study. The participants feel neither seen or heard nor respected or understood. On the contrary, they seem to feel distrusted, disqualified, and disempowered, which might result in feeling helpless and embarrassed. As this study shows, the problem of sharing the experience of burnout and the normal sceptical challenge can undermine the quality of clinical care and knowledge.

The study also shows that there seems to be distrust related to several communication levels. The first level is between the GP and the patient; the second is between the patient and caseworkers at NAV. There also seems to be third level which Hans termed the "NAV directive" related to how the GP seemed "induced" by NAV to push the participants to go to work. According to the participants' experience of feeling distrusted, the study seems to indicate that the norms, values, and attitudes inherent in the biomedical and societal system affect the encounters between the GP, NAV, and the patient in a negative manner. Moreover, the study also seems to indicate that political decision making is based on the norms inherent in the biomedical model, which in turn determine what is recognized as illness. Therefore, we suggest a need for reviewing what norms, values, and attitudes that are needed to improve the outcome of medical care. Additionally, issues of power need to be addressed properly and considered in the context of these interpersonal relations.

CONFLICT OF INTEREST

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

FUNDING INFORMATION

The authors received no financial support for the research and/or authorship of this article.

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How to cite this article: Engebretsen KM, Bjorbækmo WS. Naked in the eyes of the public: A phenomenological study of the lived experience of suffering from burnout while waiting for recognition to be ill. *J Eval Clin Pract*. 2019;25:1017–1026. https://doi.org/10.1111/jep.13244

Article 4

REVISED AND RE-SUBMITTED TO QUALITATIVE HEALTH RESEARCH

Out of Chaos – Meaning Arises

A phenomenological study of the lived experience of re-habituating the habitual body

Karin Mohn Engebretsen and Wenche Schrøder Bjorbækmo

ABSTRACT

Sufferers from burnout might experience a sincere bonding to their lost lifeworld, which can result in their holding on to their previous worlds while simultaneously trying to unleash themselves. In this article, four experiential dimensions are presented in discussion with the phenomenological insights provided by Merleau-Ponty. These dimensions are, “Trapped in the present body”, “the balancing act”, “precious moments of joy” and “this is my Lifeworld now”. In the rehabilitation process, the participants demonstrated deliberate choices and reflective self-cultivation to adjust to their present situation. The illness seemed to promote a search for meaning – and out of the existential chaos, a “new” habitual body might appear. The study provides invaluable information about the rehabilitation process and the need for more holistic, integrated person-centred interventions.

1. Introduction

> *I feel helpless because I’m not in control of my life. There seems to be some kind of lid on my existence. The tiredness exists in every cell in my body – all parameters are somehow on minimum. I just have to be me, lie down and disconnect from the rest of the world. It was an amazing job and fantastic colleagues. That gave me energy before, but I’m not there. The job definitely gives me a kick, but at the same time, it wears me out completely. I lie there 4-5 days later thinking about the positive things and cannot even plan what to have for dinner. There is this despair at not being able to do it. It feels like the nerve fibres don’t have any isolation anymore. Tears just stream. That’s a hard one, because the job is my whole life as I’ve lived it and want to continue living it. The realization of not being able to anymore, makes me horribly afraid. Will this empty space always be here – that darkness? Will it never pass?*

Merleau-Ponty (1945/2003) sees the habitual body as it has been lived in the past – in virtue of the habitual ways in which it now relates to the world. The habitual body is also recognised in terms of what endeavours it has acquired in the past. Further, he distinguishes the habitual body from the present body, which might be experienced quite differently, as when suffering from burnout. Thus, these two layers of the body become the temporal point where the past, the present and the future meet. In this moment, the past is carried forward into the outlining of the future and living this bodily momentum is the experience of living the present body

(Langer, 1989). This body is our home in which we breathe in experiences of joy and pain. The body is biology. However, it is also formed by the zeitgeist and our lifeworld experiences. The body is motion and thus, our opening towards the world. It can however also be a prison from which we cannot escape, as in situations where the person who suffers from burnout endures symptoms of mental and physical fatigue. The bodily signals related to fatigue are often characteristic of the person in question. Moreover, bodily sensations seem to be independent of how one relates to them. These sensations are not just experienced by the biological body but more importantly also by the lived body. The participant in the excerpt above seems to be painfully aware of the discrepancy between the habitual and the present body. In recognising what the body no longer can do, he must face the process of modifying the habitual body. Over time, his "past" experiences of the body will eventually fade, and the present body will become the "new" habitual body. Our study addresses the lived experiences of sufferers from burnout during the process of re-habituating the habitual body.

Burnout is a condition that occurs in an occupational environment (Freudenberger, 1974) and primarily affects high achievers (Chambers, Frampton, Barclay, & McKee, 2016). The condition might be understood as a reaction to long-term, job-related unresolvable stress leading to physical and emotional exhaustion, which affects the sufferers' well-being and quality of life negatively. Research has shown that burnout can predict severe health implications, such as myocardial infarction (Apples & Mulders, 1989; Toker, Shirom, Shapira, Berliner, & Melamed, 2005), coronary heart disease (Pedersen & Middel, 2001; Toker, Melamed, Berliner, Zeltser, & Shapira, 2012a), type two diabetes (Melamedm, Shirom, Toker, & Shapira, 2006a) and musculoskeletal disorders (Armon, Melamed, Shirom, & Shapira, 2010). Therefore, it is important to pay attention to symptoms of burnout at an early stage to avoid the condition becoming chronic.

Social psychology approaches to burnout have mainly focused on the effects of different interventions (Karlson et al., 2010; Norlund et al., 2011; Stenlund et al., 2009). These approaches have shown that different factors relating to the workplace and psychosocial working conditions might have an impact on recovery (Blank, Peters, Pickvance, Wilford, & Macdonald, 2008; Karlson, Jonsson, & Osterberg, 2014). Few studies are conducted, however, that explore the factors associated with return to work in burnout and the association between these factors is not made clear (Karkkainen, Saaranen, Hiltunen, Ryynanen, & Rasanen, 2017). Most of the research in this field is rooted in a positivist paradigm where inherent ontological values are mirrored in how research is conducted and how data is assessed (Kelly, Heath, Howick, & Greenhalgh, 2015). The ontological assumptions in this paradigm motivate statistical and experimental designs and causal evidence is ranked according to the reductionist presumption that any medically relevant relations go in the direction from biological processes (causes) to mental and emotional processes, behaviour and culture (effects). Although these research designs have contributed to new knowledge about how to prevent and alleviate burnout, they tend to miss much of the complexity, ambiguity and ambivalence of individual lived experience. Moreover, most of these studies reflect a mind-body dualist split where either body or mind is always subordinate to the other. As we have seen in the treatment of burnout, the focus is on processes that merely take place in the mind without paying attention to the bodily symptoms (Engebretsen & Bjorbækmo, 2019). Thus, this approach does not do justice to the lived reality of the individuals who suffer from burnout.

To fully understand the experiential dimension of the rehabilitation process it is necessary to go beyond statistical numbers and study the lived experience of the sufferers themselves. In a dispositionalist framework (Anjum & Mumford, 2010), unique individuals cannot ever be a statistical average. This means that conclusions about individual propensities related to treatment cannot be inferred directly from a statistical distribution. To infer causal connections within a rehabilitation process, the causal mechanisms must be understood in relation to the whole person in his or her environment as both individual and relational, as well as contextual.

There are few qualitative studies regarding the experiential dimension of the return to work process amongst individuals suffering from fatigue- and pain-related diseases in general (Norlund et al., 2011). We will refer to some of them later in the text. A synthesis of qualitative research findings shows that living with chronic illness can be understood as an ongoing, continually shifting process (Paterson, 2001). This suggests that the experiences of burnout change over time. Although some of the individuals who suffer from subjective health complaints such as burnout do recover and manage to get back to work within the sick-leave period (52 weeks), research has shown that the recovery process is often demanding and time consuming (Mengshoel, Bjorbaekmo, Sallinen, & Wahl, 2019; Øyeflaten, Lie, Ihlebæk, & Eriksen, 2012). Only a few studies have explored how the sufferers from burnout deal with their condition. To contribute to fill this gap, the aim is to explore how sufferers from burnout who have been on long term sick leave (>52 weeks) deal with the process of coming to terms with their present body – the lived body as ill. In contrast to mainstream research on burnout, this study will emphasise the context within which individuals who experience burnout live and how they make meaning of their situation. More insight into their lived experiences is likely to give invaluable information about the rehabilitation process.

2. Methodology

Study design

In this work, we are inspired by the phenomenology of Merleau-Ponty. He stressed the need to understand the person as a body-subject, with consciousness always embedded in the body (Merleau-Ponty, 1945/2003). This paradigm assumes that reality is not objective but subjective and that individuals create meaning from their lived experiences. Phenomenology as method is consistent with the constructivist research paradigm in accepting that the subjective processes of human experience provide a source of explanation of human action. In addition, personal descriptions of experiences and opinions are a legitimate source of research data.

