

ORIGINAL RESEARCH

Burnout Syndrome: Therapeutic Approach With Beneficial Effects on Personality and Quality of Life

Mariş Adina; Ştefan Cristian Vesa, MD, PhD; Aurel Nirestean, MD, PhD

ABSTRACT

Context • The World Health Organization (WHO) has defined burnout syndrome (BOS) as resulting from chronic workplace stress that hasn't been successfully managed. Until now, BOS has been treated using allopathic drugs and psychotherapy because it has been confused with major depressive syndrome.

Objective • The aim of the study was to examine the effectiveness of hypnotherapy combined with cognitive-behavioral therapy in changing the personality traits and lifestyles of people in professions vulnerable to stress who have developed BOS.

Design • The research team designed a one-group pre-and posttest study.

Setting • The study was conducted in a private-practice office in Targu Mures, Romania.

Participants • Participants were 30 patients at the private practice who had been diagnosed with BOS and volunteered to participate in the study.

Intervention • The study alternated hypnotherapy sessions with psychological-counseling sessions, using a general

therapeutic plan for all patients and customizing the plan for each participant.

Outcome Measures • The study measured participants' BOS symptomatology and personality dimensions using the Maslach Burnout Inventory (MBI), the DECAS Personality Inventory, the Personality Inventory for DSM-5 (PID5), and the Survey of Work Styles (SWS).

Results • Significant changes occurred between baseline and postintervention in the dimensions of extraversion, agreeability, and emotional stability as well as impatience, anger, work involvement, time urgency, job dissatisfaction, and competitiveness. Significant differences existed in almost all personality traits evaluated with the PID-5 ($P < .05$).

Conclusions • The combination of hypnotherapy and psychological counseling can treat BOS, increasing patients' quality of life by decreasing negative personality traits. The present study is important because it proposes a new therapeutic approach to BOS. (*Altern Ther Health Med.* 2021;27(6):8-14)

Adina Maris, PhD Student, University of Medicine, Pharmacy, Sciences and Technology "George Emil Palade", Clinical Psychologist, Emergency County Hospital, Targu Mures, Romania. **Ştefan Cristian Vesa**, MD, PhD; Doctor of medical Sciences and physician in Internal Medicine, Head of the Research Department and Lecturer at University of Medicine and Pharmacy "Iuliu Hatieganu", Cluj Napoca, Romania. **Aurel Nirestean**, MD, PhD; Doctor of Medical Sciences, Physician in Psychiatry, Head of the Clinic of Psychiatry no. 2, Senior professor at University of Medicine, Pharmacy, Sciences and Technology Targu Mureş, Romania.

Corresponding author: Adina Maris
E-mail: adinamaris@gmail.com

In May 2019, the eleventh revision of the International Classification of Diseases (ICD-11) added burnout syndrome (BOS), and the World Health Organization (WHO) has defined it as a syndrome resulting from chronic workplace stress that hasn't been successfully managed.¹

The incidence of BOS has increased in recent years, and it's increasingly recognized in professional environments that require interaction with people, such as education, healthcare, and public relations.²⁻⁴ Some studies have found that the syndrome is caused by work-related stress, lifestyle, and individual psychological and social aspects.⁵ Clinical symptoms of BOS are nonspecific and include tiredness, headaches, eating problems, insomnia, irritability, emotional instability, and rigidity in relationships with other people.⁶

Various studies have confirmed that the Type A behavior pattern is a predictor of BOS.⁷ In 1978, Jenkins described that behavior pattern as follows: verbal and psychomotor

mannerisms, chronic feelings of urgency associated with constant feelings of not having enough time, a tendency to be easily aroused to anger or hostility, an intensely competitive spirit, and a profound eagerness and struggle to succeed.⁸

Upon diagnosis, a multidisciplinary approach to the syndrome is needed. In Romania, the focus has been on pharmacological treatment of the syndrome. Patients participate in complex treatment programs that can include psychotherapy and complementary therapies, such as massage, Bowen therapy, or acupuncture.

