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Psychological Mindedness, Personality Structure, and Outcomes in Short-Term Group Analytic Psychotherapy

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ABSTRACT

*The present study investigated the treatment effects of focused short-term group analytic psychotherapy and examined whether outcomes were predicted by the client's psychological mindedness and personality structure as measured by the Operationalized Psychodynamic Diagnosis (OPD). Treatment foci were formulated according to the OPD for 66 student counseling clients across nine groups. Two observers independently rated client psychological mindedness and personality structure. The pre-post Cohen's *d* effect sizes were large on the Global Severity Index (GSI) and the Inventory of Interpersonal Problems (IIP-64) and moderate on the Social Adjustment Scale Self Report, including all 66 clients starting treatment. Psychological mindedness significantly predicted two outcomes (GSI, IIP), and personality structure predicted one outcome (GSI). These measures could be helpful when selecting clients for short-term group analytic psychotherapy. We discuss study limitations and implications for future research and practice.*

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The effects of group psychotherapy have been documented in 10 meta-analyses, including a total of 329 randomized controlled trials (RCTs; Burlingame & Strauss, 2021). These meta-analytic findings demonstrate that group therapy had the same positive effects on various outcomes for many specific mental disorders compared to other treatments (Burlingame & Strauss, 2021). For example, Burlingame et al. (2016) included 67 studies that compared individual and group treatment and found indistinguishable outcomes on treatment acceptance, symptom improvement, and dropout. However, almost all included studies had a CBT approach, and the efficacy of group analytic and psychodynamic group psychotherapy has been investigated only in a few RCTs. In a systematic review, Blackmore et al. (2012) found only five RCTs published from 2001 to 2008. One study (Blay et al., 2002) found a positive treatment effect of brief psychodynamic group therapy compared to usual care; one study (Lau & Kristensen, 2007) found a lower effect of modified group analysis than systemic group therapy; and three studies did not find any significant differences in effect between psychodynamic group therapy and other active treatments (Lanza et al., 2002; Piper et al., 2001; Tasca et al., 2006). The five case-control studies and 21 pre-post studies included in Blackmore et al. (2012) found moderate to large pre-post effects of group treatment, although the lack of a control group prevents attributing the effect to the group intervention. A keyword search in PsycInfo found one new RCT after 2008 on the effect of group analytic psychotherapy. Lorentzen et al. (2013) randomized 77 clients to short-term group analytic psychotherapy and 90 clients to long-term group analytic psychotherapy and found moderate effect sizes on the GSI and the IIP-64 in both groups. Also noteworthy and unique to their study, the group analytic treatment used was manualized (Lorentzen, 2014).

Especially in short-term group psychotherapy, assessing and selecting suitable clients is essential. Group members are expected to have some capacity to interact with each other, experience and verbalize feelings, observe their behavior, and work on a circumscribed focus to change within a short period of time (Lorentzen, 2020; Rutan et al., 2007). In psychodynamic psychotherapy, psychological mindedness (PM) and personality structure have traditionally been assessed as

indicators of the client's ability to engage in the therapeutic process and used as predictors of outcome (McWilliams, 1994; Valbak, 2004; Westen et al., 2006).

PM has roots in psychoanalysis and represents an abstract complex process, not directly observable. To our knowledge, the first definition of PM occurred in the Psychotherapy Research Project of the Menninger Foundation (Wallerstein et al., 1956). Appelbaum (1973) defined PM as "a person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of [the person's] experiences and behaviour" (p. 36). PM is a process, potentially leading to insight as a product, and has similarities with the concept of reflective function in mentalization-based therapy (i.e., the capacity to understand ourselves and others in terms of intentional mental states). Allen et al. (2008) suggested that the original conception of PM could be construed as an explicit mentalizing capacity that is needed to engage effectively in psychotherapy, as it requires a focus on mental and emotional states. Especially for short-term group analytic therapy, a high level of PM might support clients' interest and ability to understand and communicate underlying personality vulnerabilities and conflicts behind the observable symptoms and behavior in the group.

The research on a possible association between PM and psychotherapy outcome has mainly assessed PM by self-report or the observer-rated Psychological Mindedness Assessment Procedure (PMAP, McCallum & Piper, 1990), wherein patients' answers to video presentations of simulated patient-therapist scenarios are rated. Several studies have found PM assessed with the PMAP to be associated with successful outcomes in group therapy for complicated grief and individual therapy for depression (McCallum et al., 2003), day-hospital treatment for personality disorders (Ogrodniczuk et al., 2011), and individual psychotherapy in a heterogeneous psychiatric sample (Piper et al., 1998). Other studies using PMAP have found that PM was only related to reduced dropout (McCallum et al., 1992; Tasca et al., 1999) and that PM had no direct effect on treatment outcome (McCallum et al., 1997). Kealy et al. (2019) found that the effect of PM on the patients' target problems was mediated by the patients' importance to the group cohesion as rated by the therapists in interpretative group psychotherapy. In other words, patients' PM might

contribute to treatment outcome in interpretative groups through the contribution of PM to group cohesion. In another study, using patient self-report to assess PM, Conte et al. (1990) included 44 outpatients and found an association between PM and successful outcome; however, no significant association between PM and outcome was found in a newer and larger study including 116 outpatients (Conte et al., 1996). Other studies have not found an association between self-reported PM and outcome (Boylan, 2006; Kronström et al., 2009). In summary, there is limited evidence for a correlation between self-reported PM and outcome, which may be related to the fact that PM is a complex cognitive-affective process virtually unrecognizable to the patient. The evidence for an association between PM assessed with the PMAP and outcome is divergent, perhaps related to varying populations and types of treatment. Emerging evidence suggests that the influence of PM on outcomes is mediated by complex therapy processes, such as group cohesion and dropout (Kealy et al., 2019). Interestingly, none of the reported studies assessed PM based on an interview.