Both Merleau-Ponty's and van Manen's ideas form a theoretical basis for much contemporary work in phenomenological psychology (van Manen, 1990). Phenomenology primarily aims to describe the lived world of everyday experiences (Finlay, 2011) and to "show" how meaning reveals itself (van Manen, 2014). This method employs a naturalistic inquiry that attempts to inductively and holistically understand human experience in context-specific settings (Patton, 1990), generating data rich in detail and embedded in the context (Creswell, 1998). These philosophical theories do not just inform the phenomenological methods: the findings that these methods generate can be analysed using these concepts heuristically. Further to van Manen (1990), theme analysis is an act of insightfully "seeing" meaning, rather than being a rule-bound process. Thus, by applying a phenomenological method, a deeper analysis of the data and a move from description to interpretation is enabled (Langdridge, 2007).

Recruitment procedure and interviewees

The first author contacted 10 psychotherapists from the Oslo area (Norway) and asked if they could help to recruit participants for the project. They were given written information about the project and a handout for their clients with contact information. Eight volunteers, two men and six women made contact. They were invited to a personal information meeting. The aim of this meeting was to present the project and make sure that they fulfilled the selection criteria. These criteria selected for individuals between 25 and 65 years who had been employed at least at an 80% position and had been on sick leave for more than 52 weeks prior to the interview. In addition, their burnout symptoms should be consistent with Exhaustion Disorder according to ICD-10, F43.8A (WHO, 2000). All the volunteers fulfilled the selection criteria and agreed to participate in the study. In addition, they were invited to keep a personal diary during the fortnight prior to the interview, which they were free to refer to during the interview.

Data generation and analysis

The focus of the study was to explore the participants' lived experience of struggling to re-habituate the habitual body and to come to terms with their lived body as ill. Semi-structured interviews were chosen to uncover how the participants made meaning out of their situation. The research question was "how do you experience being yourself in the rehabilitation process related to encountering others – and what factors enhance or restrict quality of life". This question was followed up during the interviews, which lasted between 90 and 180 minutes. During the interviews, an important consideration was to meet the participants in reciprocal humanity, while being aware that the interaction would influence the dialogue. Due to their illness, they were given the opportunity to choose the venue for the interview. Four interviews were conducted at the first author’s office and the other four at the participants’ homes. The first author conducted the interviews and transcribed the audio-recorded interviews verbatim directly after the interviews. The participants were issued with a copy of their transcript. They had the opportunity to not only read but also amend the transcript if they wanted to do so for whatever reason. Two of the participants used this opportunity to make parts of their lived experiences more explicit.

We applied a phenomenological research method, which emphasises the individual lifeworld (Finlay, 2011; van Manen, 2014) and the lived experience descriptions provided the lifeworld material for the phenomenological inquiry. Hermeneutic reflection involved practicing heuristic activities as outlined by van Manen (1990). The process of phenomenological reflection and analysis occurred primarily in the attitude of the *epoché*, the reduction and reflection on the meaning of lifeworld experiences (van Manen, 2014). This process in turn led to the creation of experiential themes. The attitude of epoché intends being aware of keeping a stance of openness towards the data – to set aside or “bracket out” personal presuppositions. The experiential themes bring attention to or exemplify the nature of the experience. This method is especially relevant when the aim is to explore rehabilitation as a lived phenomenon.

During the interviews and throughout the data analysis, the intention was to allow any emotions, patterns and themes related to the interviewees’ experience to emerge, rather than being based on predefined themes. In this process, the aim was to open up for meaning, explore, and elaborate on the participants’ pre-reflective lived experience. In the first step when analysing the data, the focus was to immerse ourselves in the participants’ lived experiences, while listening, reading and reflecting on the meaning of what the participants shared in the interviews. During the second step, thoughts, comments and questions were highlighted in the text to surface our preunderstanding and potential prejudices. As the researcher is part of the field, it is challenging to be able to set aside one’s own presumptions of how this phenomenon could be understood. Therefore, when analysing the data, the intention was to keep a stance of openness towards the participants’ expressions of their experiences. Thus, the process of analysis and interpretation as a non-linear style was concerned with the dynamic relationship between the part and the whole of the empirical material at multiple levels (Finlay, 2011).

The data analysis might be understood as a process of insightful invention to uncover meaning. As part of this process in step three, key phrases and meaning units were identified and clustered into phenomenological themes. These themes were developed as a description of an aspect of the experiences that were found in each cluster of meaning units and contained a moment of the experience. Thus, these themes can be understood as the meaning structures of the experience, which formed the basis for the thematic reflection.

Reflective writing was part of the fourth step, where the phenomenological themes were used to compose textual descriptions. In phenomenological writing, lifeworld experience descriptions are re-written and tightened to show, rather than tell the meaning of the experience. Van Manen (2014) refers to this crafting process as writing anecdotes, which intends to speak to our imagination and give us a flavour of the phenomenon. “A phenomenological text is ultimately successful only to the extent that we, its readers, feel addressed by it… the text must reverberate with our ordinary experience of life as well as with our sense of life’s meaning” (van Manen, 1990, p26). Although human experiences are always more complex than what is captured by writing alone the text as a whole is intended to represent the findings of a phenomenological exploration (van Manen, 1990).

Consent and other considerations

The project was ethically approved by the Norwegian Centre for Research (NSD no. p469). Prior to the interviews both verbal and written information about the study were given to the participants in separate meetings and written informed consent forms were signed by all of them. Clear boundaries were set about the context of the research project, the research process, and how the findings would be reported. According to the standards set out by the Norwegian Centre for Research and the University of Oslo (UiO), all data were de-identified and stored in TSD (Services for Sensitive Data). In designing the study, the participants’ vulnerable situation, being on long-term sick leave, was given special consideration. We acknowledged that the research process could cause painful awareness of their situation, and consequently the participants were informed about the opportunity to come in for a debriefing session after the interview if they experienced excessive emotions as a response to what was brought up during the interview. However, this situation did not occur.

The following section provides a narrative of the participants’ lived experience of struggling to re-habituate the habitual body and to come to terms with their lived body as ill.

3. The process of re-habituating the habitual body

As the participant states in the introductory section, his job is his whole life and how he bonds with his work seems quite sincere. This is more or less in line with what the other participants described in the interviews as well. All the participants have experienced symptoms of burnout for several years and all except for two were on work assessment allowance when the interviews were conducted. During the sick leave, all of them have felt being pushed to go back to work, either full-time or part-time, despite not feeling well. What we have seen in the participants’ narratives, the backdrop of having ended up with a fatigue reaction, is their dedication to work. We will here give a detailed description of the participants' lived experiences of the rehabilitation process. During the phenomenological analysis, textual descriptions containing the meaning structure of the experiences were composed. These meaning structures are presented in discussion with phenomenological insights provided by Merleau-Ponty (1945/2003, 1968) to highlight how meaning can be understood phenomenologically. As our intention mainly was to highlight meaning, the names of the participants are left out. The textual descriptions are presented in italics and the phenomenological insights in plain text.

Trapped in the present body

The healthy body can be described as transparent, as we have a pre-reflective sense of certainty that our body will support us in the activities that we engage in. In the usual course of events, the functionality of the body is taken for granted and not attended to. When experiencing illness, however, what the body is capable of doing is altered. Everything feels changed; the body does not only feel different now, but also how it has been lived, what it has been capable of, and how it has been experienced in the past, have changed. *That awful feeling of being trapped started five years ago; the panic I feel when I have to do something but have no energy. I know what I have to do, but I cannot manage it. I can give it everything, but still it isn't enough.* When "I cannot" is frequently confirmed, the certainty of "I can" might change into "I might be able to" due to the awareness of the experienced inability. When being unable to act as before, the focus of our attention becomes on what we are not able to engage in. Recognizing the body becomes a deliberate focal point of attention. When becoming consciously aware of what the body no longer enables us to do, the person must modify his or her actions. *My head gets tired quickly and I get fever after the slightest effort. I actually got worse throughout the autumn when I worked 25%. That didn't work out at all. So now, I've been told by both doctor and psychologist to learn how to do nothing.*