Hypnotherapy has been successfully used until now for many medical conditions: anxiety disorders,⁹ depression syndrome,¹⁰ sleep disorders,¹¹ posttraumatic stress disorder,¹² smoking cessation,¹³ weight loss,¹⁴ and cancer.^{15,16} It's mainly based on the mind-body connection and mind-body healing, thus requiring a holistic approach for the patient.

Hypnotherapy's goal is to align the levels of human consciousness and establish a harmony between them. In hypnotherapy, the three levels of awareness are described and used: the conscious, preconscious, and unconscious. Exploring the subconscious mind and optimizing conscious and subconscious thinking can have a major influence on the healing process at all levels. Both the preconscious mind and the unconscious mind hold the keys to overcoming problems, and they provide ways in which healing can occur. These healing mechanisms are the identification, dismantling, and reconstruction of fear and negative orientation.¹⁷

To date, very few studies have confirmed the impact of hypnotherapy on personality traits. In 2017, Zhang et al conducted a study comparing two groups of participants using the NEO Personality Inventory-Revised (NEO-PI-R) and the Stanford Hypnotic Susceptibility Scale, Form C (SHSSC).¹⁸ The study found slight differences between the groups, reaching the conclusion that the management of mental or somatization disorders can be achieved either by adjusting hypnotizability or by mobilizing personality functions.

Although personality traits are stable throughout life, research in the field has shown that they can be shaped using psychotherapy.^{19,20} In a recent study, longitudinal data from a community mental health center showed positive changes in emotional stability, hope, gratitude and motivation through psychotherapy.²¹ Other studies have shown that changes can occur in defense mechanisms following psychodynamic psychotherapy²² and dialectical behavior therapy.²³

Few studies have investigated the effects of Cognitive Behavioral Therapy (CBT) on the more stable characteristics of individuals, such as personality traits, and on emotional stability in particular.²⁴ In 2019, Popa and Predatu examined how CBT might benefit emotional functioning and emotional stability in anxious medical students, and the results indicated that CBT can be successfully used, demonstrating beneficial effects on reducing anxiety symptoms and negative emotions.²⁵

In another study, Popa and Nireştean combined therapeutic interventions using CBT and antidepressant medication, and the results demonstrated direct effects on anxiety as both a state and a personality dimension.²⁶ The

therapeutic intervention led to a positive modification in dimensional personality sphere.

Cognitive-behavioral counseling is an integral part of cognitive-behavioral therapy (CBT) and aims to identify a patient's behavior patterns and negative thoughts, helping him or her to become aware of them and explaining their impact on emotions and behavior.²⁷

The use of hypnotherapy and cognitive-behavioral counseling in combination is innovative in treatment of BOS, and the current research team started from the premise that burnout isn't only the result of work-related stress but is also influenced by the personality traits that the person has developed throughout life; the way the person perceives himself or herself, such as levels self-esteem and self-confidence; the person's style of approaching problematic situations; and the quality of his or her communications.

The aim of the present study was to examine the effectiveness of hypnotherapy combined with cognitive-behavioral therapy in changing the personality traits and lifestyles of people in professions vulnerable to stress who have developed BOS.

METHODS

Participants

The research team designed a one-group pre-and posttest study. The study was conducted in a private-practice office in Targu Mures, Romania. Participants were volunteers who registered to take part in the study between July 2018 and March 2020. The research team recruited them via an internet social group, through a post in which the team presented the issue of BOS, with its related symptoms, and issued an invitation to voluntarily enroll in the study.

Potential participants were included if they exhibited symptoms of BOS. Potential participants were excluded if they had been diagnosed with major depressive syndrome, generalized anxiety disorder, posttraumatic stress disorder, acute stress disorder, or insomnia disorder. Potential participants' self-declarations that they had not been diagnosed with those conditions were used in determining eligibility.

The study was approved by the ethics committee of the University of Medicine and Pharmacy in Targu Mures, Romania. All procedures were in accordance with the ethical principles of the Helsinki Declaration for research involving humans.²⁸

The participants signed an informed consent form. They were informed about the purpose of the study, the confidentiality of personal identity, the methods of therapy used, and the posttherapy effects, indicating that no risks of any side effects existed. The participants were also informed that they could withdraw from the project at any time.