Personality structure also has its origins in psychoanalysis. In a review, Hörz-Sagstetter et al. (2021) distinguished three approaches to conceptualizing personality difficulties on a continuum of severity: personality organization, personality structure, and personality functioning. According to Kernberg's (1984) object-relational theory, the level of *personality organization* is determined by the patient's identity (integrated vs. diffused), defense mechanisms (mature vs. primitive), and reality testing and spans across a continuum of severity, ranging from normal or neurotic through borderline to psychotic personality organization. The *Psychodynamic Diagnostic Manual* (Lingiardi & McWilliams, 2017) on the personality syndromes axis describes the level of personality organization on a spectrum similar to Kernberg. The Operationalized Psychodynamic Diagnosis (OPD) integrates several psychodynamic concepts (object relations, self-psychology, ego psychology) into a description of *personality structure*, defined as the availability of mental functions to regulate relationships to self and others (OPD Task Force, 2008, p. 199). OPD differentiates four levels of severity ranging from high through moderate and low to disintegrated levels of structural integration. Finally, *personality functioning* is conceptualized by the alternative DSM-V model for personality

disorders on a 5-point scale of impairment in self and interpersonal functioning from none to extreme (American Psychiatric Association, 2013). Although these conceptualizations of personality vary, there is consensus that it refers to a set of enduring psychological structures that dynamically organizes mental processes and content into a coherent organization. All approaches share a focus on self and interpersonal aspects of the personality. Moreover, they aim to promote case formulation and treatment planning, including helping clinicians understand individuals' difficulties in the larger context of personality functioning (Bach & Simonsen, 2021).

Within psychoanalysis, treatment strategy and interventions can be described on a continuum from more interpretative to more supportive depending on the patient's level of functioning (Caligor et al., 2018). Patients with a borderline organization (Kernberg, 1984), a deficit pathology (Killingmo, 1989), or with a low level of structural integration (OPD Task Force, 2008) are assumed to need longer and more ego-supportive treatment, compared to clients with a higher-level structure. Therefore, clients with structural impairments might benefit less, or not at all, from short-term group psychotherapy.

Research supports a positive association between personality functioning and outcome. In a systematic review, Koelen et al. (2012) included 18 studies and found that a higher pretreatment level of personality organization was moderate to strongly associated with better treatment outcome when outcome was measured as changes in general symptomatic distress and psychosocial functioning. Using OPD to measure personality structure, researchers have reported some evidence that a better level of structural integration is associated with a better outcome in individual psychotherapy (Müller et al., 2006; Rudolf et al., 1996; Spitzer et al., 2004; Strauß et al., 1997; Thomasius et al., 2001). For group therapy specifically, in an RCT including 139 outpatients with complicated grief, Piper et al. (2001) found that a high quality of object relations was related to symptom improvement in interpretative and not supportive psychotherapy. Lorentzen et al. (2015) found that patients with personality disorders (defined as the number of fulfilled criteria on the SCID-II) improved significantly more in long-term psychotherapy; whereas, no outcome differences between short and long-term psychotherapy were found for patients without a personality disorder.

In the present study, Lorentzen's (2014) manual guided the treatment. A pre-post study without a control group, like this study, can be an initial step toward establishing the relevance for a particular treatment. Moreover, PM and personality structure were measured by the OPD-2 (OPD Task Force, 2008). The OPD-2 is a multiaxial diagnostic system consisting of four axes: (1) experience of illness and prerequisites for treatment (including PM), (2) interpersonal relations, (3) inner conflict, and (4) personality structure (i.e., level of structural integration). The OPD was developed by psychoanalytically oriented clinicians and researchers in Germany with the goal to complement and enrich the descriptive and symptom-oriented classification systems of the *ICD* and *DSM* by including psychodynamic dimensions relevant for treatment planning and research. A 60- to 90-minute semistructured psychodynamic interview is used to rate PM and personality structure and to formulate treatment foci (OPD Task Force, 2008), potentially enhancing clinical feasibility. In recent years, the assessment of personality disorder has undergone a paradigm shift toward a continuous understanding of severity (Bach & Simonsen, 2021), and more studies on the association between severity levels and treatment outcomes are warranted.

The present study aimed to investigate the pre-post treatment effects of focused short-term group analytic psychotherapy and to examine whether the client's PM and personality structure measured with the OPD-2 could predict these effects. The hypothesis was that higher levels of both PM and personality structural integration at pretreatment would be associated with better outcomes for individuals completing short-term group analytic psychotherapy when compared with lower levels of PM and personality structural integration.

METHOD

Setting and Selection Criteria for Participants

The study was conducted in the student counseling center in Aarhus, one of four counseling centers in Denmark. The Danish Student Counseling Service is financed by the Danish government and offers short-term counseling free of charge to about 5,000 students from all universities, university colleges, and business academies in Denmark.