The body can no longer be taken for granted or ignored. It must explicitly be attended to in various ways. The body completely determines the daily activities. This experience might result in a sensed narrowing of the felt body. *When the "Bang" feeling strikes me, I feel trapped. The energy disappears and I am aware that I become irritated and impatient because I realize I cannot do anything about it. I just have to get through it as best I can. I have lost courage somehow. I don't know how long I can stand feeling like this.* Illness triggers a fundamental change in the relation between self and body. A person who suffers from burnout might be especially sensitive to signals of fatigue. In illness, the body appears to be out of control of the self and seems to demonstrate an opposing will on its own. *This process is very hard. All the time I have to be strict with myself and pull myself together. My whole body feels like a wrung-out mop. I am absolutely wiped. It's as if you flip a switch and all the energy is gone. It's completely unpredictable.* The bodily unpredictability makes it impossible to implement time for working. Therefore, the person who suffers from burnout must hand him- of herself over to the unpredictable body. In the experience of illness, the significance of past, present and future is changed, which is experienced as a chaotic disturbance in the person's world. Individuals who suffer from burnout might talk about their body as being separated from the self. The sufferer seems to split the body to re-connect with the body. *At this moment it's no fun. I'd rather get away from being me, as I'm neither the work person nor the private person. I cannot manage anything anywhere. I can't accomplish what I want to do. It's shitty to be half a man to put it like that. That's heavy.*

Illness is experienced as a disruption of the lived body. The disruption causes the sufferer to explicitly attend to his body as body, rather than simply living it unreflectively. The body is thus transformed from lived body to object body. When no longer being simply lived unreflectively, the body is suddenly perceived as a thing that is external to the self. This objectification might be experienced as an alienation of the lived body. This disruption of the lived body strikes at the very self. *I can't get out of it – I am stuck… Not being good enough.* The felt change in how the body is experienced can be difficult to accept because the body is the medium through which we interact within the world and express ourselves. Illness generates feelings of helplessness and represents a concrete loss of independence. This change is profoundly felt, not only as a loss of bodily integrity but also more importantly as a diminishment of selfhood. *I spend a lot of time on this sofa and that worries me. How do I get out of it? I feel stuck here – as if my world is this sofa. I am in a situation where I cannot go out into the world on my own two feet and take part. I become invisible, because I'm not joining in. What I really want is to be outside, be active and moving around, and to be with others.*

The balancing act

Phenomenology accepts the human being as an agent existing in continuing interplay within the "organism-environment-field". The organism-environment-field is defined as a systematic web of relationships, which may be understood as a totality of mutually influencing forces that together form a unified interactive whole. Thus, the human being is in constant interaction with his or her environment, aware of the immediate-present phenomena such as the experience of bodily sensations in response to internal and external influences. *I have felt very resistant and been reluctant to sit down. On a day where I feel I've got a bit to give, I can sit down and see what happens. I'm glad I have had those pieces of work lying there and had the opportunity to do one page and then stop – that was today's task.*

Whereas our embodied capacities ordinarily provide the background to the figure of our worldly involvements, in illness the body becomes itself the figure of our intention against which all else is merely background. Additionally, the primary meaning provided by the body may be disrupted. A person who suffers from burnout must relearn to become aware of his or her bodily responses by either monitoring or sensing the body. Monitoring refers to a deliberate activity while sensing is more passively becoming aware of physical sensations.

Through the bodily signals, they can experience that they are their body. *I am very good at enduring, but I do become very exhausted. I'm not aware of it there and then. It can hit me tomorrow - or the day after. The problem is that I don't know my own limitations. Now I try to be more aware; 'I'm going to do this', but I have to spend three days doing it. Not do it in one morning.* The body in the words of Merleau-Ponty is "an expressive unity, which we can learn to know only by actively taking it up" (Merleau-Ponty, 1945/2003, p239). Thus, bodily alertness implies that reflection is involved in almost everything we do. Even ordinary tasks require attention because of overwhelming sensory perception that might cause overload and result in a fatigue reaction. *I have been forced to set boundaries and say 'no, just can't do this'. When I start getting a little energy back, I go all out, but then I start to check with myself and decide OK – I've rushed it. So, in fact I have to force myself to think 'let's do only this. And leave the other stuff until tomorrow. Or, another day.*

The primary perceptual relation between the body and object is that of form giving. Sensory perception is already charged with meaning in that the object is always grasped as a significant whole against a background of co-perceived things. Any change in movement results in a change in the background attitude. The field is dynamically changing, and the person is constantly engaged in contact processes to adapt to those changes. *It feels very good to go out and putter around with one thing or another. All the time I keep in mind how setting fire to all the gunpowder will not bring me forward. I think about this almost every day. Am I doing too much now, or not? This is where I do my balancing act.* The notion of purposiveness and intentionality is essential to embodiment. Therefore, the lived body exhibits an if-then temporality of bodily action to predict contingency. When healthy, we act in the present in light of more or less specific goals, which relate to future possibilities. In illness the character of lived temporality changes. and bodily intentionality is thwarted when the "I can" is experienced as "I cannot". Everything that affects my body affects me and becomes bodily if-then experiences. Because the taken-for-granted, if-then causality of the body is interrupted, the purposiveness is also disrupted. This interruption results in a focus on the present moment and we become unable to effectively project into the future.

Precious moments of joy

The cognitive capacity of the lived body should be understood in terms of a bodily knowledge that allows us to perform everyday activities and engage with others in meaningful ways. Through its intentionality, the lived body grasps and relates to the world as a world of meaning. *I have to make the best of what my life is right now. And, my life at the moment means that I am able to do very little. Last Sunday I spent some time sitting comfortably in the sunny winter weather and watching my children play in the garden. I was served "cream-cakes". Taking part in their play was really nice and I want to join in more often*. When suffering from burnout the body is experienced as a sensitive source of information that alerts us to slow down. In some situations, however, the bodily awareness can be put on hold, which gives openings for bodily enjoyment. *Despite it being terribly tiring, I decide to go to a café and to do things I enjoy. Even if I have to go home again straight away, I have tried. I don't allow myself to give in. To get going and do the little that I can manage is an important motivational factor.* The unpredictability of the body demands that we plan all daily events. Even joyful moments require conscious planning. The person suffering from burnout may refuse to be "dictated to" by his or her body. Despite the limits imposed upon them by their body, freedom is enacted which brings moments of joy into life. *As when the whole family stay together in our cottage, I rest while they are skiing. Afterwards when we enjoy meals together life feels good. I long for the day when I will feel healthy.* The lived body is just experienced as a limitation when you are unable to do what you want to do. Thus, well-being might temporarily be experienced when the body functions as before.

When we become aware of and respond openly to our embodied relational existence, we tend to perceive the animal world as a shared community. This field is inhabited by kindred others, who are calling for our conscious attention and ultimately for our love. *The interaction with the dog – the fact that someone is depending on me and loves me unconditionally makes me want to pull myself together and take her out to train a bit. I just enjoy what we are doing. That makes me happy.* The invisibility of burnout can create a need in the sufferers to justify their condition to others. This need may be enforced by the fluctuations in symptoms, as they understand that their condition might be confusing to others. *I think it's very odd that I can cope with the dog because I can't really tackle anything else. I don't know where I would have been without it, because then I wouldn't have had a sense of belonging or achievement anywhere. I am very grateful and happy for having the dog to hold onto. I think it has been an important factor for keeping me going and not giving up.*

Language as both spoken and bodily expressed is destined to play a crucial role in the perception of others. In the experience of dialogue, a common ground is created between the other person and me. My thoughts and his/hers are interwoven into a single fabric. My words and those of the other are inserted into a shared operation and becomes an emergent phenomenon. *I feel that I have had a long, hard road to walk and I have walked all this way alone. I'm getting closer to a light in the tunnel. That's because I have been able to share what I have in the baggage with the psychologist and my husband.* In the dialogue with the other, we become a dual being, where the other and I are no longer separate. We are collaborators for each other in a divine reciprocity. Our perspectives merge into each other and we co-exist through a common world. "In the present dialogue I am freed from myself; for the other person's thoughts are certainly his; they are not of my making, though I do grasp them the moment they come into being, or even anticipate them. And indeed, the objection which my interlocutor raises to what I say draws from me thoughts which I had no idea that I possessed, so that at the same time that I lend him thoughts he reciprocates by making me think too "(Merleau-Ponty, 1945/2003, p413). Being able to open up for co-existing through a common world can be experienced as a healing effect. *I did not see light anywhere and needed someone to see me and help me. That November day at the psychologist's when she suggested sick leave, at last there was someone who held me – who carried me. There was this need in me for that to happen. And I have managed to open up and tell my husband what I need instead of telling him how inept he is. I have been terribly angry with him for a long time, but now something is happening. When he supports me, I can sense the healing effect.*

The perception of other people and the intersubjective world is problematic only for adults. The child lives in a world, which he or she believes accessible for everyone. They have no awareness of themselves or of others as private subjectivities. They subject their thoughts to critique without attempting to criticise the other. For them a self-evident world exists where everything, even dreams, take place. *It's only in the last two years that I have managed to focus more on myself again and to look after myself. That's when we chose to foster a young boy. He's been an absolute marvel, a therapist de-luxe who has helped me get out of the black hole. This little man, who's all shiny and new, can take me to a whole new place. And then the world turns a little bit and starts to give some sort of meaning.* In search of meaning, we are ourselves the meaning-maker of the field.

