Group Interview

In Sweden, best practice recommendations for the treatment of anxiety and depression promote the use of Cognitive Behavioural Therapy, with psychodynamic therapy given lower priority (National Board of Health and Welfare, 2021). This does not mean that psychodynamic therapy is uncommon in public healthcare. However, there are few examples of well integrated treatment programs based on ISTDP in a clinical setting. The Personality Disorder Unit, located at Sahlgrenska University Hospital in Gothenburg, is the largest clinic in Sweden for the treatment of personality disorders with approximately 1,000 registered patients. In 2022, the clinic

ISTDP teamwork with Cluster C personality disorder

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management decided to invest in a treatment program based entirely on ISTDP. The program is a unique and innovative example of how ISTDP could be organized as teamwork, set within an adult psychiatry context. So, what made the management enthusiastic enough to implement an ISTDP treatment program? First, the clinic management wanted to provide group therapy to patients within the clinic. Christer Axelsson, an ISTDP therapist with many years experience in psychiatry, saw this as an opportunity to offer ISTDP on a larger scale, and began to consider how this might be organized. Second, for patients with a personality diagnosis within Cluster C (as compared to patients with Borderline Personality Disorder), no structured treatment programs were currently available. Third, and most importantly, the increasing evidence base in support of ISTDP for the treatment of personality disorders ultimately convinced the clinic management to give Christer green light to the idea of a treatment program entirely based on ISTDP (Abbass et al, 2008; Solbakken & Abbass, 2014; Solbakken & Abbass, 2016; Svartberg et al, 2004; Town et al., 2017).

Description of the program

As of 2023, the ISTDP treatment program is operated by a six-member team. There are five psychologists and one psychiatric nurse. Among the psychologists, three have completed core training, and two are midway through core training. The psychiatric nurse has completed pre-core training, and works primarily in a group therapy context.

The target population is patients with a diagnosed personality disorder falling within cluster C of the DSM-5[1]. Patients belonging to this category are diagnosed with either avoidant, dependent, or obsessive-compulsive personality disorder, all of which involve underlying traits of excessive anxiety, fear, control, and/or inhibition. Compared to patients falling within cluster B personality disorders, such as Borderline Personality Disorder, cluster C patients in this clinic are often older in age and have had a longstanding psychiatric history.

The program approach was inspired by Jon Frederickson and Kristy Lamb's ISTDP treatment program for addiction (Bold Health Inc, 2024), due to its use of ISTDP principles in a combination of group and individual therapy to target complex behaviors and difficulties.

Treatment therefore involves ISTDP delivered in both group and individual formats, and is offered in a stepwise manner with the goal of offering treatment in response to the severity of the patient's needs. This is decided by the team in collaboration with the psychiatrist during the initial psychiatric assessment. Importantly, the approach and structure of the program has been continuously revised since they started, in response to the experiences and needs of the clinicians and patients.

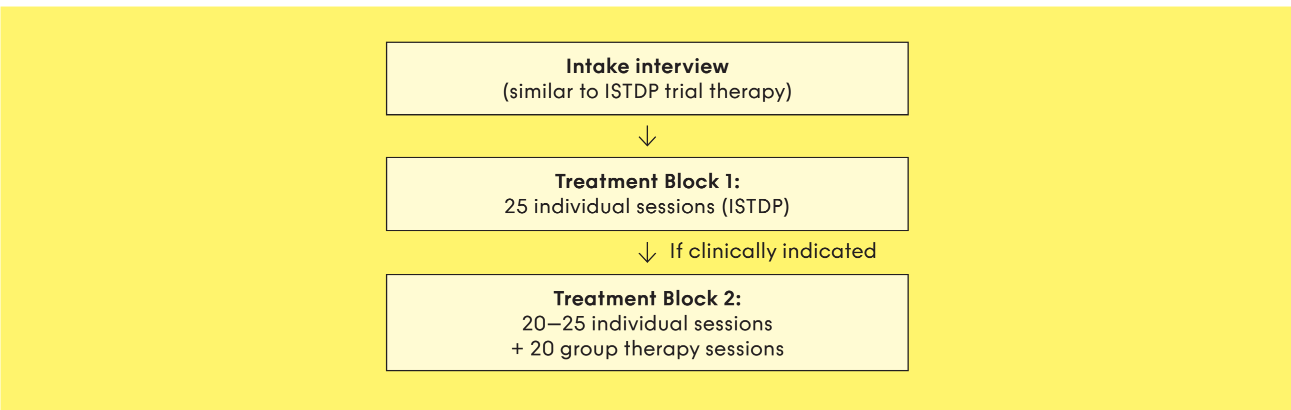
Before entering the program, the patient takes part in an intake interview with one of the team members. During this interview, and as done in ISTDP trial therapy, building a conscious alliance with an intrapsychic focus is emphasized by the clinician. Once such an alliance is established, the patient begins the first block of treatment – a series of 25 individual therapy sessions. After this, if the team determines the patient's symptom severity warrants further treatment, the patient is offered a second block of treatment consisting of an additional 20-25 individual sessions alongside 20 group therapy sessions.