Procedures

The study included 3 stages: (1) an evaluation before therapy at baseline, (2) the therapeutic intervention, and (3) an evaluation postintervention at one month

postintervention. The purpose of the evaluations was to identify the presence of BOS and to determine participants' personality traits using psychometric tests.

After acceptance into the study, each participant was evaluated using a semistructured interview, in which data were collected on personal history, dream quality, relationship with self and others, quality of life, types of beliefs—positive and negative, coping strategies, and the ways in which the participant perceived work in relation to personal evolution.

Intervention. A general therapeutic plan was designed for the entire study group, which was further customized for each participant. The 12 therapy sessions, which occurred once a week, took place in a private office and were free of charge.

The hypnotherapy and cognitive-behavioral counseling sessions occurred alternately. The conscious mind was addressed through the cognitive-behavioral counseling and the unconscious through hypnotherapy.

Outcome measures. BOS symptomatology was assessed using the Maslach Burnout Inventory (MBI).²⁹ Each participant's personality was assessed using the DECAS Personality Inventory^{30,31} and the Personality Inventory for DSM-5 (PID-5).³² The Survey of Work Style (SWS)³³ provided additional information regarding the way the person related to his or her work process.

At baseline, in the second session of the intervention, and postintervention, all participants self-administered the psychological tests that were printed on paper. The interpretation of the tests was manual for the MBI and PID5 and computerized for DECAS and SWS. For the MBI, the research team calculated each dimension's score, and for the PID5, the team calculated the score for each personality trait. The research team also calculated the SWS scores for each type A personality trait.

The results of the baseline evaluations, expressed in raw scores, were compared with the results obtained postintervention.

Intervention

The therapeutic plan included 8-10 therapy sessions depending on each participant's needs. Participants took part in 60-minute sessions: (1) session 1: medical history interview establishing therapy objectives and explaining therapeutic techniques; (2) session 2: psychometric testing; (3) session 3: cognitive-behavioral counseling to identify negative thoughts and raise awareness of their effects on behavior, relationships, and health; (4) session 4: hypnotherapy to replace negative thoughts and emotions with positive thoughts and emotions; (5) session 5: cognitive-behavioral counseling to explain how negative thoughts affect self-esteem and self-confidence; (6) session 6: hypnotherapy to improve the relationship with the self; (7) session 7: cognitive-behavioral counseling to explain how negative thinking and negative emotions can cause burnout symptoms; (8) session 8: hypnotherapy to reduce symptoms using positive suggestions, such as "I feel relaxed; I feel calm; I can sleep; sleep quality has improved"; (9) session 9: counseling to identify negative

emotions and negative thoughts related to the workplace and analyze the quality of communications and relationships; (10) session 10: hypnotherapy to improve communications, relationships, and work style and increase motivation in the workplace; (11) session 11: counseling for identifying specific negative emotions and thoughts related to finding a professional path and true vocation; and (12) session 12: hypnotherapy to find a vocation and recalibrate the professional path according to the participant's needs.

Hypnotherapy. Approaching the therapy in a way different from classical Ericksonian hypnosis, the research team included the following techniques: (1) progressive muscle relaxation, (2) guided imagery, (3) neuro-linguistic programming, and (4) suggestion therapy.

These therapies were used as methods of hypnotic induction, with the focus on a bright, golden-white light that enters the cells and organs to help the body to relax. A musical background was used to favor relaxation and lead the brain into a theta state. Hypnotic deepening was also obtained through guided imagery, by counting from 15 to 1 and inviting the patient to imagine entering a pleasant and warm golden-light environment while climbing steps that led to this environment. After entering the light, guided imagery was created, with the participant being placed on a healing bed and the bright light falling on him or her, deepening the relaxation and providing a state of well-being.¹⁷

After inducing a state of profound relaxation, suggestion therapy, using neuro-linguistic programming, addressed the unconscious, giving the participant positive suggestions. The positive suggestions focused on self-image and self-esteem: building a positive self; reconnecting with inner wisdom; managing stress; developing positive, healthy, and rational thinking; and overcoming anxiety and depression. These suggestions, which were especially intended for each issue, were used during each session.