This is my lifeworld now

In illness, the sufferer from burnout comes face-to-face with the radical contingency of his or her existence and the inescapable limitations of their embodiment. *When you have so little strength, it becomes easy to think that others should help you. Like you are looking for something from outside. And they are not there. Nobody except myself can make me feel better.* Freedom to act is situated in such a way that there is no freedom without a field – and since we as embodied subjects are of the world with which we are in constitutive relation, it is not outside ourselves that we are able to find a limit to our freedom. *But how far can I manage to heal myself or to accept myself? I don't want to be such a weak and incurable person. I would rather be strong. So, it means having to acknowledge a chapter that is finished. Which is part of accepting and carrying on. It's hard, but how long should I go and grieve for that job and that I drove myself to fall flat on my face? Some time I just have to say stop*. Whether we want it or not we must learn to accept and deal with the physical limitations, which our illness imposes upon us. *It is so hard to accept that what has happened has actually happened, since nobody else accepts it. I ponder long and hard over how I will be able to come to terms with it. I am still optimistic; thinking that over time things will sort themselves out. Even if I don't exactly see that now.* In a critical way, we are forced to recognise our inherent vulnerability. The sense of inescapability and limitation is intrinsic to illness-as-lived. *There is no guarantee there will be a cure, so until I know it will have to be as it is. I can't do anything about it. Right now, this is my life.*

Phenomenology provides, through accounts of how we are born into a world already inhabited, shaped and made meaningful by others, a way of understanding how human existence is characterised by basic openness to others and the world. *I do go around pondering a bit about stuff in my everyday life, and I have found that if I don't reflect, I will stagnate. There is only one way to get out of this and that is to grab hold of it and do something about it. And by reflecting I can discover what I can do something about.* Our very perception of something as a choice needs to be understood against our whole situation including our bodily capabilities, our goals and plans, as well as our perceptions of others, the world and ourselves. *I see that there is no space for a job right now. It hurts because it's not where I wanted to go. It hasn't come easy for me to accept the situation instead of working against it.* The intentionality of the lived body constitutes it as fundamentally open to new possibilities and to forming its own style of being in interconnection with its conditions. *As I'm getting a bit better, I am more aware of the consequences of what I'm doing. Eventually I learn to look after myself. I'm much more conscious of what I need and what the meaning of life really is instead of just going along for the ride. I feel more in charge of my own life.* According to Merleau-Ponty, to grasp my lived body, as body requires an act of reflection, which necessarily transforms it into an object-body, which is the experience of how my body might be perceived as an object in the gaze of the other. *For myself I hope I will become better at voicing my own opinions. But that part is pretty hard because I am worried about disappointing and to not live up to expectations.* When ill, I recognize the brute fact of my being as material stuff. This experience is one of alienation. As an object for others, it altogether escapes my subjectivity.

The situation might be experienced as radically changing and perhaps forcing the enactment of non-habituated action and movement. *I am not as ill today as I was six years ago. Today I can put my foot down and manage things better than I did then. It has become a necessary lesson, because I believe this was a reason for ending up in that burnout ditch.* Even if my bodily style of being makes certain choices and decisions more likely for me than others, there is room for creative adjustments. *At least I have learnt not to set off all the gunpowder at once. Even if the urge to be in the flow from the past is there, working 100% is impossible. But I would like to work as much as I am able to. I guess that's what I would like back – if not life as it once was, but the feeling of managing my own life.* Merleau-Ponty's description of the lived body and its compartment in the world and relation to others offer a rich account of bodily integration. When Merleau-Ponty insists that to be born is both to be born of the world and to be born into the world, he captures how human beings exist in a double way of being both already constituted with a certain meaning and at the same time themselves constituting meaning. *It no longer worked giving so much and receiving so little. Then the long, tiring and redemptive process of pulling the threads in the chaotic ball began, and slowly I started to understand that I was too hard on myself. There's a lot I can't change, but I can alter my own attitude to myself. That in fact is what is happening. At least I have a small and growing protest inside me about not being so insignificant.*

4. Out of Chaos, meaning arises

In this study, we used a phenomenological approach informed by the insights of Merleau-Ponty (1945/2003) related to the lived body. The aim was to explore how sufferers from burnout who have been on long term sick leave (>52 weeks) deal with the process of coming to terms with their present body. We have seen how the illness obstructs the participants' ability to live according to their assumptions about their bodily existence as well as their inability to free themselves from the facticity of suffering burnout. Thus, when unable to fulfil the desire to enact habitual actions, loss of future possibilities was experienced as a constriction to their lifeworld. The participants' lived experiences show how the very nature of the body as being in the world is transformed, and the fundamental unity between the body and themselves is experienced as disrupted.

Carel (2012) points to illness as an intruder that alters the person's very being in the world. Due to a loss of bodily transparency in illness, sufferers from severe diseases are forced to relearn how to balance worldly demands, as the previously experienced "I can" no longer can be taken for granted (Carel, 2013). The experience of bodily doubt constitutes the transition from bodily capacity to bodily incapacity, and creates an anxiety on a cognitive level as well as on a physical level (Carel, 2013). This is in line with how Toombs (1995) has described illness in her work. In degenerative diseases such as Multiple Sclerosis (MS) the disruption of the lived body effects the taken for granted awareness of the social world of everyday life. Thus, the bodily disruption causes a disorganisation of the person's self and his or her lifeworld (Toombs, 1988). Other researchers have also mentioned the struggle to maintain balance between demands and resources in a fight for survival when suffering from fibromyalgia (Raheim & Haland, 2006; Søderberg, Lundman, & Nordberg, 1999) and burnout (Ekstedt & Fagerberg, 2005). These previous findings align with the phenomenological descriptions presented in our study.

We have also seen how the participants objectified their lived body in various ways while living through illness. They described the lived body as an object outside their subjectivity in the midst of a world that was experienced as alienated. This experience might be recognised as a state of living in-between (Ekstedt & Fagerberg, 2005; Jingrot & Rosberg, 2008). Svenaeus (2000) refers to the loss of bodily integration as the gradual loss of homelikeness. This process is recognised as one of self-alienation (Leder, 1990) as well as a feeling of a split between body and mind (Svenaeus, 2000). Søderberg et al. (1999) shows in his work how the loss of bodily integrity, loss of control and freedom to act might lead to an existential breakdown in the familiar world. This finding is supported by Jingrot and Rosenberg (2008). Their study also shows that the gradual detachment from the interviewees' lifeworld could be understood as a process of losing one's homelikeness, which ended up in an existential breakdown. Correspondingly, the participants in another study described their experience as a fundamental collapse of their lifeworld (Lian & Lorem, 2017). Our study supports these findings as we interpret that the body image not only is an experience of the participants' biological body, but of their lived body. Therefore, a threat to their body necessarily incorporates a threat to their very selves, which in turn ended up as a bodily disintegration. Thus, the disruption of the lived body is not merely experienced as a breakdown in the mechanical functioning of the biological body. As the participants' lived experiences show, the significance of past, present and future is changed, which seemed to be experienced as a chaotic disturbance in the participants' world. In the words of Merleau-Ponty, "in illness it is the intentional arc that goes limp" (Merleau-Ponty, 1945/2003, p136). Thus, a new lifeworld must be re-made.

As our phenomenological analysis shows, the inherent human ability to adjust to the never-ending temporal processes of life seems to take place as the participants demonstrated deliberate choices and reflective self-cultivation to adjust to their present situation. By being able to demonstrate new habitual actions, the participants might be able to constitute a "new" defined self, which in turn might result in a re-habituation of the lived body. Similarly, Svenaeus (2014) asserts that suffering from pain may be transformed when core life values are changed by a reinterpretation of the life-story, which eventually might ease the experience of the present lifeworld. Finlay and Molano-Fisher (2008) correspondingly conclude that Pat in their study had to learn to cope with her transformed self to come to terms with her past, present and future being.

All the participants seemed to be closely tied to their previously lived worlds through their bond with their work. Although the illness had put an end to this sincere relationship, the lost world was still present in their lived bodies through intentionality. In longing for the experienced past, it seems that the intentional direction is pointing "backwards" in time instead of "forwards", which might restrain the reorientation and ability to act. The participants struggled to free themselves from their memories of the past and seemed to vacillate between two poles: holding on to their previous worlds and unleashing themselves. Honkasalo (2000) in her study refers to the pain experienced in the past as still present in her participants' lived experiences, showing that they hold on to their previous worlds. She refers to this experience as a refusal of mutilation, which might be understood in the light of Merleau-Ponty's (1945/2003) description of a man with a phantom limb. Through his description of this man's relation to the past, we get an image of the ambiguous presence of the lost. His description illuminates our understanding of the intentional body. Accordingly, this might highlight how demanding the participants might experience being stuck in the past whilst simultaneously being forced to relate to a lifeworld that is changed.