Individual sessions are conducted typically as we know ISTDP. Group therapy sessions are based on the BOLD seat[2], which is a structured group approach where one patient commences the session with a problem for which they want help. This patient is the focus of the therapist's interventions throughout that session, and the rest of the participants are invited to actively participate in the process.

To assess changes over time, self-report measures (CORE-OM, BAI, IIP) are collected from the patients at three timepoints in the treatment process; before, during, and after treatment. These measures assess overall mental health, anxiety and interpersonal functioning.

One advantage of working in a team setting is the possibility for continuous learning and therapeutic growth. To facilitate this, all team members take part in regular group supervision and a weekly group discussion hour called mirroring, where the team discuss current cases and assist one another with clinical challenges.

FIGURE 1: TREATMENT APPROACH OFFERED TO THE PATIENT



Team member interview

What follows is an interview with five of the team members at the Personality Disorder Unit: Lina Lönnberg, Karin Lagerkvist Holmberg, Kristoffer Liljedahl, Per Larsson and Sara Heyman Simonsberg. The interview was conducted in October 2023 by the author, and a dialogue was kept alive with the team members after the interview.

What was the idea behind your treatment program?

–Our idea has been to develop a treatment program that aims to meet the needs of a group of complex patients, a group that is generally forgotten within psychiatric care. Experiences with intensive treatment programs in Norway and the Netherlands have inspired us. In the Netherlands, the *Viersprong program* combined residential care with ISTDP, and it seems to have been very effective! We hope our treatment program can shorten the general duration of treatment for our patients.

Team members at the Personality Disorder Unit: Lina Lönnberg, Karin Lagerkvist Holmberg, Kristoffer Liljedahl, Per Larsson and Sara Heyman Simonsberg.

What are the preliminary outcomes of the program so far?

–We evaluate our program with self-report questionnaires. So far, we can say that the results from our first finished treatment series are promising. Several patients who previously had other forms of treatment report improvement after participating in our program. The other day, I had a patient reporting a major decrease in self-criticism. That is something that motivates you to keep going.

And what about the rest of your clinic, have they benefited so far?

–Patients with Cluster C diagnoses within public health care are in general four times larger than the group of patients with Borderline Personality Disorder. Our patient group often has a low level of functioning, which in combination with a lack of structured treatment results in never-ending, time-consuming supportive therapy. We have noticed that we get a lot of referrals, which is great. We think it is because we have done a good job communicating with the rest of the clinic about how we work, what we can do, and what patients they can refer for treatment.

What are the advantages you have experienced from working together?

–Working as a team with ISTDP creates a sense of connectedness in which we can develop and support each other. Since we all come from diverse backgrounds, we can learn from each other. With feedback from team members, we can continuously increase our understanding of our patients and improve as therapists. For example, seeing the patients both individually and in group therapy, we get the opportunity to integrate observations we make from each area, which can improve our assessment of the patient and how we direct our interventions.

Is it always smooth sailing within your team? Collaborating is not always easy...

–Yes, we are a passionate group of people with strong wills, which has resulted in a lot of discussions... for example, concerning the development of the treatment program. In the end, we managed to settle with changes that we all agreed on. But it took a lot of discussion.

Did you encounter any challenges?

–One challenge has been, and continues to be, translating ISTDP into a group training format. Jon and Kristy's material is great, but we had to make adjustments to tailor it to our patient›s needs and our strengths and weaknesses. For example, we have found that several patients have anxiety above threshold, and some of them have a hard time regulating their anxiety by themselves. They can't make great use of the group format. They often need more help with anxiety regulation from the group leaders, but with multiple patients in the room, there is not always time for everyone.