Following suggestion therapy, which lasted around 15 minutes, directed imagery and neuro-linguistic programming were used again, inviting the participant to imagine being healthy; communicating well in his or her relationships; feeling rested and balanced; and being motivated to work in a new job or to develop an opportunity to change his or her career. At the end of the session, the participant was restored to the normal state by counting from 1 to 5.¹⁷

The sessions were recorded, and the participants listened to them every night before bedtime to record good suggestions in the subconscious.

Cognitive-behavioral counseling sessions. The cognitive-behavioral counseling was intended to find and increase the participant's awareness of maladaptive beliefs so that they could be used to create positive suggestions. Negative ideas and thoughts were identified and positive suggestions were given during hypnotherapy sessions; for example, substituting "Nothing works" for "You can achieve anything that you set your mind to."

Cognitive-behavioral counselling was conducted through the interview technique, with guided questions to

identify problematic situations at work and in everyday life, together with the emotions and feelings they generate. After identifying them, the counselor explained to the participant that the situation itself didn't lead to experiencing certain feelings and emotions, but that thoughts generated the emotions and then the behaviors. After identifying negative thoughts, the participant processed them and transformed them into positive thoughts through the hypnotherapy.

Outcome Measures

MBI.²⁹ The scale contains 22 items that fall on three subscales: (1) depersonalization (DP)—5 items, (2) reduction in personal accomplishments (RPA)—8 items, and (3) emotional exhaustion (EE)—9 items. DP is characterized by a cynical and detached response to other people, such as “Through my work, I have become much more insensitive to the lives of my coworkers.” An RPA occurs when a person feels not competent in his or her work. EE refers to feelings of depleted emotional resources, such as “I feel emotionally exhausted because of my work.”

Participants rated how frequently they experienced these feelings on a 7-point scale, ranging from 0 = never to 7 = daily. They were diagnosed with BOS if they had a high score in at least one of the MBI's 3 subdomains: (1) DP ≥ 19 , (2) DPA ≥ 27 , and EE ≥ 24 .

DECAS.^{30,31} The inventory is the adaptation of the BIG5 model for the Romanian population, using both the international exigency standards from the perspective of psychometric characteristics and the Romanian cultural specifics. The test consists of 95 items that require true or false answers, to be completed in 12-15 minutes. The scale measures the 5 dimensions of personality according to the BIG-5: openness, extroversion, conscientiousness, agreeableness, and emotional stability.

PID-5.³² The inventory is a 220-item, self-report assessment and is generally considered a pathological variant of the seminal Five-Factor Model, which involves five personality factors. The PID5 evaluates 25 personality traits and 5 personality dimensions. The overall score for each personality trait or dimension is between 0 and 4; a score above 3 indicates a pathological level of that trait or dimension. The study used 25 traits because the personality dimensions were evaluated with DECAS.

SWS.³³ The survey provided additional information regarding the way in which a participant related to his or her work process. The SWS contains 96 items and identifies the specific traits of the type A personality: impatience, anger, work involvement, time urgency, job dissatisfaction, and competitiveness.

Statistical Analyses

Statistical analyses were performed using the MedCalc Statistical Software, version 14.8.1 (MedCalc Software, Ostend, Belgium). Data were considered as nominal or quantitative variables. Nominal variables were characterized using frequencies. Quantitative variables were tested for

Table 1. Sociodemographic Data (N=30).

Age, y	
Mean	40.23 ± 7.2
Range	29-58
Gender	
Male	2
Female	28
Type of Profession	
Physicians	3
Nurses	3
Therapists	2
Economists	4
Lawyers	3
Reporters	2
Schoolteachers	5
Workers in public nutrition	3
Assistant managers	3
Call center operators	2

Table 2. Differences in Dimensions of Burnout Syndrome Between Baseline and Postintervention

Dimensions of Burnout Syndrome	Baseline Mean ± SD	Postintervention Mean ± SD	t	P Value
DP	26.0 ± 12.5	11.8 ± 3.55	4.025	.002 ^a
RPA	31.0 ± 10.0	19.0 ± 6.13	4.931	.000 ^a
EE	36.3 ± 10.3	13.0 ± 6.13	6.646	.000 ^a

^aP value indicates that the change in the dimension's score was statistically significant.