Our phenomenological analysis shows how the participants are reflecting on their changed life-situation and how to be able cope with it, which enhanced their self-understanding. This in turn seemed to empower non-habituated action and movement. Even if their bodily style of being makes certain choices and decisions more likely for them than others, there seems to be room for creativity. Once we accept the existence of a subjective phenomenology, the human being must be conceived in terms of an autonomous agent, aware of his or her bodily responses in relation to different ways of taking care of him or herself. As our study indicates, the lived body possesses its own operative intentionality of habituated actions where the interaction between the participant and his or her environment-field is a contact process. Through this process, meaning emerges. We saw that the participants managed to engage with others despite struggling to survive. This is especially evident in the participants' experienced precious moments of joy where an awareness of well-being seems to evolve into consciousness. Thus, the participants exist within the continuum of awareness and consciousness of constantly shifting experiences. Their mode of being-with-others seems to form and constitute their lived experience positively. In search of meaning, the participants became aware that they themselves were the meaning-makers of their lives – and out of the existential chaos, new meaning appeared. This finding is similar to what Salminen et al. (2015) describe in their study where the analysis revealed the overarching theme: "my well-being in my own hands". Their findings showed that accumulation of support led to a revival of joy in the participants' lives, which in turn enhanced the participants' experience of well-being and perceived control. Despite suffering from a different type of illness, long-term users of physiotherapy similarly expressed their own meaningful ways to recover (Mengshoel et al., 2019). Another study concludes that internal and external resources are intertwined and can directly increase the probability in patients suffering from exhaustion disorder to regain ability to work (Norlund, Fjellman-Wiklund, Nordin, Stenlund, & Ahlgren, 2013).

5. Final comments

Although all the participants in our study experienced that they had become more capable of managing their own life, none of them was able to return to work full-time at the time of the interview. For some of them it was still very difficult to accept that a chapter of their life was terminated. They expressed hope however that they would be able to come to terms with their present situation and some of them hoped to be able to start working again.

Phenomenology does not refer to an autonomous self, but to situated freedom and the interplay between freedom and facticity. Sartre's account of freedom (1958) emphasises that although we may have little or no control over our illness, we always have freedom to choose how to respond to the difficulties within our lives, and how to constitute the likelihood of feeling better. In this regard, Sartre sees embodiment not only as radical limitation but also as possibility. The recognition of those aspects over which it is possible to exercise some control may provide hope. Thus, his account (Sartre, 1958) of the contingent necessity of embodiment may provide an affirmative response. The existential breakdown might provide a starting point for rehabilitation and self-acceptance as presented in Aroll and Howard's study (2013). This finding is supported by our study and is in line with what Sartre refers to as the contingent necessity of the body. The body is at once, “the necessary condition for the existence of a world and the contingent realization of this condition” (Sartre, 1958, p462).

Burnout is often labelled as ‘subjective health complaints’ and the exact physiological causal mechanism is still unknown. The symptoms are complex with seemingly individual combinations that often persist and fluctuate in intensity over time. As the participants’ lived experiences show the rehabilitation process is time-consuming. In Western societies, the political health economic imperative is to reduce costs. In Norway there is a focus on shortening the rehabilitation process by focusing on treating depression, which is a common symptom in burnout (Bianchi, Schonfeld, & Laurent, 2015). Moreover, the medical system and the social security system seem to agree that subjective health complaints often are due to psychopathology (Lian & Lorem, 2017; Maeland et al., 2012; Nettleton, 2005; Åsbring & Närvänen, 2003). Thus, working is considered part of the rehabilitation process, as the participants are not recognised as physically ill.

The findings in our study suggest that the biomedical understanding of burnout does not adequately capture the personal experience of the syndrome, which in turn restrains the participants’ ability to integrate the bodily experience of burnout into their lives. This finding is in line with previous findings of how persons living with disabilities struggle to contextualise their disabling condition (Gibson, Placek, Lane, Brohimer, & Lovelace, 2005) and how the disabling disease and not the lived experience is the focus of interventions and research (Lutz & Bowers, 2005). Psychological interventions are often based on cognitive behavioural therapy, which aims to provide the patient with the necessary self-confidence to cope with their condition (Alderson, Foy, Glidewell, McLintock, & House, 2012). The effects of these interventions have however proved very small (Coventry et al., 2013; S. M. Smith, Soubhi, Fortin, Hudon, & O'Dowd, 2012). The reason for this fact might be the limited focus of the biomedical model on the heterogeneity and complexity of syndromes such as burnout. To be able to support these individuals we need a person-centred approach that takes the whole person into consideration as well as how they themselves define their situation (Engebretsen, 2018; Lutz & Bowers, 2005).

Although the findings in this study provide new insights into causal mechanisms that can influence the rehabilitation process of sufferers from burnout, additional research on causal mechanisms related to the rehabilitation process is needed. Our hope is that this knowledge will contribute to advance a holistic theory of burnout in the near future. By providing a deeper understanding of burnout, this knowledge can help us to prevent symptoms from becoming chronic, which in turn will improve the prognosis for recovery.

6. Methodological Considerations

The concept of validity has been controversial in qualitative research. Researcher bias and the effect of the researcher on the participants, also referred to as reflexivity, is mentioned as two main types of threats to validity (Maxwell, 2013). Hermeneutic phenomenology research aims to represent the experience under investigation as close as possible to how the participants experience it, while recognising the interactions and overlapping perspectives between researcher and participant. The researcher as interviewer, analyser of data and author of the resulting narrative, purposely becomes a vital part of the study. Therefore, in this study we paid attention to the need for increased integrity and accountability regarding the research process.

Another common problem for phenomenological researchers is to be challenged in defending that the conducted research project is based on phenomenological methodology (van Manen, 2014). This problem might be related to the critique raised against van Manen's work (1990), (2017a), (2017b) and (2018) as well as Smith's work (J.A. Smith, 2018; J. A. Smith, Flowers, & Larkin, 2009) for promoting confusions concerning the nature of phenomenology (Zahavi, 2019). In general the critique related to phenomenology as a qualitative research method has been raised for being radically under-specified – lacking an implicit theory of "meaning" (Paley, 2017). This problem is related to the lack of standardisation, which might raise concerns about reliability. Concepts such as trustworthiness, authenticity and quality are often used alternatively to validity and reliability, as they seem more appropriate for evaluating qualitative research. The credibility of qualitative research might be demonstrated in its persuasiveness, plausibility and ability to convince. In hermeneutic phenomenology, these qualities might resonate within a phenomenological description that demands a phenomenological nod affirming recognition of the interpretation (van Manen, 1997).

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Article 5

Forthcoming in: RL Anjum, S Copeland & E Rocca (2020) Re-thinking Causality, Complexity and Evidence for the Unique Patient. A CauseHealth Resource for Healthcare Professionals and the Clinical Encounter, Springer Nature

Chapter 11

Reflections on the clinician's role in the clinical encounter

Karin Mohn Engebretsen

Editors' abstract. A practicing Gestalt psychotherapist and academic researcher on the topic of burnout, Karin Mohn Engebretsen provides in this chapter a personal narrative from a professional perspective. The narration gives insight into the nature and impact of the healthcare practitioner's influence on the clinical encounter. In the case study, Engebretsen puts herself in focus, touching on how her own dispositions affect the way that the patient's dispositions manifest when she engages them in therapy. This is an essential aspect of the Gestalt approach, but Karin's reflections go further to illustrate how the mutual manifestation of these dispositions can, in turn, interact as the treatment proceeds. This way the features of mutual manifestation and causal complexity, presented in Part I of this book, are placed at the very core of the clinical interaction itself. Indeed, the practitioner's awareness of their own influence has an impact on the outcome and success of that treatment. In contrast with the biomedical model, which sees the patient as a passive subject of the treatment imposed upon them by the caregiver, both Gestalt theory and dispositionalism recognise that the treatment itself is something both the healthcare professional and the patient must be actively engaged in for it to work, as discussed in the first part of this book. Thus, the clinical encounter is essentially relational.