The data were collected from one therapy group each semester from spring 2012 to autumn 2016. Eight counselors and one psychiatrist working in the Aarhus center referred clients to the group treatment. The inclusion criteria were relational difficulties, interest in working with personal problems and relationship patterns in a group, and a significant level of psychological distress. Fifty individuals (75.8 percent) were referred to the groups because their counselor, after 1–2 individual sessions, reached the opinion that the clients would not benefit enough from the 4–6 individual sessions routinely offered at the student counseling center, and 16 students (24.2 percent) were referred after 3–20 sessions of individual counseling had elapsed without sufficient effect. The exclusion criteria were organic brain disease, psychosis, suicidal behavior and risk, and current substance abuse.

All participants gave informed consent to participate in the study. Information provided to the clients included the purpose of the study, video recordings, secure data storage, and how the video would be rated by two researchers who did not know anything about them. The raters were shown a still picture of each client before watching any video and were instructed to refrain from watching the video if they knew the client. Clients declining to participate in the study were offered a comparable treatment. The Regional Ethical Committee was consulted, and the Danish Data Protection Agency approved the study.

Treatment

All nine groups were conducted by the same therapist (first author)—a clinical psychologist and group analyst with eight years of group analytic experience when the first group started in 2012. Six groups were facilitated alone, and three groups were cofacilitated with two different junior cotherapists who were not otherwise involved in the study. The groups were closed (fixed start and termination dates), meeting once a week for 1.5 hours. The scheduled sessions were 16 in five groups and 17 in four groups. The mean number of attended sessions was 15.5 (range 9–17), corresponding to an attendance rate of 94.4 percent. The clients had a mean of 3.1 (range 1–20) individual sessions before starting the group treatment. Twelve (18.2 percent) had an in-house psychiatric consultation before or during the group treatment, primarily to discuss medical

treatment. Nine (14.5 percent) received medical treatment (medication management) for affective or anxiety disorders.

The treatment was guided by modified group-analytic principles, described in Lorentzen's (2014) manual for short-term group analytic psychotherapy. This treatment builds on a psychodynamic understanding, including a developmental perspective on personality, internal representations of interpersonal relationships, psychological causation, and influences of unconscious individual and group processes on behavior. Compared to long-term group analysis, the group analyst was more active, focused on the group's beginning and termination phase, and worked more in the here-and-now on individual treatment foci. The therapist formulated the treatment foci after the assessment interview and before the group started without watching the video recordings of the interview. These foci were formulated according to OPD-2, wherein a treatment focus is defined as a dysfunctional relational pattern (Axis 2), an inner conflict (Axis 3), or a structural vulnerability (Axis 4) that contribute to the cause and maintenance of symptoms and play a vital role in the psychodynamic nature of the disturbance (OPD Task Force, 2008).

In the assessment interview, the group analyst discussed with each client how these foci might be actualized and worked on in the group. The group members were encouraged to communicate openly in the group and notice how they experienced themselves and others and how others experienced them. In the first group session, the group members were asked to present their foci to speed up the process. The group analyst gave space for the group members to talk, interact, and negotiate roles. With this low level of directiveness, the group member's inner conflicts were reenacted and personified. Group members, including the group analyst, come to represent inner objects, such as parents, siblings, and unconscious representations of self and society. This spontaneous, unconscious process transforms inner conflicts into interpersonal, emotional conflict constellations between group members, which were then analyzed in the here-and-now. Both supportive interventions and interpretations at the individual, interpersonal, and whole-group levels were used. These interventions were tailored to the level of functioning of each client and the group. Each group was heterogeneous, concerning individual treatment foci, personality structure, and PM level.

Measures

Self-Reported Outcomes. The Global Severity Index (GSI) of the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1992) measures symptomatic distress. The SCL-90-R has 90 self-report items, each rated on a Likert scale from 0 = *not at all* to 4 = *extremely*. The measure has a total mean score, the GSI, which served as the primary outcome measure. The SCL-90-R has been standardized in a representative Danish community sample (Olsen et al., 2004). In the present study, the internal reliability for the GSI at pretreatment was excellent (Cronbach's $\alpha = .94$).

The Inventory of Interpersonal Problems (IIP-64; Alden et al., 1990) measures interpersonal problems. Sixty-four self-report items were rated on a Likert scale from 0 = *not at all* to 4 = *extremely*. The mean total score of the IIP-64 was used as an outcome measure. The IIP-64 has shown high test-retest stability across 10 weeks (Horowitz et al., 1988) and sensitivity to change (Huber et al., 2007). In this study, the internal reliability for IIP-64 at pretreatment was good (Cronbach's $\alpha = .87$).

The Social Adjustment Scale-Self Report (SAS-SR; Weissman & Bothwell, 1976) measures social functioning. The SAS-SR has 54 questions each rated on a 5-point scale; higher scores indicate more impairment (the response categories differ from question to question). The mean total score of the SAS-SR was used as an outcome measure in this study. The SAS-SR has shown high two-week test-retest stability (Edwards et al., 1978) and sensitivity to change in depressive patients (Rush et al., 2008). In the present sample, the internal reliability for SAS-SR at pretreatment could not be calculated because of missing data (questions about the marital partner role and the parental role were not relevant for most participants).

All outcome data were collected via paper and pencil at three time points: (1) In the week before the group started (i.e., pretreatment), (2) immediately after the group ended (i.e., posttreatment), and (3) one year after (i.e., follow-up).