Abbreviations: SD, standard deviation; DP, depersonalization; RPA, reduction in personal accomplishment; EE, emotional exhaustion

normality of distribution using the Shapiro-Wilk test and were characterized as means and standard deviations (SD). Quantitative variables were compared using the paired *t* test. The level of statistical significance was set at *P* < .05.

RESULTS

Participants

Thirty patients participated in the study (Table 1), of which 93.3 % were women and 6.6% were men. Their mean age was 40.23 ± 7.2 years. All participants came from urban areas.

Participants were 3 physicians, 3 nurses, 2 therapists, 4 economists, 3 lawyers, 2 reporters, 5 schoolteachers, 3 workers in public nutrition, 3 assistant managers, and 2 call-center operators.

Burnout Syndrome

The improvements between baseline and postintervention were statistically significant for the three areas of BOS (Table 2): DP (*P* = .002), RPA (*P* = .000), and EE (*P* = .000).

DECAS

The improvements between baseline and postintervention (Table 3) were statistically significant for extraversion ($P = .004$) and emotional stability ($P = .002$). The highest increase was observed for the emotional stability score, with the therapy helping participants to relax and gain inner peace and affective balance. The change for the better in extraversion showed that participants had opened themselves up to others and were becoming more approachable in terms of social and professional relationships. This also led to a nonsignificant increase in agreeableness, allowing participants to be tolerant, intelligent people, who showed team spirit.

PID-5

The PID-5 test showed low and medium scores for each personality trait, placing participants in the normal personality category (Table 4). The improvements in personality traits between baseline and postintervention were statistically significant for 92% of the domains. Anxiety decreased the most, from 1.79 ± 0.49 to 0.89 ± 0.54 ($P = .000$), followed by emotional lability, from 1.63 ± 0.57 to 0.81 ± 0.46 ($P = .000$) and distraction—lack of ability to concentrate, from 1.03 ± 0.43 to 0.48 ± 0.37 ($P = .000$).

The following personality traits also had statistically significant differences of the same magnitude: (1) restrictive affectivity ($P = .000$), (2) hostility ($P = .000$), (3) perfectionism ($P = .000$), (4) perseverance ($P = .000$), and (5) retiring ($P = .000$). Participants had become more sociable, no longer experienced anhedonia and depressiveness, and became less eccentric, impulsive, and manipulative.

Postintervention, participants were more self-confident and had a better perception of reality. The changes for only 2 of the 25 personality traits (8%) were not statistically significant: irresponsibility and risk assumption.

SWS

Table 5 shows the changes in the scores for the type A traits between baseline and postintervention. The biggest differences between baseline and postintervention were in anger and work involvement (both $P = .000$), with time urgency, job dissatisfaction, and impatience in second place (all $P = .001$). Competitiveness also showed statistically significant differences between baseline and postintervention ($P = .004$).

The characteristics of the Type A behavior pattern had changed in a positive way for almost all 30 participants. Participants became more patient and more work-oriented, and their feelings of lack of time diminished, which led to increased professional satisfaction and competitiveness. Negative emotions decreased and almost disappeared, with participants having low scores on fury.

Table 3. Differences in DECAS Scores Between Baseline and Postintervention

Personality Dimensions	Baseline Mean \pm SD	Postintervention Mean \pm SD	<i>t</i>	<i>P</i> Value
Openness	8.77 \pm 3.03	8.62 \pm 4.48	0.208	.839
Extraversion	8.08 \pm 3.57	10.38 \pm 3.04	- 3.527	.004 ^a
Conscientiousness	11.62 \pm 2.36	10.54 \pm 2.63	1.620	.131
Agreeableness	8.15 \pm 2.79	10.15 \pm 4.68	- 1.862	.087
Emotional stability	5.23 \pm 2.71	10.23 \pm 3.29	- 3.815	.002 ^a

^a*P* value indicates that the change in the dimension's score was statistically significant.

Abbreviations: DECAS, DECAS Personality Inventory; SD, standard deviation.