11.1 Introduction

Several years ago, I decided to examine the philosophical and cultural roots of my therapeutic activities. I was aware of how different ontological perspectives, and in turn methodological choices related to the epistemological question "how do we know" could affect the therapeutic encounter. There might be some hundred different approaches to psychotherapy but the crucial division between the psychotherapies is not between the "schools" but mainly between what I will refer to as the positivist and the post-positivist/constructivist paradigms. Those years ago, I lacked a clear orientation and became aware that I was vacillating between different methods. I also thought I was able to work without the intention of healing my clients if I just stayed with what was happening in the process. When I realised that, in reality, I did actually have an intention of healing, I decided to explore to see what philosophical theories I might be working from. During this process I wondered about the nature of my underlying motivations for the ontological and epistemological choices I had made in my search for answers to the fundamental questions that are either implicitly or explicitly contained in the way I practice gestalt psychotherapy. Today, psychological theory has become more of a philosophical world-view to me, or a way of thinking and perceiving—more than a taught theory about psychological interventions. In reviewing the path I have followed, I have over time come to know several different traditions in psychotherapeutic practice and, consequently, my opinions about important therapeutic concepts have changed, becoming both extended and refined.

With my desire to heal, came a tendency to see myself as being able to know what was best for my clients. This attitude, I suppose, is still prominent in many clinical encounters. For instance, Cognitive Behavioural Therapy (CBT) is the "preferred" methodology seen from a political/governmental point of view. This preference is due to how it fits into the norms, methods and practices of evidence based medicine and the positivist (Humean empiricist) paradigm. Institutionalised norms, methods and practices certainly influence our attitudes when working clinically, and inherent values affect patients in clinical practice and medical care. Although I here use my own experience as a gestalt psychotherapist, I think much of what I say will apply to any encounter where there is a power imbalance as is the case between patients and clinicians. I start from a client-centred approach (Rogers 1962) building on Rogers' "non-directive" therapy. In this perspective a healthcare system should acknowledge the client as an integrative whole, where the medical issues must be understood not only on the physiological level, but also within a biographical, social and cultural context.

It is equally important to acknowledge the clinician as a person, with everything that he or she brings to the clinical encounter in terms of values, expectations, perspectives and interpretations. How does the clinician influence the encounter with the patient, in positive or negative ways? And how important is it to be aware of one's own role in the clinical encounter?

11.2 Reflections on how values affect clinical encounters

Historically, gestalt psychotherapy has rejected diagnosis as being depersonalizing and anti-therapeutic. This can be seen as a reaction to the dualistic biomedical model, which seems to isolate the issue of psychological suffering as pathological. The DSM (Diagnostic and Statistical Manual of Mental Disorders) is a psychiatric diagnosing tool (American Psychiatric Association 2013) where the diagnostic criteria are, for the most part, based on manifest descriptive psychopathology rather than inferences or criteria from presumed causality or aetiology. The organisational framework by which disorders are grouped into similar clusters are based on shared pathophysiology, genetics, disease risk, and other findings from neuroscience and clinical experience. Being descriptive, it is compatible with how gestalt psychotherapists diagnose clients. In a gestalt perspective, however, psychological suffering is not seen as psychopathology but rather as a creative adjustment to threatening life-experiences and thus, it is based on observations of phenomenology. This includes a focus on body and mind processes, the clients' well-being, character structure and level of emotional development, but also attention to the strength of the therapeutic relationship and stage of treatment. This means that gestalt theory takes into account the total contextual field of the clinical encounter, and thus takes a holistic, non-reductionist and non-dualistic view. As such, the two diagnostic tools differ radically as the DSM does not fully take into consideration the person within his or her context.

When it comes to the diagnostic practices within medicine, I often experience that clients who are referred to me by their general practitioner (GP) are diagnosed with depression. When no physical biomarker is found, the patients' symptoms seem to be attributed to psychopathology and the patients' subjective health complaints are often conveniently reduced to a diagnosis of depression, which may of course be one of their symptoms. This is also often the case for persons who suffer from fatigue and pain related symptoms. The biomedical model and evidence based medicine (EBM) are rooted in the positivist paradigm. Within this paradigm, knowledge is achieved exclusively by what is directly observable and objectively measurable, and little space is left for reflections about subjective factors and underlying mechanisms (Kerry et al. 2012). Being diagnosed as depressed often upsets these clients and they often openly disagree with their GP. The result of such disagreement can result in a lack of trust and worsening of the experienced symptoms.

In clinical interactions, the patient can be addressed as an object, or as a person. Consider the often-used metaphor, that the biomedical model construes the human being as a complex machine. In this machine, dysfunctions might be caused by internal or external harmful factors and the machine is unable to re-establish well-functioning on its own. On this view the person has lost his or her agency and becomes the passive victim of the diseased part subjected to external repair-work.

In contrast, gestalt theory sees the human being as an agent who is in constant interaction with his or her environment, aware of phenomena such as the experience of bodily sensations in response to internal and external interacting factors. Patients are to be recognised as subjects in their own right with their own habitual preferences of behaviour. A clinician cannot truly know what is best for the patient – therefore, it is necessary to give up the desire to be appreciated as some kind of a healer. If not, the patient becomes a means to an end in the clinical process. According to Buber (1965), human interactions can be characterised by a meeting of subjects or a 'thingification' of the other. The subject ”I”, can be seen as part of an I – Thou attitude or the ”I” of an I – it attitude. In Buber's terminology "Thou" means "you". Therefore, addressing the client in an I – Thou attitude is a central perspective in relational gestalt psychotherapy and any other person centred practices. Accordingly, I will address two pertinent questions. The first one is: *how important is the clinicians' role within the clinical encounter*?

Gestalt psychotherapy is rooted in an existential-phenomenological world view. In this world view, all events are a function of the relationships between multiple interacting forces where no event occurs in isolation (Yontef 1993). If we apply this view to the clinical encounter, any therapeutic process is a function of the relationship between the interacting therapist, client and their common field as a whole. Thus, the field is co-constructed as an integral part of the therapist/client experience, which will have an impact on the possibilities for different outcomes of the process. This means that we can no longer speak of individual growth as "self-development" – in fact it is "self/other development". Additionally, growth of the entire individual/contextual field is only possible if the field has the capacity to adequately support its members. Similarly, in medical practice, any medical treatment might be seen as a function of the relationship between the interacting doctor, patient and the field as a whole, which might be the case in person centred medicine.

In person centred care, the focus is mainly on the patient: how the treatment influences the particular individual, and how the patient responds to the treatment. First of all, I will highlight the word 'treatment'. How can we understand this term? When you are treating somebody, it is easy to imagine the doctor as providing the patient with something that might be what he or she needs. When the dialogic encounter is understood from a dispositionalist perspective, however, the focus must be on all the participants who are present. As such, the dialogic encounter can be seen as an emergent phenomenon where the client and the therapist are mutual manifestation partners for the outcome of the therapeutic process (see Anjum, ch. 2, this book). Thus, the dialogic encounter is not simply uncovering the client's experience of her situation, but can be seen as a genuine interactive process where both the client and the therapist bring themselves in as human beings and thereby influence the encounter reciprocally.

Gestalt psychotherapy is based on the meeting between the therapist and the client as the central healing mode. This means a healing through meeting in reciprocal humanness. In this view it is important to acknowledge the clinician as a person, with everything that he or she brings to the clinical encounter. The development and growth of any healthy self in the field requires a field that includes other healthy selves. We are all inter-dependent and the quality of my life will influence the quality of my environment. Therefore, a relational approach requires careful and consistent observation of all the data in the field including my own processes, values and beliefs as a therapist. This leads us to the second question: *how might the clinician influence the encounter in positive or negative ways?*

In my experience, it is "easy" to handle therapeutic processes individualistically and react as if my existence is separate from my environment - especially when my own self-process is jeopardised. In such cases, how might the encounter be affected?

Being part of the therapeutic process, I am not only engaged as a supportive ground, but as a co-participant as well. When "acting" as a tool in the therapy process, the therapist might be drawn into phenomena such as transference and countertransference (Rycroft 1979). These two notions can be understood as the process by which feelings, behaviours or attitudes of clients and therapists that belong in the past, are transferred to the therapy participants in real time. Transference is our unconscious activity that is shaped by normal preverbal perceptions of self and other, which organise our subjective universe (London 1985). Client and therapist actively co-create the shared perceptual field of the therapeutic relationship. Therefore, from a dialogic perspective, the client's processes of transferring cannot be interpreted as emanating from the client in isolation but must be seen as emerging as part of an inter-subjective relational system (Hycner 1991). Countertransference refers to the therapist's feeling towards the client, in response to the projected transference.

When the therapist is unconsciously drawn into transference processes, the outcome of the therapeutic relationship might in best case be ruptured and in worst case be quite the opposite of therapeutic. In my experience, relating objectively to phenomenological data constitutes a major challenge, even for well-trained psychotherapists. Therefore, I see supervision as crucial when working dialogically. I have experienced meeting clients who are sensitive to what they experience as personal critique. Their emotional reaction might be due to shame proneness. Some of these clients seem to have been severely shamed by previous therapists, before seeing me. The presentation of the work I did with one of my clients later in this text shows how easily this can happen, and also reminds us of the importance of being consciously aware of the therapeutic process. The attentive attitude requires humility and explicitly promotes respect and appreciation of differences.