Clinician-Rated Predictors. The Operationalized Psychodynamic Diagnosis (OPD) Levels of Structural Integration Axis (OPD-LSIA; OPD Task Force, 2008) is a clinician-rated scale measuring the

client's availability of mental functions to regulate the self and its relationship to internal and external objects. OPD-LSIA describes personality structure in terms of four basic functions, each of which is differentiated in a self and other dimension: (1) perception of self and objects, (2) regulation of self and relationships, (3) emotional communication with the internal and external world, and (4) attachment to self and objects. OPD-LSIA was rated on a 7-point Likert scale (1 = *high*, 2 = *moderate*, 3 = *low* to 4 = *disintegrated*). A high level is characterized by a stable identity, an ability to reflect on oneself, a capacity to regulate emotions and self-worth, empathy, and mutual relationships. Moderate integration implies a reduced self-reflection, restricted emotional experiences with overcontrol of impulses, and excessive self-criticism. The central fear is losing the other. With low integration, the understanding of self and others is jeopardized by a lack of differentiation between self and others, limited capacity to regulate emotions, leading to (self-) destructive behavior or withdrawal from relationships. The central fear is to be harmed by others, or destructive introjects. Disintegration is characterized by fragmentation of self and a lack of reality testing. The central fear is a symbiotic merging of the self and objects (OPD Task Force, 2008, pp. 200–202, 360–367). OPD-LSIA has been shown to predict the presence and number of personality disorders on the DSM-IV (Zimmermann et al., 2014). Several studies have found that OPD-LSIA can be reliably rated with interrater reliability between 0.67 and 0.83 (Zimmermann et al., 2012).

In the present study, two independent raters performed the OPD-LSIA ratings after watching one or two videotaped assessment interviews carried out by the first author/therapist. He and a psychology graduate student independently rated two groups (15 clients), and two psychology graduate students independently rated six groups (39 clients). All raters were certified as OPD raters by the task force on OPD. After watching the interview, it took about 15 minutes to rate each client on the OPD-LSIA. Training of rating was performed on 10 assessment videos not included in the study. The interrater reliability for the total mean score was good for the two first raters (ICC = 0.839, 95 percent CI [0.50–0.95]) and excellent for the two last raters (ICC = 0.918, 95 percent CI = [0.80–0.97]) when using a two-way mixed-

effects model, average-agreement. The mean of the two raters' scores on the OPD-LSIA dimensions was used as a predictor.

Clients with $M < 2.5$ on the OPD-LSIA were classified as having “predominantly conflict-based disturbances” (i.e., high to moderate level of structural integration), and clients with $M \geq 2.5$ were classified as having “predominantly structure-based disturbances” (i.e., moderate-low to low level of structural integration). In OPD, a mean value of 2.5 divides clients into groups of predominantly conflict-based disturbances—characterized by unconscious wishes, defenses, and compromise formations—and predominantly structure-based disturbances—characterized by structural vulnerabilities (OPD Task Force, 2008).

Psychological Mindedness (PM; OPD Task Force, 2008) is a clinical rating scale measuring clients' interest and ability to understand the psychological causes of their own complaints and symptoms. It includes two aspects: (1) the client's recognition of the client's own contributions and (2) how the client deals with the interviewer's interpretations. These interpretations were formulated as hypotheses inviting clients to explore and think about possible connections between intrapsychic or interpersonal events and their problems/symptoms. PM was rated on a scale from 0 = *absent*, 1 = *low*, 2 = *medium*, and 3 = *high* to 4 = *very high*. A rating of 0 indicated that the clients were unable to identify any connections between intrapsychic or interpersonal events and problems/symptoms and rejected the interviewer's suggestion about such connections. For a rating of 2 the clients can mention intrapsychic feelings and thoughts but cannot link these and their symptoms. The clients listen to the interviewer's hypotheses with an open mind but cannot use these to deepen the understanding of self and symptoms. A rating of 4 indicated that the client connects wishes, feelings, and thoughts to symptoms and behavior and uses the interviewer's suggestions to gain further insight (OPD Task Force, 2008, p. 139). It took about two minutes to rate PM after watching the assessment video. The interrater reliability was excellent for the two first raters (ICC = 0.971, 95 percent CI [0.91–0.99]) and excellent for the two last raters (ICC = 0.914, 95 percent CI = [0.79–0.96]). The average of the two raters' PM rating was used as a predictor.

Psychiatric Diagnosis. The International Classification of Diseases (ICD-10; World Health Organization, 2010), Chapter V, was used to

diagnose each client. The first author made the diagnostic evaluation based on a full psychiatric history and an investigation of the current symptoms as they were presented in the assessment interviews. No standardized interviews beyond the assessment interview, questionnaires, or independent raters were used.

