

FOCUSED GROUP PSYCHOTHERAPY IN THE REHABILITATION AND RETURN TO WORK FROM OCCUPATIONAL BURNOUT AND LONG-TERM SICK LEAVE

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ABSTRACT

The project included 22 white-collar workers with occupational burnout on long-term sick leave who participated in three focused therapy groups. During therapy, the therapist met separately with each participant and representatives from their employer and social insurance provider to discuss the participant's eventual return to work. At the follow-up, 73% of participants were working (on a full-time basis or part-time basis), compared to 14% of participants who were working at the start of treatment. In conclusion, the participants appeared to benefit from the combination of the group intervention and therapist guided meetings with representatives of other stakeholders.

KEYWORDS: Professional burnout; Group psychotherapy; Rehabilitation; Sick leave.

PSICOTERAPIA DE GRUPO FOCADA NA REABILITAÇÃO E NO RETORNO AO TRABALHO A PARTIR DO ESGOTAMENTO DO TRABALHO E LICENÇA POR DOENÇA PROLONGADA

RESUMO

O projeto incluiu 22 funcionários administrativos com burnout ocupacional e em licença médica de longo prazo que participaram de três grupos de terapia focalizada. Durante o curso da terapia, o terapeuta se reuniu separadamente com cada participante e representantes de seu empregador e provedor de seguro social para discutir o eventual retorno do participante ao trabalho. No acompanhamento, 73% dos participantes trabalhavam (em período integral ou parcial), em comparação com 14% dos participantes que trabalhavam no início do tratamento. Em conclusão, os participantes pareciam se beneficiar da combinação da intervenção do grupo com reuniões guiadas por terapeutas com representantes de outras partes interessadas.

PALAVRAS-CHAVE: Esgotamento profissional; Psicoterapia de grupo; Reabilitação; Licença médica.

PSICOTERAPIA DE GRUPO FOCALIZADA EN LA REHABILITACIÓN Y REINCORPORACIÓN AL TRABAJO DEL BURNOUT LABORAL Y LA BAJA LABORAL DE LARGA DURACIÓN

RESUMEN

El proyecto incluyó a 22 trabajadores administrativos con agotamiento ocupacional y con licencia por enfermedad a largo plazo que participaron en tres grupos de terapia. Durante el curso de la terapia, el terapeuta se reunió por separado con cada participante y representantes de su empleador y proveedor de seguro social para discutir el eventual regreso del participante al trabajo. En el seguimiento, el 73% de los participantes estaban trabajando (a tiempo completo o parcial), en comparación con el 14% de los participantes que estaban trabajando al inicio del tratamiento. En conclusión, los participantes parecieron beneficiarse de la combinación de la intervención de grupo y de las reuniones guiadas por el terapeuta con representantes de otras partes interesadas.

PALABRAS CLAVE: Agotamiento profesional; Psicoterapia de grupo; Rehabilitación; Baja por enfermedad.

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INTRODUCTION

In large parts of the world, working life has become safer from a physical point of view, but at the same time it seems to be becoming increasingly stressful for the psyche. The impact of negative stress on mental health and, as a result, increased sick leave rates are highlighted in a Swedish report on social insurance (Försäkringskassan, 2020). It states that both Swedish and international studies show that shortcomings in the organizational and social work environment are linked to increasing mental illness. In a study conducted in countries within the European Union, it was estimated that between 50 and 60% of sick leave originated from work-related stress (Leka et al., 2015). Work-related depression, mainly due to professional burnout, and other stress-related diagnoses are increasingly listed as causes for sick leave in Sweden (Försäkringskassan, 2020). Similar developments have been reported by many countries. Recent statistics support the idea that this is a globally important issue with huge economic consequences (Hewlett & Moran, 2014; OECD, 2021; 2012).

Sick leave due to mental illness causes great suffering and tends to be longer than for other ailments. For example, in Sweden, sick-leave due to mental illness lasts an average of 90 days, compared to a median leave length of 49 days for all other diagnoses (Försäkringskassan, 2020). The symptoms which caused sick leave range from worry, anxiety, depression, difficulty in time planning, concentration and communication, to dealing with stress or social relationships. Occupational burnout belongs to this category and is usually defined as a reaction to long-term work-related stress, mainly characterized by emotional exhaustion and disengagement from work (Demerouti et al., 2001).