I am aware of how contextual conditions often change the way I work. With clients who are more psychotic, I work more analytically - just being there, holding the boundaries, not intervening, challenging or contacting. With healthier clients, I work more dialogically. These choices mirror the clients' level of emotional development and character structure as well as the strength of the therapeutic alliance. I am also aware that there might be a difference between theory and practice – how my values might change in practice. In one to one setting I am gentle and soft; in groups I am often more robust and challenging. The danger of not taking differences between people seriously enough is constant. In my experience, it is exactly the art of relational psychotherapy to bring the differences into awareness. And in the dialogical encounter differences related to values or attitudes are to be appreciated – not diluted or combatted.

In what follows I present a snapshot of the psychotherapy I enact. By presenting the work I did with Marie over several months, I will illustrate how my work embodies the theory. This illustration shows how the phenomenology I enact fits into the dispositionalist paradigm. I start with a presentation of how I experienced the initial meetings with Marie and my reflections on what she might need. Then I describe parts of the work we did together.

11.3 The work I did with Marie

11.3.1 Presentation of the client

Marie[1] was a 45 year old married woman with two grown up children. Her husband was a chief executive officer in a large multinational company and travelled a lot. Due to this she spent most of her time on her own. Until recently Marie was a manager in a small company, but lost her job last winter. This made her feel lonely and lost. She told me about her happy childhood; her mum and dad and her sister who was three years younger, whom she adored. The family spent a lot of time together, either alone or with friends. Both her parents were dead, her father died when she was 20, her mother two years ago. After the death of her mother, she did not have much contact with her sister, although they lived in the same part of the town. Before she began seeing me three months ago, she had been ill for a month. Her referral to me was via her GP, who had diagnosed her as depressed. Her reason for wanting therapy was that she needed some help to fix her life. She presented with issues of anxiety and panic attacks, feeling isolated from others, especially her husband. Her GP wanted to give her

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[1] 'Marie' is a fictive name. Some details have been altered for the purpose of de-identification according to ethical and legal standards and written consent to use her story has been obtained.

antidepressants, but she refused because she did not see herself as depressed. We agreed to work for a six week assessment period to determine whether we were able to work together or not and to review our work after that on an open ended contract.

The first time I saw Marie, I was struck by her attractiveness; she was tall, slender, and well dressed, with a determined stride. Her long dark hair framed her deep blue eyes. Her voice was rich, and sensual. With the pitch of her head forward, her eyes were often cast downward and seldom met mine. Sometimes, when she did look in my direction, she glared. This look of camouflaged contempt made me feel tense. Marie's facial expressions were endless. She commented on everything with a wince, as if every feeling that passed through her body was expressed only by the muscles of her face. When she became anxious in the session, this tendency was especially evident.

My initial reaction to Marie was curiosity and I felt warm and concerned towards her. I experienced her as being extremely bright, demonstrated by the way she presented herself and her use of vocabulary. Marie's connection to her mother changed at the age of three, when her sister was born, and she was sent to her mother's sister for some weeks. Afterwards she became dad's girl. When telling me about her father's death, she teared up, but seemed to be unable to relate to the emotional situation that she obviously experienced. She turned away from me, silently sitting there for a while – then she laughed. I often experience such reactions, which I see as a normal human ability that allows us to put off dealing with emotions until we feel able to address it. When she laughed, I was aware of feeling irritated and when reflecting on why, I became aware one of my personal assumptions that I might have acquired without full awareness of its purpose: "It's silly to laugh". She described her relationship with her mother as ambivalent, never knowing where she was in relation to her. Marie told me that her mother must have been depressed - she could be silent and withdrawn for days, not addressing anybody. I was struck by how some aspects of her history paralleled my own. I also felt adored by my father and abandoned by my mother, which alerted me to the possibility of transference/countertransference processes. And, I was aware that I could easily be drawn into over-identifying with her. I knew at this early stage that I would need to discuss our relationship with my supervisor to be able to bracket off my own emotional baggage.

11.3.2 Presenting problems

Marie came to therapy with difficulties especially in her relationship with her husband. The slightest misunderstanding between herself and others left her with feelings of abandonment and deep loss. Whenever she spoke about an emotion such as her fear of being abandoned, she would immediately discount it with statements such as, "But I know that's crazy, because I should not feel that way!" In this regard she was extremely critical of the vulnerable aspects of herself. She was also highly critical of others, an aspect of herself which she joked about by stating that it was due to her superiority complex.

11.3.3 Diagnosis

From a gestalt perspective I think it is fruitful to understand Marie's process historically as a "creative" adaptation to her life situation. This adaptation can be seen as the relationship between Marie and her environment, in which she takes responsibility for creating conditions to take care of her own well-being. Thus, I see diagnosis as a descriptive statement that articulates what I notice in the present, which informs me of how I might be able to help my client.

Gestalt psychotherapy embraces Merleau-Ponty's holistic view of the human being, conceptualized as existing in continuing interplay in the "organism-environment field" (1947/1962). The organism-environment field can be understood as a systematic web of relationships, which consists of a totality of mutually influencing forces that together form a unified interactive whole. Out of this intersubjective field, "figures" emerge. The configuration of a figure against a ground displays the meaning, and meaning is achieved only through relations in the field. Thus, the relationship between the ground of the field and the figures that emerge is what gives meaning to the whole. To perceive and be aware of an emerging figure is the act of contact.

The idea of "unfinished business" is a core notion in the gestalt approach to explain how the act of contact might be interrupted. This notion refers to a tendency of the organism to complete any situation that is experienced as unfinished (Perls et al. 1951). For example, when Marie was not able to get her needs met, some specific contact episodes emerged between us at the contact boundary (Clarkson 1989). I became aware of some aspects of her behaviour, which stood out from the context like figures against a ground. These figures became interesting as a source of further exploration when I observed them as a pattern over time and across situations. Contact boundary disturbances do not refer to psychopathology, but to a disruption in the clear awareness and organismic flow between self and other, which can be either healthy or pathological. Very early on in the encounter with Marie, I became aware of the transference that was taking place between us. I reflected on whom I might represent to Marie - when I felt warm towards her, I would be her father, and when I felt irritated and critical, I would be her mother. So, when I was feeling irritated and critical towards her, she might have been unaware of conveying her feelings by giving me as the therapist an experience of how she feels, rather than by articulating. Thus, there was a possibility that I could end up behaving towards Marie like her mother did.

After this brief presentation of my initial contact with Marie, I now turn to the therapeutic process and present some of these interruptions to contact, and how I work dialogically.

11.3.4 The I-Thou Process

To illustrate how I worked with my client, I will list four discernible phases in the "I-Thou" Perspective (Buber 1965). These phases are (1) "Exploring self; an it – it attitude", (2) "Becoming aware of the therapist's presence; an I – it attitude", (3) "Struggling with abandonment depression; an I – Thou attitude", and (4) "Moments of mutual satisfaction; a Thou – Thou attitude". These four phases show how Marie's and also my own ability to integrate personality aspects that previously were not fully "owned" resulted in an emergent phenomenon, that is, the therapeutic outcome.

Phase 1: Exploring Self; an it – it attitude. When Marie entered therapy she talked about herself and objectified both herself and me as a therapist and asked, "how can you fix me?". Marie rapidly established an "idealizing" transference towards me, which can be understood as Marie's unconscious recognition of some of her mother's traits in me, and then started acting out how she previously idealized her mother. When I became aware of the idealising transference she projected onto me, and the immediate impact it had, I realised how flattered I felt. I was able to see that I was not fully present to her as another person. However, the loving attitude I felt towards her, and the mirroring I did during this phase, was an authentic desire to nurture and "mother" her.

My main goal for this phase (6 weeks of therapy) was to build a therapeutic alliance. I focused primarily on building a trusting relationship, and therefore I was initially and primarily concerned with "confirming" her (Buber 1965). By confirming in this context, I mean accepting not only what Marie is aware of, but also aspects of her existence that are denied, e.g. confirmation of the person in her fullest potential. I started to practise "inclusion" (Buber 1965) with her. By this I mean closely listening to both verbal and nonverbal communication, carefully giving her phenomenological feedback to raise her awareness of herself. In this situation I address her as a "person" – not as an "object". Intuitively I felt she was very sensitive to anything I did that she could interpret as being a rejection. However, instead of telling me directly when she felt ignored or insulted by me, she would get a certain withdrawn and contemptuous look on her face that I came to recognise. When I addressed this phenomenologically, she would comment back to me with a wince, obviously feeling misunderstood and attacked. She was not interested at this point in insight about herself, because she was convinced that all insight would simply lead to criticism. I was imagining that her self-esteem was very fragile and instead of exposing her insecure self, she presented a "false", defensive self to me. This imagining must be distinguished from empathy, which leaves out one's own side as a therapist. To be able to practice inclusion the therapist needs to be able, as much as is humanly possible, to attempt to experience what the client is experiencing, feeling, thinking or knowing from her side of the dialogue, as well as meeting her authentically and honestly as part of practicing inclusion with her.

