Interview

The Regional Medication-Free Treatment Offer at Vegsund DPS in Ålesund is provided by one of Norway's 77 (Malt, 2023) district psychiatric centers. This eight-week intensive multimodal treatment program includes ISTDP therapy and integrates its theoretical foundation throughout all treatment modalities. Allowing ISTDP principles to be present beyond the therapy room underlines the meaning of *intensive*, paving the way for lasting change within a limited time frame. In 2016, the Central Norway Regional Health Authority launched a temporary project in response to requests from user organizations. The objective was to create medication-free units within Norwegian health care and promote a culture of medication-free treatment in mental health care services.

ISTDP goes multimodal

AUTHOR **HANNA PEDERSEN**
LICENSED PSYCHOLOGIST AT ALERIS PSYCHIATRY, LIDINGÖ, STOCKHOLM, SWEDEN

This unprecedented (Standal et al., 2021) initiative aligned with the Minister of Health's vision to offer fair options for patients aiming to reduce or stop their medication. Vegsund DPS was tasked with establishing a treatment program in line with this purpose.

ISTDP was integrated into the program in Ålesund by Åshild Digernes Stave, psychologist specialist and psychiatrist Tor Øyvind Hummelsund, who both had a strong interest in ISTDP. They were inspired by a similar project in Drammen which was unfortunately closed down later. The idea was to establish an intensive, multimodal patient service offering various medication-free treatment options in line with the preferences of the user organizations.

Back from the left: Tor Øyvind Hummelsund, Ragnar Thorsen, Marit W Holst Kirkpatrick
Front from the left: Ann-Kristin Bjarnesdatter Henriksen, Malene Tenfjord, Åshild D Stave, Sunniva Indrevåg
Not present: Annette Saunes Sveen, Solveig Maria Nedregård

The program was supposed to target «treatment-resistant patients» such as those with personality disorders, chronic depression or anxiety and functional disorders. The evidence base for ISTDP for these conditions (Lilliengren et al., 2016; Abbass et al., 2020) made ISTDP a suitable option for the treatment program. The program received positive feedback from both patients and user organizations and became a permanent part of Norwegian health care in 2021.

Description of the program

The eight-week multimodal daytime treatment program is designed for six patients at a time. While most patients are referred locally, the unit also accepts referrals from other regions across Norway. To accept the referral, information about motivation for the program and a thoroughly documented psychiatric assessment is required. As mentioned above, patients offered the program should be "treatment resistant", meaning they have not responded to standard treatment approaches. They must have reduced everyday functioning but with the capacity to hold an intrapsychic focus. The program excludes patients with psychotic disorders, bipolar disorder type I, dissociative identity disorder, alcohol and substance abuse, mental health issues due to medical conditions, intellectual disability, as well as those who are not fluent in Norwegian, patients at high risk of suicide and those where assessment has shown an increased risk of acting out aggressive behaviors.

If the referral is accepted by the program, the patient will undergo thorough somatic and psychiatric assessments, as well as a 1- to 3-hour trial therapy on an outpatient basis. Based on all the information gathered, the team will determine if the patient will be offered a place in the program.

As a participant in the program, you will receive 60–90 minutes of ISTDP twice a week, along with (in sum) four hours of psychoeducation focused on ISTDP. Notably, the multimodal program in Ålesund is based on key ISTDP principles. The concepts of unconscious conflict, focus on feelings, anxiety and defense are present throughout all treatment modalities. The overall goal is to help the person connect with himself and his deeper feelings. It emphasizes the patient's resistance to change and recognizes the need to address and overcome it. This means that all team members share the same theoretical foundation and understanding of the patient's problem, regardless of their professional background. Despite using different methods to achieve the treatment goal, the understanding and conceptualization of it harmonize.

The team has nine members, including ISTDP therapists Åshild and Tor Øyvind, two physiotherapists who also work as milieu therapists, four psychiatric nurses, one music therapist, and one extra physiotherapist if needed (some work part-time). Sharing a common conceptualization of the patient's problems is beneficial in several ways, foremost by facilitating the idea of multimodal and intensive treatment, allowing the patient's goals and issues to be addressed beyond the therapy session. It also promotes effective collaboration within the team by establishing a shared language and framework. The team meets briefly every morning and has a longer session on Wednesdays to evaluate the treatment process and discuss present and upcoming challenges. Åshild and Tor Øyvind teach other team members principles from ISTDP and if the patients allow it, they show some of the video material. Working together like this increases the likelihood of the team collaborating effectively with the patient to achieve common goals.