Statistical Analyses

The investigation of outcomes in group psychotherapy can be compromised because clients are nested within groups. Appropriate statistical models must test and account for this potential between-group effect. Therefore, multilevel modeling was used to investigate the variance in posttreatment outcome explained by the group level (i.e., between-group effect) and the client level. Initially, a three-level model was estimated, wherein time at Level 1 was nested within clients at Level 2, which were nested within groups at Level 3. The intraclass correlation coefficients (ICC) were calculated from the between and within variance to estimate the variance explained by the group and client level. For Level 3 (i.e., group), the formula was $ICC = \sigma^2_{\text{level 3}} / (\sigma^2_{\text{level 1}} + \sigma^2_{\text{level 2}} + \sigma^2_{\text{level 3}})$, and for Level 2 (i.e., the client), the formula was $ICC = \sigma^2_{\text{level 2}} / (\sigma^2_{\text{level 1}} + \sigma^2_{\text{level 2}} + \sigma^2_{\text{level 3}})$. ICCs $\geq .05$ were considered indicative of moderate dependence, as suggested by Pituch and Stevens (2016). Level 3 was included in the predictor models if the group level explained more than 5 percent of the variance in the outcome or if the group level improved the model fit as estimated by the $-2LL$ fit statistics.¹

Cohen's d effect sizes (ESs) were calculated using two different methods to facilitate comparison with previous outcome studies. Firstly, ESs were calculated as the standardized mean difference between premeasures and posttreatment/follow-up measures (GSI, IIP-64, SAS-SR) based on the SD difference scores. Secondly, ESs were derived from the F -test for the mixed-effects model with time as a predictor of change according to the formula $d = 2\sqrt{\frac{F}{df}}$.

¹There is disagreement on the magnitude of the ICC that necessitates statistical controls for group dependency. Some suggest that having nested data, regardless of the size and significance of the ICCs, warrants a statistical design that accounts for this nesting (e.g., Janis et al., 2016). In contrast, others argue that ICCs less than .05 do not necessitate multilevel modeling and may even make model estimation difficult (Dyer et al., 2005).

At posttreatment, the number of clients with reliable and clinically significant change on the GSI, the IIP-64, and the SAS-SR were calculated according to Jacobson and Truax's (1991) criteria. For the GSI, psychometric values and nonclinical norms were provided from the Danish community sample (Olsen et al., 2004), and clinical norms were from an outpatient sample at the Psychiatric Center Stolpegaard (also in Denmark; Østergård et al., 2019). Regarding the IIP-64, psychometric values and nonclinical norms were taken from a youth sample randomly selected in Gothenburg, Sweden (Lindberg et al., 2018), and clinical norms were from the present sample. For the SAS-SR, psychometric values and nonclinical norms were taken from Weissman et al. (1978), and clinical norms were from the present sample. For the GSI, the reliable change index (RCI) and the clinical cutoff point demarcating clinical from the nonclinical population were calculated to be 0.21 and 0.83, respectively. On the IIP-64, the RCI and the clinical cutoff point were calculated to be 0.29 and 1.18, respectively. For the SAS-SR, the RCI was 0.47, and the clinical cutoff point 1.88. Based on these calculations, clients were classified as recovered (clinical and reliable change), improved (only reliable change), not reliably changed, or reliably deteriorated.

Multilevel modeling was also used to test predictors of the posttreatment effects and included the OPD-LSIA, PM, personality disorder (present or not present), gender, age, medication (yes, or no), and groups with cotherapy (yes, or no) as predictors. The equation for testing the predictors in a two-level model was: $Y_{ij} = (\beta_{0j} + U_{0j}) + \beta_{1j}(\text{Time}_{ij}) + \beta_{2j}(\text{Predictor}_{ij}) + \beta_{3j}(\text{Time}_{ij} \times \text{Predictor}_{ij}) + R_{ij}$, where y is the outcome (i.e., GSI, IIP-64, and SAS-SR), i = time, j = client, R_{ij} = error, and U_{0j} specifies the intercept as random. With only two observation points (i.e., pre- and posttreatment), the slopes were specified as fixed (i.e., β_{1j} , β_{2j} , and β_{3j}).

Simple slope analyses were performed to explore significant interaction effects by splitting PM by the median and by splitting the OPD-LSIA at $M = 2.5$, which made it possible to calculate separate ES for clients with a "high to moderate level of structural integration" and clients with a "moderate-low to a low level." The maximum likelihood method was used to estimate the parameters. Treatment dropout was defined as attending less than 11 of the 16 to 17 scheduled sessions.

RESULTS

Participant Flow

Sixty-six (86.8 percent) of the 76 clients referred to the group psychotherapy treatment began the treatment. All clients starting in the treatment completed all outcome measures at pre- and posttreatment. The OPD-LSIA and PM were rated for all 58 (87.9 percent) clients in eight of the nine groups (by mistake, all assessment videos from one group were deleted). Thirty (45.5 percent) clients completed the follow-up after one year (all 30 clients participated in the first five groups; the last four groups did not receive follow-up questionnaires because the first author changed job-position). Two clients dropped out in Sessions 9 and 10 because of studying abroad.

Comparing clients with and without follow-up data and clients with and without predictor measures, independent sample *t*-tests and chi-square tests found no differences in any pretreatment or treatment characteristics, including age, gender, PM, OPD-LSIA, GSI, IIP-64, SAS-SR, number of individual and group sessions, and pre-post treatment outcomes (*ps* > 0.10).

Characteristics of the Participants

Pretreatment client characteristics are shown in [Table 1](#). Thirty-eight (57.6 percent) were women. Ages ranged from 20 to 31 years, with a mean of 24.3. Sixty-four (97.0 percent) grew up in Denmark, of which 62 had Danish-speaking parents from a nonimmigrant background, and two had a Danish parent and a parent who had immigrated (from northern Europe and the Middle East). Two (3.0 percent) participants grew up in northern Europe and moved to Denmark to study at the university. Thirty-nine (59.1 percent) were diagnosed with a personality disorder; 28 (42.4 percent), with an affective disorder; and 17 (25.8 percent), with an anxiety disorder. The pretreatment means (and *SDs*) on the GSI, IIP-64, and SAS-SR were 1.37 (0.46), 1.58 (0.40), and 2.24 (0.44), respectively. On the GSI, 58 (87.9 percent) of the clients had a pretreatment score above the clinical cutoff based on the Jacobson and Truax's (1991) criteria.