In an earlier study (Sandahl et al., 2011), focused group psychotherapy (FGT) for long-term sick leave due to professional burnout was compared to cognitive behavioural (CBT) group treatment and individual treatment with similarly good outcomes in terms of symptom reduction for the three treatment approaches. However, outcome in terms of return to work was only partially successful for all included patients in both approaches. This was, to some extent, to be expected as group and individual psychotherapy traditionally have been conducted to provide increased self-awareness, coping in general and better mental health. It is often assumed that this will lead to a more satisfying work situation. However, if nothing has changed at work it might not be an attractive solution to return to the same context which is perceived as the cause of the problems. In cases of professional burnout, it might be beneficial to address participants' work environments during the course of treatment. There are examples of close collaboration between patient, therapist and employer which have provided good conditions for individual treatment (Sandahl & Karlson, 2011). We wanted to apply a similar approach using FGT as the treatment alternative.

In focused group therapy, the starting point is what functions well in a person's life. The focus is on experienced obstacles to coping and solving problems in relations to others. Attention is directed towards current experiences. In working with a relational focus in FGT, the problems should be described in everyday behavioural terms. Group leaders and group members should be able to recognize a problem when it surfaces in interaction in the group therapy setting. Therefore, FGT requires a group focus and an individual member focus that must be clearly stated, clearly understood, and evident in the therapeutic process. Focused group psychotherapy is a here-and-now approach to therapy. It is time-limited with two meetings a week during the first half of the treatment and one meeting a week during the second half. The short-term format requires some structure and a somewhat more active therapist compared to what is common in traditional psychodynamic approaches (Sandahl et al., 2020; Sandahl & Lindgren, 2006). One similarity with CBT is that the aim in FGT is to contribute to a specific change in the clients' ways of being in relation to others—an observable behavioral change. However, CBT usually involves pre-planned content for each session, make little use of the here-and-now and the interaction between group members.

This article is about how group therapy can be designed so that it also enables more participants experiencing occupational burnout to return to work following sick leave. We have worked with FGT as a basis for the participants to achieve better health and, to a greater extent, be able to return to working life. Some years ago (2006–2007), we tested a collaboration in Stockholm, Sweden, in which the psychotherapist, the client, and representatives of the employer and the social insurance agency met to discuss how the return to work could be arranged in an optimal way. One consequence was that the contract of confidentiality had to be negotiated in a way that is unusual for psychotherapists. The overall goal of the groups was, thus, that the participants could enter working life again and that sick leave would decrease and, preferably, cease. The groups were carefully monitored with the intention to share with a wider audience our experiences from this unusual approach.

The clients' participation in the project included informed consent and was free of charge. It was voluntary to participate, and clients were informed that the pilot project was going to be evaluated and that they were free to terminate their participation at any time.

Because of the delicate task that was required of the group psychotherapist to be both a group leader and to support the individual client during the encounters with the employer and the social insurance agent, we decided to involve an experienced group analyst who was involved in the development of FGT and had experience from organizational consultation. She also participated in the above-mentioned research project on work related depression, has worked with burnout, and is the first author of this article.

We believe that there is an opportunity for improved outcomes of rehabilitation efforts if psychotherapists can find ways of collaborating with social insurance agents and employers, under the condition that the integrity of the clients is guaranteed. The purpose of this case study is to illustrate such an approach.

METHODS

Participants

The project included 22 white collar workers, including health personnel and pre-school teachers, ranging in age from 24–62 ($M = 45$; $Md = 43$). Seventy percent of participants were female. All clients were insured in a large Swedish occupational pension fund and had been on sick leave from a period of six months to two years. Most were married and had children under the age of fifteen.

The 22 participants were identified consecutively by the contact persons at the social insurance agency and referred in the same order to the group psychotherapist. In the same order as she received the name, she created three groups each one after the other. The groups consisted of 7–8 participants. The group members were from different types of workplaces and had different lengths of sick leave. They expressed that they wanted to feel better and that they wanted to change their situation. This is not to say that everyone wanted to end sick leave and return to their place of employment.