Phase 2: Becoming aware of therapist's presence; an I – it attitude. Previous sessions had taught me that experiments had triggered resistance and would be seen as criticism of Marie's behaviour. For example, Marie suddenly stopped talking in terms of herself and switched from saying "I" to saying "we" without any apparent awareness. Instead of saying: "why don't you try an experiment and say "I" instead?" I would rather say: "I was wondering if what you were talking about suddenly felt too painful to continue talking of in terms of yourself?" This response made it easier for Marie to explore her painful feelings and helped her to stay in contact with me, and increased her self-awareness without triggering unbearable anxiety.

Marie had introjected her mother's self-image and idealised her mother in order to maintain any sense of having an ordered, loving family. An "introject" may be seen as accepted personal habits acquired without full awareness of their meaning and purpose (Perls, Hefferline and Goodman 1951/1998). When she described what she was aware of when she attempted to make contact with her husband, she became more aware of her "impasse". Here, the impasse can be understood as how Marie acted out the experience of seeing herself as a dis-empowered object (Newirth 1995). She imagined that her husband was much too busy to want contact with her, and the conversation just stopped. This experience left her frustrated, lonely and longing for connection. I asked her to describe her experience of longing, which she experienced as a vulnerable and lonely feeling in her stomach. She added that she feared rejection and quickly stated that her mother never had accepted her husband - and he was not worth connecting to anyway. I encouraged her to stay with this feeling of criticism, and we explored further the frustration that emerged in her. When she was able to disclose more of her feelings of insecurity and low self-esteem, she was able to ask for more environmental support. At this point, she was able to take in the support I offered her when raising her awareness of how her attempts to deal with her vulnerability by being critical towards herself only left her feeling more frustrated and distressed. Gradually she became able to honour herself.

During this phase I experienced that she started to sense her feelings of anger, being aware of her need to express herself, to mobilise her energy, and finally to vent her feelings towards her mum.

Phase 3: Struggling with abandonment depression; an I – Thou attitude*.* Once this trusting and accepting relationship was established, the next phase began, where some of Marie's problems related to interactions with others were further explored. There were more moments in which I – Thou encounters occurred, than there were moments in which I – it encounters occurred. As Marie started to see me as a person I became more important to her. This was when the therapeutic relationship was challenged.

11.3.5 Key Episode 1

Marie started to project the anger outwards, which she had previously controlled, and became very critical towards me. When I heard her stating: "no one can be relied upon", I was aware that this was similar to one of my own introjects and I recognised the wounds from feeling rejected by my mother. It was therefore important for me to "bracket off" my own emotional reactions in order to be available to explore and to fully understand how Marie made meaning out of this statement. In this context "bracket off" means that I held some of my own concerns in abeyance in favour of attending to what was going on when interacting with Marie. I tried to meet her honestly and authentically. I did, however, feel wiped out by her and knew that this was something I would have to explore in supervision. Initially, I was able to stay in contact with her, but I was aware of feeling induced to behaving towards her like my mother did towards me. And because of the sensed similarity between Marie's mother and my own, I was particularly vulnerable to this induction.

When she started to reveal her dependent, needy side I was aware of feeling irritated and angry with her. I had, in a sense, fulfilled what she expected – being rejected was what she really feared. She exhibited the anger she previously had controlled and talked to me with sarcasm and contempt, when the narcissistic and maternal supplies she was seeking from me were withheld. I thought in that moment and subsequently that Marie had benefited from my firm, withholding posture and that I had managed to resist her seductiveness. I was however left feeling uncomfortable about how harsh I had been and continued to be over the next two sessions. I sensed that Marie was withdrawing. We both had reached an impasse. I struggled a lot and felt dreadful until I had discussed what had happened and worked through the process with my supervisor.

Phase 4: Moments of mutual satisfaction; a Thou – Thou attitude. In this last phase Marie was able to practice inclusion with me, which means that she was able to stay in the present moment, meeting me honestly and authentically. This happened after I decided to disclose the pain I had felt and explained to Marie what I thought had happened in the process.

11.3.6 Key Episode 2

I was able to disclose my humanness to her and say I was sorry for the mistake I had made after being able to non-defensively own parts of my own history and been able to heal old wounds. When doing so, the contact between us was paradoxically re-established. I felt I was risking a lot, but in this moment of Thou – Thou mutuality, being authentically present, I felt grace and deep satisfaction. By authentically disclosing myself as who I am, something changed.

Over the course of this work, Marie started to see herself differently. There has been a shift in her attitude towards herself. Instead of seeing herself as the bad part of the mother-daughter relationship, she has started to see that it was not all her fault. In this process, she has started to grieve for the mother who was not there for her. Marie reported that the panic attacks had not occurred since Key Episode 2. She is now able to feel more satisfaction in her life, and her relationship with her husband has deepened.

11.4 Reflections

I see philosophy as the way I hypothesise about everything in my life and the essence of how I work as a psychotherapist and researcher. Philosophy also helps deconstruct being social; "how do I connect with what is?" This fundamental question is an inquiry into what collective experience is possible. On the contrary, to treat knowledge as intellectual, prescribed and something we are taught, is to forget its social and interpretative nature. Thus, this question is of concern to all of us, and not so much in terms of "I", more so in relation to "we".

In this short text I have reflected on the clinicians' role and how we as clinicians might influence the outcome of the encounter. I am intrigued by the relationship between the therapist and the client, as well as the relationship between the client/therapist and "significant others" in the clients' lives. This relational aspect is the concrete basis for how I work clinically. The ontological stance we take, either consciously or unconsciously, will influence our norms and methods and in turn the way we practice. I hope that this text will stimulate further reflection and discussion on the clinicians' role in the clinical encounter.

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Errata list

Side	Original text	Correction	Text alteration
1	Karin Mohn Engebretsen	Inserted	and Wenche Schrøder Bjorbækmo
	Toivo	Deleted	-
		Brackets	Merleau-Ponty (1945/2003)
2	Toivo	Deleted	The participant
		Brackets	(Apples & Mulders, 1989; Toker, Shirom, Shapira, Berliner, & Melamed, 2005)
		Brackets	(Pedersen & Middel, 2001; Toker, Melamed, Berliner, Zeltser, & Shapira, 2012a)
		Brackets	(Karlson et al., 2010; Norlund et al., 2011; Stenlund et al., 2009)
3		Brackets	(Blank, Peters, Pickvance, Wilford, & Macdonald, 2008; Karlson, Jonsson, & Osterberg, 2014)
5		Brackets	(Mengshoel, Bjorbaekmo, Sallinen, & Wahl, 2019; Øyeflaten, Lie, Ihlebæk, & Eriksen, 2012)
		Brackets	(Finlay, 2011; van Manen, 2014)
		Brackets	van Manen (1990)
6		Brackets	Van Manen (2014)

	(xxx)	Deleted	the Norwegian Centre for Research (NSD no. p469)
	a secure manner	Deleted	TSD (Services for Sensitive Data)
	Toivo (fictive name)	Deleted	As the participant states in the introductory section
		Brackets	Merleau-Ponty (1945/2003, 1968)
		Brackets	Merleau-Ponty (1945/2003)
12		Brackets	Carel (2012)
13		Brackets	Toombs (1995)
		Brackets	(Raheim & Haland, 2006; Søderberg, Lundman, & Nordberg, 1999)
		Brackets	(Ekstedt & Fagerberg, 2005; Jingrot & Rosberg, 2008).
		Brackets	Svenaeus (2000)
		Brackets	Søderberg et al. (1999)
		Brackets	Jingrot and Rosenberg (2008)
14		Brackets	Svenaeus (2014)
		Brackets	Finlay and Molano-Fisher (2008)
		Brackets	Honkasalo (2000)
		Brackets	Merleau-Ponty's (1945/2003)
15		Brackets	Salminen et al. (2015)
		Brackets	(Mengshoel et al., 2019)
		Brackets	Aroll and Howard's study (2013)
16		Brackets	(Lian & Lorem, 2017; Maeland et al., 2012; Nettleton, 2005; Åsbring & Närvänen, 2003)
		Brackets	(Coventry et al., 2013; S. M. Smith, Soubhi, Fortin, Hudon, & O'Dowd, 2012)
		Brackets	(Engebretsen, 2018; Lutz & Bowers, 2005)

17		Brackets Brackets	van Manen’s work (1990), (2017a), (2017b) and (2018) Smith’s work (J.A. Smith, 2018; J. A. Smith, Flowers, & Larkin, 2009)