Table 4. Changes in Personality Traits (PID-5) Between Baseline and Postintervention

Personality Traits	Baseline Mean \pm SD	Postintervention Mean \pm SD	<i>t</i>	<i>P</i> Value
Anhedonia	1.17 \pm 0.48	0.68 \pm 0.34	4.632	.001 ^a
Anxiety	1.79 \pm 0.49	0.89 \pm 0.54	7.671	.000 ^a
Attracting attention	0.83 \pm 0.66	0.55 \pm 0.37	2.359	.036 ^a
Severity	0.46 \pm 0.35	0.29 \pm 0.23	2.711	.019 ^a
Hypocrisy	0.62 \pm 0.45	0.39 \pm 0.33	2.930	.013 ^a
Depressives	0.72 \pm 0.39	0.23 \pm 0.27	4.615	.001 ^a
Distraction	1.03 \pm 0.43	0.48 \pm 0.37	6.609	.000 ^a
Eccentricity	0.96 \pm 0.62	0.48 \pm 0.56	4.475	.001 ^a
Emotional lability	1.63 \pm 0.57	0.81 \pm 0.46	6.807	.000 ^a
Grandiosity	0.93 \pm 0.64	0.63 \pm 0.60	2.596	.023 ^a
Hostility	1.42 \pm 0.47	0.79 \pm 0.34	5.056	.000 ^a
Impulsivity	1.18 \pm 0.66	0.63 \pm 0.52	3.432	.005 ^a
Avoiding intimacy	0.85 \pm 0.46	0.45 \pm 0.32	3.144	.008 ^a
Irresponsibility	0.41 \pm 0.30	0.33 \pm 0.36	0.915	.378
Manipulation	0.80 \pm 0.50	0.36 \pm 0.30	3.742	.003 ^a
Perceptual disorder	0.81 \pm 0.43	0.36 \pm 0.30	4.153	.001 ^a
Perseverance	1.18 \pm 0.42	0.64 \pm 0.31	4.909	.000 ^a
Restrictive affectivity	1.2 \pm 0.51	0.65 \pm 0.42	5.931	.000 ^a
Perfectionism	1.66 \pm 0.54	1.02 \pm 0.51	4.955	.000 ^a
Risk assumption	1.03 \pm 0.44	0.97 \pm 0.40	0.787	.447
Separation insecurity	0.91 \pm 0.67	0.54 \pm 0.41	2.995	.011 ^a
Submission	1.13 \pm 0.48	0.57 \pm 0.41	4.284	.001 ^a
Suspiciousness	1.56 \pm 0.49	1.12 \pm 0.43	3.337	.006 ^a
Unusual beliefs	0.92 \pm 0.85	0.64 \pm 0.58	2.753	.017 ^a
Retiring	1.21 \pm 0.6	0.58 \pm 0.56	4.769	.000 ^a

^a*P* value indicates that the change in the dimension's score was statistically significant.

Abbreviations: PID-5, Personality Inventory for DSM-5; SD, standard deviation

Table 5. Changes in Pattern A Behavior Between Baseline and Postintervention

Pattern A Behavior	Baseline Mean ± SD	Postintervention Mean ± SD	t	P Value
Impatience	51.4 ± 8.29	39.5 ± 10.4	4.190	.001 ^a
Anger	47.8 ± 10.9	35.6 ± 12.2	4.944	.000 ^a
Work involvement	53.7 ± 8.32	46.3 ± 5.08	5.152	.000 ^a
Time urgency	58.3 ± 9.9	45.92 ± 11.4	4.674	.001 ^a
Job dissatisfaction	54.5 ± 10.4	39.5 ± 11.7	4.346	.001 ^a
Competitiveness	44.5 ± 6.42	39.0 ± 8.37	3.497	.004 ^a

^aP value indicates that the change in the dimension's score was statistically significant.

Abbreviations: SD, standard deviation.

DISCUSSION

The present study makes a valuable contribution to therapy for patients with BOS, providing a nonpharmacological treatment that combines established therapies used for other conditions, such as depression, anxiety syndrome, sleep disorders, obesity, and addictions. Prior to the current study, the combination of hypnotherapy and cognitive-behavioral counseling hadn't been used to help patients with BOS.