Table 1. Client Pretreatment Characteristics (Danish Sample)

Characteristics	(<i>n</i> = 66) <i>M</i> (<i>SD</i>) or <i>n</i> (%)
Age (years)	24.3 (2.31)
Gender (women)	38 (57.6%)
Medicine for affective or anxiety disorders ^a	9 (14.5%)
Previous psychological treatment	37 (66.1%)
Psychological Mindedness (PM) rating ^b	2.22 (0.85)
Operationalized Psychodynamic Diagnosis (OPD)-LSIA rating ^b	2.27 (0.30)
Affective disorders	28 (42.4%)
Major depression, single	20 (30.3%)
Major depression, recurrent	7 (10.6%)
Dysthymia	1 (1.5%)
Anxiety disorders	17 (25.8%)
Social phobia	10 (15.2%)
Panic disorder	1 (1.5%)
Mixed anxiety and depressive disorder	5 (7.6%)
Adjustment disorder	1 (1.5%)
Personality disorders	39 (59.1%)
Anxious (avoidant)	10 (15.2%)
Anankastic	3 (4.5%)
Dependent	1 (1.5%)
Schizoid	2 (3.0%)
Histrionic	1 (1.5%)
Other, specified or unspecified	22 (33.3%)
Other diagnosis	5 (7.6%)
Clinical cases	
GSI	58 (87.9%)
IIP-64	56 (84.8%)
SAS-SR	54 (81.8%)

Note. PM = Psychological Mindedness (OPD Task Force, 2008); OPD-LSIA = Operationalized Psychodynamic diagnosis—Levels of Structural Integration Axis (OPD Task Force, 2008); GSI = Global Severity Index of the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1992). IIP-64 = Inventory of Interpersonal Problems (Alden et al., 1990). SAS-SR = TSocial Adjustment Scale—Self Report (Weissman & Bothwell, 1976). Clinical cases were based on Jacobson and Truax's (1991) criteria.

^a*n* = 62, and ^b *n* = 58 because of missing data.

Thus, for almost 90 percent of the clients, the level of symptomatic distress was more similar to psychiatric outpatients than to the general Danish population. Fifty-six (84.8 percent) had interpersonal problems (IIP-64) in the clinical range, and 54 (81.8 percent) were in the clinical range on social functioning (SAS-SR).

Outcomes

Between-Group and Between-Client Differences. In a three-level model, the group level explained 4 percent of the variance in the treatment outcome on the GSI (ICC = 0.04) and the IIP-64 (ICC = 0.04), and the model did not converge with the SAS-SR as the outcome. Furthermore, including Level 3 (i.e., group) did not improve the overall model fit as evaluated by a change in the $-2LL$ fit statistics. The client level explained 15 percent of the variance in the treatment outcome on the SCL-90-R (ICC = 0.15) and 26 percent on the IIP-64 (ICC = 0.26).

Effect Sizes. Table 2 presents the outcomes and ESs as Cohen's d . The pre-post treatment standardized mean ES was 1.12 on the GSI, 0.85 on the IIP-64, and 0.58 on the SAS-SR, including all 66 clients starting treatment. When including only clients with pretreatment scores above the clinical cutoff on the GSI, IIP-64, and SAS-SR, the standardized mean ESes were 1.33, 0.97, and 0.66, respectively. The ESes derived from the F -test for the mixed-effects model were larger with 2.26 on the GSI, 1.72 on the IIP-64, and 1.17 on the SAS-SR. At the one-year follow-up, the ESes increased with 0.23 to 0.52 SD for the 30 clients with data.

Number of Clients Changed. The number of clients recovered, improved (i.e., reported reliable change), with no reliable change and deteriorated on the GSI, the IIP-64, and the SAS-SR are reported in Table 3. More clients recovered on symptomatic distress (48 [82.8 percent]), compared to interpersonal problems (33 [58.9 percent]), and social adjustment (20 [37.0 percent]). The number of deteriorated clients was five (7.6 percent) on the GSI, six (9.1 percent) on the IIP-64, and three (4.5 percent) on the SAS-SR.

Prediction of the Outcome. On the GSI, the treatment effect was predicted by the OPD-LSIA, $F(1,58) = 6.734$, $p = .012$, and by PM, $F(1,58) = 9.188$, $p = .004$. On the IIP-64, the effect was predicted by PM, $F(1,58) = 4.115$, $p = .047$, and not by the OPD-LSIA, $F(1,58) = 2.185$, $p = .145$. Neither the OPD-LSIA nor PM predicted the effect measured on the SAS-SP ($ps > .10$).