Have you done something to improve that?

–This was an area of discussion. But we have now settled for changes where, in the new version of the program we will have individual sessions before entering group therapy. Having sufficient time to do capacity building work individually in order to help patients handle high anxiety and/or projections will hopefully prepare the patients for group sessions in a better way than before.

What are your visions for the future?

–Our program is still new, so we want to keep developing it based on insights we have had along the road together with patient feedback. We want our program to be as effective and useful to patients as possible, and one way of doing it is to learn as much as we can about our patients and how we best can target our interventions.

Anything else you feel like saying?

–We hope that what we have done so far will show other healthcare providers the benefits of working with ISTDP so that they will have the confidence to invest in similar treatment programs. Also, being in a healthcare setting is a constant pressure because of limited resources. We need to be clear in our communication with the management about the strengths and benefits of ISTDP so we can make suggestions and advocate for what we believe in.

Concluding remarks

As an ISTDP therapist with almost a decade of experience in public healthcare services, I know that the challenges are many. Working with ISTDP is intensive in nature. It involves moment-to-moment assessments of the client in order to adjust our interventions accordingly. At the same time, we must maintain a solid conscious alliance, both for the safety of the client and the therapist. As therapists, we are also human beings with our own triangles of conflict. Simultaneously as we are working with the patient, we need to make sure that we attend to ourselves at least as much as we do to the patient. Working outside of our own window of tolerance or violating our own boundaries is not a good way to build a sustainable career.

And, as if this was not enough, working in a public healthcare setting specifically can expose us to additional forms of pressure. Within systems with limited funding and resources, where demand is high and complex, there is a constant pressure from many sides to make our work more efficient. Thus, as clinicians, we have several factors to consider with an equal amount of possible dilemmas concerning work ethics and personal considerations. Do I get the proper conditions I need to do what I think is most helpful to my clients? Is it possible to make compromises to meet expectations from my employer, without sacrificing quality and ethical standards? Knowing what I know about myself, can I work under these conditions and still be healthy and proud of what I do?

Given the nature of our work as healthcare providers, it is not hard to see why we are susceptible to experiencing therapist burnout, as noted by McCormack and colleagues (2018). Initiatives like the one in Gothenburg can be an important inspiration for healthcare providers when they are looking to create sustainable workplaces. Here are two reasons why the ISTDP team can be a good investment:

Connection. It is not a new concept to organize psychotherapy practices into treatment teams, as has been done in Gothenburg. There are various examples of this across different methods and organizations in the psychotherapeutic field. For instance, in Dialectical Behavior Therapy for patients with Borderline Personality Disorder, it is standard practice for multiple therapists to participate in a treatment team providing regular case consultations and supervision in order to integrate continuous professional input and peer support. The team also serves as a function to hold the therapist through providing emotional support (Linehan, 1993). This is one of the most significant aspects of the team, and shown in this quote from one of the team members: "Working as a team with ISTDP creates a sense of connectedness in which we can develop and support each other".

Organizational stability. There are also practical challenges which the team-based approach may help to address. Prioritizing ISTDP as a core treatment service, instead of a subordinated option only available to some, can make patients and clinicians less vulnerable to sudden organizational changes such as budget cuts and staff turnover. By integrating the program into the core of the personality disorders unit, the management team has made an important commitment to the value that ISTDP can provide to patients within cluster C, a complex and neglected patient population.

Teamwork organized in this way can be beneficial on multiple levels. Collaborating as a team may not solve all conflicts, but it can help establish a framework that eases some of the pressure, whether it is internal or external. Most importantly, it could act as an antidote for burnout and isolation. Hopefully, initiatives like the one in Gothenburg can guide and inspire other ISTDP practitioners to organize themselves in similar ways. This can benefit both patients and therapists, as it can lead to professional development, improved well-being for clinicians, and the possibility of developing ISTDP in a sustainable way that can reach patients with complex needs. Some people would say that we are better together.

Footnotes

1 Personality disorders are grouped into three clusters based on traits they share (American Psychiatric Association, 2013).

2 See boldhealthinc.com/the-bold-method for more information.

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