The details of the approval of the project from the Ethics committee at the Karolinska Institute (the medical university in Stockholm) are the following: Application no. 04-481/3 Work-oriented rehabilitation and group psychotherapy for fatigue syndrome - a randomized and controlled study. Approved 01/10/2004. Approved with a supplement 2005-02-16 (Dnr: 2005/210-32) and another supplement 2005-05-12 (Dnr: 2005/586-32).

Procedure

The group model

The group effort was largely in line with FGT, as described in Sandahl et al. (2020), except that the role of the group leader was modified to accommodate the ability for the group leader to have direct contact with the group participant's work through a human resources representative or a manager. This open collaboration with people outside the group is a central part of the approach and was discussed with all clients before the group therapy started. Confidentiality was an important issue, and it was clarified that the therapy process should not be talked about during the meetings with outsiders, only conditions related to return to work. The meetings were prepared individually with the clients and then it was decided what issues should be brought up. The process and outcomes of the meetings with the employer or rehabilitation agent were always discussed in the group.

Each client had their own rehabilitation plan with their own network of contacts, which might consist of a physician for the sick leave plan, the workplace manager, the rehabilitation team etc. The administrator within the Swedish Social Insurance Agency had a central function. The administrator's task included approving the rehabilitation plan with changes such as current sick leave and financial support. They also recruited the patients from their register of patients on sick leave for more than six months.

The group leader's role included collaborating primarily with the administrator, but also with the others within the participant's contact network. Thus, the group leader participated together with the client in meetings outside the group. The experiences from the meetings were always presented in the group. They created debate and constituted important learning.

The group therapist met each client individually two times before the group started. During these meetings, the clients were prepared for therapy and an individual focus was formulated. This contact between therapist and group member allowed the alliance to the therapist to develop. During the first few meetings, group cohesion was established. Each group met 18 times for 1.5 h sessions, twice a week the first 10 times and then once a week. The semiweekly sessions in the beginning of therapy allowed the alliance to the group as a whole to develop quickly, i.e., the bonding between members, the mutual understanding of the goal of therapy and the group members shared understanding of how the group was intended to work (Lindgren et al., 2008). This allowed the members to reflect together on their different foci, which contributed to a trusting climate. The discussions that took place provided rich opportunities for different types of tasks to be tried out and performed during the time between the group sessions. The group's work was systematically focused on the here-and-now situation and on the work scenario.

The role of the group leader

The group leader had a central role throughout the group's process. The responsibilities of the role included several tasks, such as the initial individual interviews, contact with the participants' caregivers and workplaces and, above all, convening the group conversations in a gentle and supportive manner. The alliance with the individual member was established when each client's focus was developed and then further developed in the group's dynamics.

During group sessions, the group leader had to pay attention to each participant and at the same time to the group as a whole. It was important to keep the group's boundaries, focus on building bridges between the participants to point out similarities, to encourage everyone's voices to be heard, and to pay attention to undercurrent themes and lift them to the surface if necessary. Above all, it was important for the group leader to be active in the process in its various phases without dominating the conversation.

A complex task which required a good deal of ethical judgement was the above-mentioned contact with each participant's contact persons in the rehabilitation team and workplace. Before the three-part meeting including the patient, the group psychotherapist and the contact person confidentiality was discussed in detail with the individual group member. The primary loyalty of the therapist was always the client, and it was important not to let him or her down or to give the employer reasons to undermine the client's self-confidence. The client was supported by the therapist, who acted as an advocate for him or her. However, in most of the cases, the atmosphere was constructive. In general, contact persons and employers were very positive to the approach. During these meetings the group leader functioned as a form of interpreter in the sense that she had in-depth knowledge of the client, and, at the same time, through her organizational knowledge, was able to understand the requirements on the client involved in returning to work. Through this process a smooth adjustment of the work and individual demands on the client could be negotiated. Together with the client, the group leader planned each meeting to clarify what should be put forward and implemented. Confidentiality was discussed on the same occasion.

An additional advantage of the group leader's participation was that both could share the experiences with the group, which in turn were updated. In this way everyone could reflect on the workplace meeting, its results, and its meaning for each member of the group.