In agreement with Nguyen et al's longitudinal study,²¹ the current study found an increase in participants' emotional stability and motivation. Also, in agreement with Popa and Nireştean's results showing the direct effects of CBT on anxiety as both a state and a personality dimension,²⁶ the current study found that hypnotherapy and cognitive-behavioral counseling had beneficial effects on reducing anxiety and negative emotions and a positive influence on the dimensional aspects of personality.

Like Zhang et al's conclusions that the management of mental or somatization disorders can be achieved either by adjusting hypnotizability or by mobilizing personality functions,¹⁸ the current study found that the use of hypnotherapy and cognitive-behavioral counseling managed to mobilize personality functions, with good results in reducing the symptoms of BOS.

Despite having obtained positive results, the study had several limitations, such as being a small-scale trial. Patients with BOS are often diagnosed with major depressive syndrome or anxiety disorder, and physiological symptoms are attributed to psychosomatic diseases, such as gastric and duodenal ulcers or cardiovascular problems; neurological problems; or circadian rhythm. Thus, a large-scale trial could be very challenging and only a strict evaluation of BOS, with the exclusion of other past conditions, could make it possible to detect the true presence of BOS.

Upon diagnosis, patients with BOS can benefit from the current study's therapies because they work on both the conscious side of the psyche (thinking) and the subconscious side (emotion), and changes that occur directly in the subconscious are much faster and safer because they go

directly to changing the cause that produced the effect. The combination of the two therapies in the current study was original and helped patients be aware of their problems and find a solution to them by mobilizing the resources of the psyche, resources that are latently found in the subconscious and could be activated.

CONCLUSIONS

This study explains how personality traits can be altered using techniques known and used to date. It demonstrated that the combination of hypnotherapy and cognitive-behavioral counseling could bring major benefits to patients' quality of life by activating the abilities of the psyche, reducing negative feelings, helping them to relax, and teaching them to analyze the quality of thoughts and beliefs. The current study's have no side effects, so occupational health professionals can send patients with BOS to therapists who use these methods, thus helping them to feel better and be able to reintegrate into the work process.

REFERENCES

- World Health Organization (WHO). Burn-out, an occupational phenomenon. International Classification of Diseases. 28 May 2019.
- Ptáček R, Vnučková M, Raboch J, et al. Burnout syndrome and lifestyle among primary school teachers: A Czech representative study. *Medical Science Monitor: International Medical Journal of Experimental and Clinical Research*. 2019; 25:4974.
- Alexandrova-Karamanova A, Todorova I, Montgomery, et al. Burnout and health behaviors in health professionals from seven European countries. *International Archives of Occupational and Environmental Health*. 2016; 89(7):1059-1075.
- Palazzo LDS, Carlotto MS, Aerts DRGDC. Síndrome de Burnout: Estudo de base populacional com servidores do setor público. *Revista de Saúde Pública*. 2013; 46:1066-1073.
- Klosowska J. Temperament structures as risk factors for teachers' stress and burnout. *Ad Alta*. 2011; 1(1).
- Poncet MC, Toullic P, Papazian L, et al. Burnout syndrome in critical care nursing staff. *American Journal of Respiratory and Critical Care Medicine*. 2007; 175(7):698-704.
- Utami I, Nahartyo E. The effect of type A personality on auditor burnout: Evidence from Indonesia. *Global Journal of Business Research*. 2013; 5(2):89-102
- Malim T. Aggression. Type A Personality. In: *Social psychology*; 2003.
- Alladin A, Amundson J. Cognitive hypnotherapy as a transdiagnostic protocol for emotional disorders. *International Journal of Clinical and Experimental Hypnosis*. 2016; 64(2):147-166.
- McCann BS, Landes S J. Hypnosis in the treatment of depression: Considerations in research design and methods. *International Journal of Clinical and Experimental Hypnosis*. 2010; 58(2):147-164.
- Becker PM. Hypnosis in the management of sleep disorders. *Sleep Medicine Clinics*. 2015; 10(1):85-92.
- Rotaru TŞ, Rusu A. A meta-analysis for the efficacy of hypnotherapy in alleviating PTSD symptoms. *International Journal of Clinical and Experimental Hypnosis*. 2016; 64(1):116-136.
- Barnes J, McRobbie H, Dong CY, et al. Hypnotherapy for smoking cessation. *Cochrane Database of Systematic Reviews*. 2019; 6.
- Entwistle PA, Webb RJ, Abayomi JC, et al. Unconscious agendas in the etiology of refractory obesity and the role of hypnosis in their identification and resolution: A new paradigm for weight-management programs or a paradigm revisited? *International Journal of Clinical and Experimental Hypnosis*. 2014; 62(3):330-359.
- Montgomery GH, Sucala M, Baum T, Schnur JB. Hypnosis for symptom control in cancer patients at the end of life: A systematic review. *International Journal of Clinical and Experimental Hypnosis*. 2017; 65(3):296-307.
- Wortzel J, Spiegel D. Hypnosis in cancer care. *American Journal of Clinical Hypnosis*. 2017; 60(1):4-17.
- Gabor E. Manual of Hypnotherapy, Level one. Targu Mures, Romania: Farmamedia, 2018.
- Zhang Y, Wang Y, Shen C, et al. Relationship between hypnosis and personality trait in participants with high or low hypnotic susceptibility. *Neuropsychiatric Disease and Treatment*. 2017; 13:1007.
- Allemand M, Flückiger, C. Changing personality traits: Some considerations from psychotherapy process-outcome research for intervention efforts on intentional personality change. *Journal of Psychotherapy Integration*. 2017; 27(4):476.