Simple slope analyses exploring the two significant interaction effects on the GSI (OPD-LSIA x Time, and PM x Time) found that the treatment effect was larger for clients with an OPD-LSIA mean

Table 2. Outcome and Effect Sizes

Outcome	Pretreatment		Posttreatment		Follow-up at 1-year		
	<i>M (SD)</i> (<i>n</i> = 66)	<i>M (SD)</i> (<i>n</i> = 66)	Cohen's <i>d</i> ^a (<i>n</i> = 66)	Cohen's <i>d</i> ^b (<i>n</i> = 66)	<i>M (SD)</i> (<i>n</i> = 30)	Cohen's <i>d</i> ^a (<i>n</i> = 30)	Cohen's <i>d</i> ^b (<i>n</i> = 30)
GSI	1.37 (0.46)	0.87 (0.46)	1.12	2.26	0.76 (0.50)	1.54	2.91
IIP-64	1.58 (0.40)	1.21 (0.49)	0.85	1.72	1.04 (0.54)	1.08	1.94
SAS-SR	2.24 (0.44)	2.01 (0.43)	0.58	1.17	1.90 (0.43)	1.10	1.66

Note. GSI = Global Severity Index of the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1992). IIP-64 = Inventory of Interpersonal Problems (Alden et al., 1990). SAS-SR = Social Adjustment Scale-Self Report (Weissman & Bothwell, 1976).

^aCohen's *d* was calculated as the standardized mean difference.

^bCohen's *d* was derived from the *F*-test for the mixed-effects model with time as a predictor of change.

Table 3. The Number of Clients Reporting Change

Outcome	Recovered^a	Improved	No change	Deteriorated
GSI	48 (82.8%)	2 (3.0%)	11 (16.7%)	5 (7.6%)
IIP-64	33 (58.9%)	3 (4.5%)	24 (36.4%)	6 (9.1%)
SAS-SR	20 (37.0%)	0 (0.0%)	43 (65.2%)	3 (4.5%)

Note. GSI = Global Severity Index of the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1992). IIP-64 = Inventory of Interpersonal Problems (Alden et al., 1990). SAS-SR = Social Adjustment Scale–Self Report (Weissman & Bothwell, 1976). The number of clients recovered, improved, with no change, and with deterioration were based on Jacobsen and Truax's criteria Jacobson and Truax (1991).

^aOnly clients with pretreatment scores above the clinical cutoff were included in the calculation.

below 2.5 (predominantly conflict-based disturbances), $F(1,44) = 61.266$, $p < .001$, $d = 2.36$, compared with clients with an OPD-LSIA score equal to or greater than 2.5 (predominantly structure-based disturbances), $F(1,14) = 6.975$, $p = .019$, $d = 1.41$. Moreover, the treatment effect was larger for clients with a PM above the median of 2.25 (medium-high to very high PM), $F(1,34) = 46.839$, $p < .001$, $d = 2.35$, compared with clients with PM below the median, $F(1,24) = 26.300$, $p < .001$, $d = 2.09$.

For clients with an OPD-LSIA mean below 2.5, five of 42 (11.9 percent) were referred to treatment after the group ended compared to six of 11 clients (54.5 percent) with an OPD-LSIA mean above 2.5 (i.e., predominantly structure-based disturbances). On the PM, nine of 29 clients (31.0 percent) with a below the median PM were referred to further treatment compared to two of 24 clients (8.3 percent) in the group with medium-high to very high PM.

On the GSI, the treatment effect was positively associated with having a personality disorder but did not reach significance, $F(1,66) = 3.017$, $p = .087$. A personality disorder did not predict outcome on the IIP-64, $F(1,66) = 0.876$, $p = .353$, or on the SAS-SR, $F(1,66) = 0.677$, $p = .414$. Neither gender, age, medical treatment, or having had cotherapy predicted the treatment effects ($ps > .10$).

DISCUSSION

The aims of the study were to investigate the treatment effects of focused short-term group analytic psychotherapy and examine whether the posttreatment outcomes could be predicted by the client's psychological mindedness and level of structural integration

measured by the Operationalized Psychodynamic Diagnosis (OPD). The treatment was based on the guidelines in Lorentzen's (2014) manual, and the client's treatment foci were formulated according to the OPD-2. The clients from the student counseling clinic were relatively severely disturbed, with more than 80 percent above the clinical cutoff on the symptomatic distress (GSI), interpersonal problems (IIP-64), and social functioning (SAS-SR) scales. Including all 66 clients who started treatment, large ESes based on group means and standard deviations were found on the GSI ($d = 1.12$) and the IIP-64 ($d = 0.85$), and a moderate ES was shown on the SAS-SR ($d = 0.58$). When the F -test of the multilevel model was used to calculate Cohen's d , the ESes were 2.26, 1.72, and 1.17 on the GSI, the IIP-64, and the SAS-SR, respectively. The ESes increased at 1-year follow-up for the 30 clients with data.

The ESes are equivalent to, or larger than, the ESes found in prior studies. For example, in another pre-post effect study from the same student counseling center as the present study, Østergård et al. (2019) included 739 clients and found a moderate ES ($d = 0.59$) for clients who started treatment. Thirty-one percent of the clients dropped out of the treatment. Lorentzen et al. (2013) found a small to moderate ES in the short-term groups (GSI $d = 0.3$ and IIP-64 $d = 0.6$) and a moderate ES in the long-term groups (GSI $d = 0.5$ and IIP-64 $d = 0.6$). In a separate Danish study, Jensen et al. (2010) included 236 psychiatric outpatients with mixed diagnoses in psychodynamic group therapy and found moderate to large ES based on completer data (GSI $d = 0.74$). The large ESes in the present study indicate that focused short-term group analytic psychotherapy should be considered a treatment model for students with complex problems, even if the treatment model needs to be tested in an RCT. It appears that student clients based in Denmark (Østergård et al., 2019) and many other countries have high levels of distress and are, in general, undertreated. For example, a survey conducted by the World Health Organization found a prevalence rate of any DSM-IV mental disorder of 20.3 percent among 1,572 college students from 21 countries; only 16.4 percent of these students received treatment (Auerbach et al., 2016). Moreover, the results of the present study are encouraging for the manual-based approach to group analytic psychotherapy offered in Lorentzen (2014).