Group process

Pre-therapy preparations

Before the groups started, a group focus was formulated by the therapist. The group focus helped the participants to understand what the purpose of the treatment was and gave some hints regarding what was expected of them in the group member role. The following is the formulation used in this project as a guide for the clients:

Together with others who have experienced burnout, explore feelings and thoughts about what has happened, observe, and share with others what I have done and do in situations that are pressing, and try out new ways of dealing with difficult situations.

The group focus was formulated before the individual assessment interviews with the therapist. Then, an alliance was established between the prospective group participant and the group leader. An individual focus for the treatment was formulated together with the client before treatment. This work by necessity becomes personal and contributes to a deepened alliance to the therapist. According to FGT, the focus needed to be expressed both as a weakness and a strength. This is an example of a client's focus:

I want to use my purposefulness to establish appropriate boundaries in my relationships with others. When I feel unsure of myself and just want to escape, I will try to take a stand and speak up for myself even if it is scary.

The focus that was developed was linked to the participant so that it would encourage more effective coping strategies and facilitate a return to working life.

The engagement stage

Becoming a group member was not an easy task. Clients wrestled with many fears, such as not fitting in, being misunderstood, that the group would be talking about uninteresting topics. However, the fears seemed to have diminished drastically after the first meeting in the three groups. The participants expressed at the next session that they felt understood and they felt sympathy for the others.

The individual interviews laid the foundation for a relationship with the group leader, while the group's first five sessions laid the foundation for a trusting work climate, group cohesion and alliance to the group. Personal introductions were mixed with group reflections, mainly around similarities and recognition of the experiences of others. At this stage, it was the group focus that was processed in different ways.

After five sessions, the groups were prepared and eager to introduce each participant's personal focus. Usually, a member read their own focus out loud from a piece of paper provided by the group leader and then talked about what was felt as the most essential aspect of the focus. A group discussion followed, and the members gave each other feedback based on the knowledge acquired during the previous sessions.

The interaction stage

Once all foci were exposed in the group, the contact deepened. Each client's struggles, professionally and personally, were revealed. Participants also realized that there was a responsibility in the group, both for their own development and for each other's; that the only way to receive reactions and to learn from others in the situation was to be generous in giving responses to them.

As previously mentioned, all participants in the groups, parallel with the group's events, also had rehabilitation efforts outside the group. These efforts were included in the group's discussions. The meetings that the participants attended, sometimes together with the group leader, were ventilated. Many emotions, such as desires, mistrust and ambivalence, were mixed with ambition and hopefulness. The meetings and emotions were put in relation to each participant's focus to test the possibility of better coping strategies, a sense of competence and increased autonomy.

Some questions discussed in group included: "How should I deal with my own and my coworkers' demands?", "How do I make my boss understand that the company's organization is undermining my role?", "How can I say 'no', when I'm so used to saying 'yes'?"

Although the emphasis in the group discussions was on working life issues, occurrences in private life were included as a natural part of the conversations. The stories from events in the family complemented the images from the work and often concretized the focus processing.

An example: Bob, who was used to doing everything himself to avoid being annoyed that it was not done properly, could no longer do everything himself. He panicked. The group made him realize that his family was suffering from a lack of trust. Filled with joy, he later came to the group and told them that he had taught his son how to mow the lawn. The son cut the lawn with pleasure and the father was relieved. He saw the pedagogical point in the fact that even though his son did not cut perfectly,

he was still there as support without taking over. Bob realized that he demonstrated this behavior in the workplace; he did not trust others to complete their duties properly, so he attempted to do everything himself. When this became too much, there was chaos. Bob, together with his boss, tried to steer the organization so that his duties were distributed. He experienced the relief as adequate and positive, but it was a challenge for him to put up with mistakes that the employees made, to be there as support without taking over.

One theme that came to mind throughout the group process was the participants' fatigue and, thus, sensitivity to stress. It was a new phenomenon for the participants who always had had a lot of energy and were able to do most things. In the rearview mirror, they could see how they overestimated their capacity. Finding more effective coping strategies became a recurring topic of debate. Clients' ambitions conflicted with their lack of energy. As the conflict was recognized by all, clients' guilt lessened while they both received and offered support to their groupmates. Intergroup exchanges could be quite tough. "You must understand that you have to say 'no' to that approach and try to modify it", someone might say.