20. Kramer U, Beuchat H, Grandjean L, Pascual-Leone A. How personality disorders change in psychotherapy: A concise review of process. *Current Psychiatry Reports*. 2020; 22(8):41-41.
21. Nguyen PLL, Kim HL, Romain AMN, et al. Personality change and personality as predictor of change in psychotherapy: A longitudinal study in a community mental health clinic. *Journal of Research in Personality*. 2020; 103980.
22. Johansson P, Höglend P, Ulberg R, et al. The mediating role of insight for long-term improvements in psychodynamic therapy. *Journal of Consulting and Clinical Psychology*. 2010; 78(3):438.
23. Euler S, Stalujanis E, Allenbach G, et al. Dialectical behavior therapy skills training affects defense mechanisms in borderline personality disorder: An integrative approach of mechanisms in psychotherapy. *Psychotherapy Research*. 2019; 29(8):1074-85.
24. Roberts BW, Luo J, Briley DA, et al. A systematic review of personality trait change through intervention. *Psychological Bulletin*. 2017; 143(2):117-141. <https://doi.org/10.1037/bul0000088>.
25. Popa C, Predatu R. The effect of an integrative CBT/REBT intervention in improving emotional functioning and emotional stability in Romanian medical students. *Journal of Evidence-Based Psychotherapies*. 2019; 19(1):59-71.
26. Popa C, Nireştean A, Ardelean M, et al. Dimensional personality change after combined therapeutic intervention in the obsessive-compulsive personality disorders. *Acta Med Transilvanica*. 2013; 2:290-2.
27. David D. Treatise on Cognitive and Behavioral Therapy, Iasi, Romania: Polirom, 2017.
28. World Medical Association. World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. Bulletin of the World Health Organization. 2001; 79:373.
29. Maslach C, Jackson SE, Leiter MP, et al. Maslach burnout inventory. Palo Alto, CA: Consulting Psychologists' Press. 1986; 21:3463-3464
30. Sava FA. Personality Inventory DECAS. User's Manual. Timisoara, Romania, ArtPress. 2008.
31. Sava FA, Popa RI. Personality types based on the big five model: A cluster analysis over the Romanian population. *Cogn Brain Behav*. 2011 Jun; 15:359-384
32. Al-Dajani N, Gralnick TM, Bagby RM. A psychometric review of the Personality Inventory for DSM-5 (PID-5): Current status and future directions. *Journal of Personality Assessment*. 2016; 98(1):62-81.
33. Jackson DN, Gray AM. Survey of Work Stress, User's Manual. Cluj Napoca, Romania, Odyseea, 2004.