Table 1 outlines a list of the various treatment modalities offered in the program. The program is evaluated by self-report questionnaires before, during and after treatment (6 months, one- and two-year follow-up). The scales used are GAD-7, PHQ-9, IIP-64, CORE-OM, SCS-SF, WAI and RAND-36 which measure overall functioning, symptoms and interpersonal functioning. The unit is currently compiling data.

TABLE 1

ISTDP therapy: Systematic work to undo resistance, connect to complex feelings within current and past relationships and if needed graded work to build emotional capacity.	**Mindfulness and Vitality training (Haugli & Steen, 2001):** Deepen connection to emotions and bodily signals, build mental strength to face challenges and reinforce healthy behaviors.
ISTDP psychoeducation: Cognitive focus on theoretical principles to increase understanding of the treatment process as well as themselves to motivate and to help mobilize against resistance.	**Basic Body Awareness Therapy:** Improve understanding and comfort with the body.
Physical activity, climbing, nature therapy, yoga: Strengthen sense of agency, build self-confidence through accomplishment, challenge hopelessness and provide a positive experience of doing good things for yourself.	**Music therapy:** Give the patient positive experiences, boost the UTA.
Group therapy: Strengthen connections with other participants, practice new behaviors and gain positive experiences from being emotionally open.	**Family presence:** One-day seminar for relatives who can visit the clinic during stay. Children and relatives are offered consultations.

FIGURE 1. TREATMENT MODALITIES OFFERED TO THE PATIENT

OUTPATIENT ASSESSMENT:
Trial therapy (1–3 hours)
Psychiatric and somatic assessment

EIGHT-WEEK,
MULTIMODAL TREATMENT PROGRAM:
ISTDP therapy
ISTDP Psychoeducation
Physical activity, climbing nature therapy, yoga
Support group
Mindfullness
Basic Body Awareness Therapy
Music therapy
Family presence

OUTPATIENT FOLLOW UP:
Follow-up sessions

Team interview

The interview was conducted in June 2024 with Psychologist Åshild Digernes Stave and Psychiatrist Tor Øyvind Hummelsund at The Regional Medication-Free Treatment Offer at Vegsund DPS. It has been translated from Swedish and Norwegian.

Starting off, how did your project transition from being a temporary to a permanent offer? It must have been a good sign?

– It must be a sign that we developed something good, yes! I believe one of the main reasons for our success is that the idea of medication-free treatment options originated from patient and user organizations, and these organizations were closely involved in developing and assessing our services. In the beginning, there was disagreement about which patient group to focus on, with the organizations initially pushing for medication-free services for psychotic patients. However, as both we and the user organizations gained experience with the program, it was recognized as valuable and effective, which led to a decision to continue offering it. This kind of evaluation likely played a significant role in the decision made by the specialist department at the Central Norway Regional Health Authorities.

The medical model is still deeply rooted in society, was the introduction of medication-free treatment ever controversial in any way?

– Yes, it was controversial and probably still is. The medication-free wave was firstly about patients with psychotic disorders, and the University Hospital in Tromsø established a program for this group. There were no specific guidelines for what the programs were supposed to look like, which may have been a weakness in the mandate of the Minister of Health to the healthcare institutions. Since we decided to develop our program for a different patient group (personality disorders, trauma, treatment-resistant anxiety or depression), medication-free treatment options were less controversial. But, we can also see that these offers – ours is not an exception – are under pressure in Norway. Our health regions are, as in Sweden, experiencing financial challenges which is also leading to cuts in services here. We hope that we will be able to continue our work in the future as well.

Tor Øyvind, as a psychiatrist working with ISTDP, what are your experiences with medication in combination with therapy? Could it affect treatment negatively or are there times when medication is needed?

– It is important to highlight that the program does not exclude the use of medication. In our treatment program, we help patients adjust their medication to minimize disruption as much as possible. If needed, we offer support for reducing or discontinuing medication. Alternatively, we may decide that maintaining the current medication is the best choice. Many individuals who benefit from ISTDP choose to gradually stop taking medication once they have consistently experienced positive effects over time. In my opinion, ISTDP is an effective method for evaluating whether medication is interfering with the therapeutic process. Generally, if the patient exhibits mobilization (observable anxiety), we believe that the medication does not hinder therapy. If the patient can't be mobilized, we need to determine whether the medication or some other factor is causing this. From our experience, it's rare for medication to significantly interfere with the therapeutic process. When it does, it's usually because of benzodiazepines or antipsychotics, and in some rare cases, antidepressants. Having a conversation with the patient about this is the best way to form a plan on how to proceed.

Eight weeks is a limited time. What are your experiences from working with a limited timeframe?