The interaction between the participants ranged from deep anxiety and despair to hopefulness and laughter.

An illustrative group episode from session 8

To illustrate the group process, here is a description of an episode from one of the groups. It took place a few sessions after everyone had gained knowledge about each other's focus, which all contained the theme of caring for themselves and setting boundaries. The group had left the engagement stage and was in the interaction phase. It describes how an individual problem was treated in the group, how the other participants were reminded of their own similar difficulties and how the group wrestled with the issues involved. Focused group psychotherapy is a here-and-now approach. An important task of the therapist is to be sensitive to the group process. Therefore, group themes evolve as a result of interactions between group members, including the therapist who also keeps the individual foci in mind.

The group participants struggled with the question of how to set boundaries. One of the problems discussed was how they wanted things to be done exactly as they wished but lacked the courage to demand this from others. They were outraged over the demanding behaviors of others, children, coworkers, bosses etc. The role of victim was developed. One example after another was given and the frustration was clear: "How should you be able to set your boundaries when the environment is so difficult?" The participants united in their right to speak out.

Then, Mats (24 years old) said that he was frustrated with his new girlfriend's behavior in his house. He described how she did not do as he was used to; for example, she put the cutlery wrong in the dishwasher and in the kitchen drawers. After Mats' outburst, the group became completely silent. Lotta (39 years old) stared at Mats and said: "I can't stand the disorder in the kitchen drawers either. I have poured all the knives, forks, and spoons into one drawer. So now my husband and children have to find their own cutlery".

Suddenly the participants began to laugh more and more so that the tears fell. Participants found Mats' compulsiveness and Lotta's angry indulgence to be incredibly funny. All had examples of their own tame or drastic attempts to speak out and difficulties in finding balance in their interaction with others.

After this intense exchange, the contact was deepened even further in the group and the participants reflected on the victim roles, their peculiarities, and opportunities to find more appropriate strategies. The group's humorous ability continued to be an asset for the participants as severe and complicated themes were discussed.

The termination stage

The initial semiweekly meetings provided an intensive start, which gave an opportunity to deepen the conversations. When the sessions transitioned to weekly, it gradually prepared the participants for the end.

The separation from the group became apparent. The individual goals were concretized. What had been achieved, what goals should be left, and what lay ahead were addressed. The increased self-awareness of vulnerability to stress was taken into consideration when discussing future plans.

Prior to the group's dissolution, the group's experiences were summarized during the last two meetings. The future was discussed, but, more importantly, group members gave each other final pieces of advice and feedback. The suggestions included that they could be encouraging, warning, bitter, hopeful and, above all, empathetic. The participants' common journey ended with feelings of loss paired with anxiety and hope for the future.

OUTCOME

Before the group started, the members did not believe on themselves to be able to be assertive in relationships. During the group process, they experienced mastering challenges in the group as well as in everyday life. To be able to master difficult situations is a strong motivator for continued change. In this way, the patients gradually developed a sense of autonomy, which helped to develop greater self-confidence.

Here follow two examples, one from family life and one from work, which illustrates how participants' initially stated focus was used in efforts to change:

Malin's (59) focus: "Trust your life experience and judgment when you want to show commitment and thus develop an active approach based on mutual communication".

In the group, Malin had talked about difficulties in both work and family. She over adapted to what she thought coworkers and children wanted from her, but now, she said, she no longer had the strength to be responsible for everything. The group drew attention to the fact that her focus was on working for "an active approach based on mutual communication". Where was the reciprocity? At the next group meeting, Malin, happily told that she had talked to her daughter. Instead of being on standby for the three grandchildren, she wanted to plan time with them. To Malin's surprise, an important encounter took place. The daughter thanked her afterwards with flowers and cards for clarifying her wishes. Everyone in the group was moved by Malin's courage to explore how to solve the situation.

Erik's (39) focus: "Expand your life by taking yourself seriously, test your ideas and increase your ability to communicate with others, and use your survival energy and courage when you want to withdraw".