– Based on our experience, a limited timeframe can play a significant role in therapy and patients can achieve a lot in eight weeks. However, the end of therapy and the transition to everyday life can be a particularly vulnerable phase. In some cases, we have continued with further ISTDP treatment for certain patients, and our experience aligns with existing literature, indicating that patients with a fragile psychological structure and those exhibiting high resistance and syntonic defenses require more treatment hours to develop the capacity for lasting change compared to patients with moderate resistance. While change takes time, intensifying treatment in the initial phase is beneficial and boosts the process for many patients. The same applies to systematically focusing on method development and working as a team around the patient. We believe it is essential to work systematically to develop skills and knowledge within the method through deliberate practice (Rousmaniere, 2016). Through increased skills and knowledge, the flexibility in meeting with the patient improves. In our experience with ISTDP, we have found that it effectively integrates the various approaches within the program. For example, getting in touch with the body, being aware of breathing and emotions through yoga, body awareness, mindfulness and climbing. The program also involves working with self-observation, emotions and destructive patterns in group therapy. Additionally, Gestalt techniques, emotions, and creative methods are used in Vitality Training. The program emphasizes becoming aware of nature, being present in outdoor therapy, and experiencing autonomy and mastery. These elements are just a few examples of what is included in the program.

Say more about how you make use of deliberate practice within the team.

– I reformulate deliberate practice into goal-oriented skills training, which I see as all the work you do to get better at deliv-

ering a treatment method. From the start, Tor Øyvind and I have recorded therapy sessions with the patient's consent. We have reviewed these videos both individually and together, and have received regular guidance from psychologist specialist Filip Myhre at the Norwegian Institute of ISTDP. During these sessions, we have focused particularly on cases where we are stuck and thus received guidance on process, technique, and how to move forward. We also use information from the self-report form to assess the progress and identify patients who do not appear to be improving.

I understand that ISTDP runs like a red thread through the program, do you want to tell me more about that?

– We continuously work on the process, both with patients and within the team. Step by step, we teach our staff ISTDP. And when the patients allow it, we use video from therapy in teaching. Reading about ISTDP is important for everyone on the team. We actively use the Triangle of Conflict and the Triangle of Persons, and it is important to place the method within a broader theoretical framework of understanding. We have received extensive guidance from the Norwegian ISTDP Institute, and we have supported each other. Our approach in the program is fundamentally biopsychosocial, we work with the whole person, as the content of the treatment program shows. For me (Åshild), it is important to emphasize that I am focused on similarities and overlaps between methods and concepts in, for example, ISTDP, CBT, MBT, and that developmental psychology and attachment theory are key aspects of the basic understanding.

How do you assess the quality of the program?

– We use a self-report form to inform the treatment together with the patient along the way, to evaluate and assess whether we are on the right track. Research shows that this approach contributes to better outcomes. We are currently working on systematizing the data, eventually having a larger data register with data from before, during and after treatment (at 6 months, 1 year and 2 years). We hope to be able to analyze the data more thoroughly, identify correlations, gain insights into factors that drive change, all in order to develop more effective treatments.

"I really enjoy this job, and one of the most important things is that I believe in what we do. I see that it has an effect and that we contribute to change. I have worked with istdp since 2016, and I find that working with goal-oriented skills training is fun and meaningful."

Do you have a sense of whether there are patients who benefit more from the program?

– It's challenging to determine which patient group benefits the most, as our inclusion criteria are broad and our data isn't systematized. ISTDP is transdiagnostic, and I find that to be true – you intervene according to the patient you have in front of you. It's essential with the trial therapy to evaluate the suitability of the method and the program, establish a good working alliance with the patient, and to ensure that the patient is willing to work with this method and is open to participating in group treatment. However, from experience, patients with more severe personality disorders and weaker ego structures may require a longer treatment period. However, even in a short eight-week period, significant changes can occur, and these changes can continue during follow-up.

Åshild, you have worked at the clinic for several years. How do you like it?

– I really enjoy this job, and one of the most important things is that I believe in what we do. I see that it has an effect and that we contribute to change. I have worked with ISTDP since 2016, and I find that working with goal-oriented skills training is fun and meaningful. We develop and learn more and more from our patients and about ourselves.

What have you two learned so far from running this project?

– The importance of goal-oriented skills training and personalized treatment for each individual cannot be overstated. Our team has achieved a great collaborative process by working with a shared understanding and consistently focusing on all the aspects of the process. I believe this approach is crucial to providing better treatment for more patients. It would be great to develop the way we view treatment in the public health system. One vital lesson learned is that change is a gradual process, and as a society, we must decide if we are willing to dedicate time and resources to this cause. The potential societal benefits are immense, as effective treatment can facilitate the return to work for many individuals. If our treatment program and experiences could serve as an inspiration and bring about positive change in the field, ultimately enabling us to offer more effective treatment, no one would be happier than us!

Concluding remarks

In Sweden, a majority of the regions are experiencing financial difficulties, leading to budget cuts in healthcare services (Sveriges Kommuner och Regioner, 2024). However, speaking with Åshild and Tor Øyvind in Norway, I heard something different. The request for medication-free treatment originated from user organizations, with the aim of achieving positive outcomes rather than merely reducing costs. The program in Ålesund was initially planned as a temporary project, but because of its successful outcomes and positive reception by patients, it was established as a permanent treatment option within the Norwegian healthcare system. The project was evaluated in collaboration with user organizations, where the voice of the user organizations became useful to ensure that patients considered treatment resistant would keep benefitting from ISTDP within Norwegian healthcare.

As with the approach in Gothenburg I reported on in the first issue of this journal (Pedersen, 2024), several factors seem to have contributed to making ISTDP a reliable option within public healthcare. Firstly, as in Gothenburg, there is a great deal of engagement from enthusiastic ISTDP therapists. Good initiatives seem to inspire and spread throughout the community. Engagement also includes a commitment to systematic development and collaborative efforts to improve as therapists, which is crucial for sustainable work enjoyment and delivery of high-quality therapy. Additionally, there is a desire to develop ISTDP within healthcare services to reach patients with complex conditions who may not be able to pay for costly individual therapy, despite being among those who suffer the most. Secondly, there is some research supporting the use of ISTDP for patient groups with severe pathology where evidence for other treatment methods is limited.

Another interesting aspect worth highlighting is that ISTDP principles are integrated into the multimodal program. Although it might be harder to evaluate the effectiveness of the different treatment modalities, the upside is that istdp therapy can be complemented by other treatments that work toward and reinforce the same goals. This provides the patient with a great deal of support and potential for change within a limited time frame.

The program in Ålesund is likely to inspire others. However, despite its great success, there is no guarantee of its survival in this era of cost-cutting. With this in mind, I believe there are actions we can take as a community to act as a counterforce. In addition to conducting more research, even small data samples like in Ålesund, can prove to be valuable. I also hope that as we grow as therapists and as a community, we will be able to reach patients who have often been overlooked or let down by others. Based on what we have learned from Ålesund, it is clear that the voices of the people we aim to help are crucial at multiple levels.

References

Abbass, A., Town, J., Holmes, H., Luyten, P., Cooper, A., Russell, L., ... & Kisely, S. (2020). *Short-term psychodynamic psychotherapy for functional somatic disorders: A meta-analysis of randomized controlled trials*. Psychotherapy and Psychosomatics, 89(6), 363-370.

Lilliengren, P., Johansson, R., Lindqvist, K., Mechler, J., & Andersson, G. (2016). *Efficacy of experiential dynamic therapy for psychiatric conditions: A meta-analysis of randomized controlled trials.* Psychotherapy, 53(1), 90.

Haugli, L., & Steen, E. (2001). *Kroniske muskel/skjelettsmerter og selvforståelse: utvikling og evaluering av en læringsmodell som vektlegger kroppen som meningsbærer.* [Doctoral Thesis]. Universitetet i Oslo.

Malt, U. (5 september 2023). *Distriktspsykiatrisk senter (DPS).* Store Norske Leksikon. https://sml.snl.no/distriktspsykiatrisk_senter_-_DPS

Pedersen, H. (2024). *ISTDP teamwork with Cluster C personality disorder: A group interview about an innovative approach in Gothenburg, Sweden. Journal of Contemporary ISTDP, 1(1),* 114-119.

Rousmaniere, T. (2016). *Deliberate practice for psychotherapists: A guide to improving clinical effectiveness.* Routledge.

Standal, K., Solbakken, O. A., Rugkåsa, R., Ringen Martinsen, A., Seeger Halvorsen, M., Abbas, A., & Sverdik Heiervang., K. (2021). *Why Service Users Choose Medication-Free Psychiatric Treatment: A Mixed-Method Study of User Accounts. Patient Prefer Adherence, 15,* 1647–1660.

Sveriges Kommuner och Regioner. (14 maj 2024). *Fler tuffa år väntar för kommuner och regioner.* https://skr.se/skr/tjanster/pressrum/nyheter/nyhetsarkiv/flertuffaarvantarforkommunerochregioner.81792.html