Erik enjoyed his work at a preschool, but had become increasingly stressed by working with the youngest children. Old habits and loyalty with decisions made had become an obstacle to change. It became clear to Erik that his life had become too limited, both at work and in private life. The group supported Erik to, according to his focus, "expand life by taking himself seriously". In the meetings with his employer, he discussed a development of the work at the preschool. One year after the end of the group, he had dared to make a change to work with children aged 4-6. His work felt meaningful now, and he was engaged in a new way.

When the groups ended, most participants had taken important steps away from their fatigue and depression and had ideas about strategies that needed to be phased out or developed. This was confirmed during the follow-up one year after the end of the groups when the group leader contacted the 22 participants by phone. The interviews contained questions regarding sick leave, work situation, mental health status, experiences from the group psychotherapy and how the work with the individual focus had influenced them. In our view, the most important finding was that they had changed the work situation to suit their competence and interests better than before sick-leave. They demanded that work tasks and roles were to be defined clearly, which contributed to a feeling of security and control. Several had also improved their family relations.

It turned out during the follow-up interviews that the participants' focus still felt meaningful and was included in their continued personal development work. Several said that they had kept their notes with their individual focus in wallets, visible on the fridge or the desk at the workplace, to remind themselves of the work they had accomplished in therapy.

At the one-year follow-up, 73% had started working again (41% full-time, 9% three-quarters and 23% half-time), compared to 14% who worked part-time before therapy. Some of them had returned to the old work and five had found new employments. This is a case study, which makes it impossible to establish a causal relationship between the group therapy and work-related outcomes. The Swedish social insurance system does not include limitations on leave other than the expectation to return to work when there is no ground for a diagnosis anymore, or when the client is not expected to be possible to rehabilitate, in which case early retirement or other measures can be taken.

Two participants were still on full-time sick leave at the one-year follow-up. Difficulties that they had experienced during the group therapy remained. One of them had established contact with psychiatry due to his severe sleeping problems; the other had a hidden alcohol abuse problem that prevented an orderly rehabilitation.

Two participants (59 and 62 years old) had received full-time sickness benefits related to depression and burnout and were very satisfied with this.

The employers and social insurance agents were not interviewed at the one-year follow-up. However, during the rehabilitation process most of them were actively engaged and grateful for the support that was given to the clients and the support they themselves received by this approach.

CONCLUSIONS

Obviously, one must be very careful in drawing far reaching conclusions from this exploratory case study. There was no control condition, and it is a small sample size. The dual role of the first author and group leader includes some bias, which could impact the research. However, we have been observant and divided the work to counteract the effect of this possible problem. The main role of the first author was to describe the intervention while the second author was conducting analyses and reviewing the data. We have tried to follow generally accepted guidelines for case study research (Yin, 2012).

We believe that results are promising and motivate further research. In the literature, one can find general support for interactional short term group psychotherapy (Sandahl et al., 2020). Therefore, a future randomized controlled study should ideally include one condition of FGT only and the other condition FGT plus collaboration with employer and social insurance agency, as it has been described here. This structured cooperation can take place in any context where long-term sick-leave is a problem and can be applied to several patient categories, not only occupational burnout.

A trusting relationship between participants and group leader was of crucial importance for personal development. The trust was built during the preparations in connection to the formulation of the participants' focus. Especially when it came to contacts outside the group, trust was necessary. The risk of a breakdown was high if boundaries and confidentiality were not maintained by the group leader.

It was clear that the participants, by having their own focus to work with, had less inclination to place the demand on the group leader to "cure" the client. It put pressure on one's own competence to make change happen.

The participants received support from each other. Most of them learned a lot about themselves and how others live their lives. It increased their sense of freedom of action and ability to master difficult situations and to communicate. They no longer felt that they were substandard, quirky, or incomprehensible to themselves and others. It increased their self-esteem and sense of competence and they experienced that they had more effective strategies to find a way out of difficult situations. Most clients were convinced that the support from the group in combination with the well-prepared meetings with representatives of employer and social insurance agency, facilitated by the therapist, had been helpful in the process to recovery.

AUTHORS' CONTRIBUTIONS

Conceptualization: Sandahl C and Ahlin HN

Methodology: Sandahl C

Investigation: Ahlin HN

Writing – Original Draft: Sandahl C

Writing – Review and Editing: Sandahl C and Ahlin HN.

DATA AVAILABILITY STATEMENT

The data will be available upon request.

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