The large ESEs and the low number of premature terminations, even for clients with a predominantly structure-based disturbance, might be related to both treatment, therapist, and client characteristics. The treatment was in general supportive and adapted to the group and structural level of each client, as suggested by OPD-2. The therapist's qualifications and expertise level can be considered high. Besides being a teacher at the Institute of Group Analysis in Aarhus, the therapist is a certificated OPD trainer. The clients were highly distressed, and 59.1 percent fulfilled the criteria for a personality disorder. However, many also had resources, such as being young, intelligent, and motivated to get better and were able to complete or resume university studies.

In general, the hypothesis was supported: PM predicted outcomes on symptoms (GSI, $p = .004$) and interpersonal functioning (IIP-64, $p = .047$), and OPD-LSIA predicted the outcome on symptoms (GSI, $p = .012$). Social functioning (SAS-SR) was not associated with PM and OPD-LSIA. An ICD-diagnosis of personality disorder did not predict treatment effects on any outcomes. The PM and OPD-LSIA are dimensional measures of psychological functioning and might be better measures of the ability to benefit from short-term group therapy than an ICD-10 categorical diagnosis of personality disorder.

Regarding PM, Piper et al. (2001) found that video-assessed PM was beneficial for patients both in interpretative and supportive psychodynamic group therapy. Piper et al. (2001) argued that PM might reflect a general ability to analyze internal and external conflicts and solve problems. More recently, Piper's group has found that group members with higher levels of PM were more active and formed better therapeutic alliances in both interpretative and supportive groups (Kealy et al., 2017), although PM was indirectly related to outcome only in interpretative groups (Kealy et al., 2019). It is relatively unique to use clinical ratings of assessment interviews to assess PM, as is done in the present study. In our opinion, it makes it more feasible to rate PM as an integral part of clinical practice because an assessment interview is typically a part of routine practice. Moreover, the definition of PM included both clients' ability to understand their problems in psychological language and their reactions to the interventions in the assessment interview. These intrapsychic and interpersonal components of PM may be crucial for the clients' ability to use the group, which includes working actively with their treatment foci and talking about complex psychological dynamics

underpinning the responses of self and others. Thus, the level of PM indicates the client's interest and ability to speak the language of the group and engage in the group process for the benefit of oneself and others (Kealy et al., 2017). Speculatively, members with high PM may have supported members with lower PM in the present study with heterogeneously composed groups regarding PM levels. Another possibility is that clients with lower PM also changed because of processes related to nonverbal, corrective emotional experiences in the group rather than PM-related processes leading to insight.

Regarding personality structure, OPD-LSIA was significantly associated with the treatment effect measured on the GSI. Moreover, the clients with a predominantly structure-based disturbance had a smaller treatment effect ($d = 1.41$) than the clients with a predominantly conflict-based disturbance ($d = 2.39$). Most clients with a structure-based disturbance (54.5 percent) were referred to treatment after the group ended compared to 11.9 percent of the clients with a predominantly conflict-based disturbance. These results are consistent with Kernberg (1984), Killingmo (1989), and OPD Task Force's (2008) assumption that clients with structural deficits need longer treatment than conflict-based disturbances. The results are also in line with Piper et al. (2001), mentioned in the introduction, and with Lorentzen et al.'s (2015) finding that patients fulfilling a higher number of criteria for a personality disorder improved significantly more during long-term group analytic psychotherapy compared to short-term group analytic psychotherapy. With a low level of personality structure, the self-functioning is disturbed and the relationship to others is burdened—for example, by reduced empathy and a tendency to relate to others as a means to regulate the self. Clients will have a hard time trusting communication in the group sessions, making personality dysfunction a disorder of communication. Therefore, it is as expected that clients with lower OPD-LSIA had less treatment effect and often were referred for further treatment. At the same time, group analysis offers an opportunity to work with these deficiencies in communication and trust in others.

Several clinical implications can be discussed based on the findings. OPD-LSIA and PM can be systematically attended to in the assessment of group patients and during treatment and might be helpful client selection criteria for short-term group analytic therapy. Routine outcome monitoring (ROM) of the client's improvement in symptoms and

interpersonal functioning during therapy may assist the therapist in deciding when to terminate the treatment, as suggested by Burlingame et al. (2018). However, the ROM measures typically rely on self-report measures. Without self-report bias, an OPD-2 assessment might add valuable observer-rated information about prognosis, treatment foci, and progress. In a psychodynamic framework, symptoms are understood as expressions of underlying conflicts, interpersonal problems, or personality vulnerabilities, which must be addressed in the treatment. Pretreatment and ongoing assessment of clients may lead to more-realistic expectations of improvement within specific timeframes.

Study Strengths and Limitations

The study's main strengths were applying the OPD-2 to select and test variables of the clients' mental functioning and personality structure. These ratings were completed by the therapist and independent observers of video recordings with high reliability. Outcomes were measured as symptoms, interpersonal, and social functioning. At posttreatment, no outcome data were missing. However, the study also has several limitations. The absence of a control group prevents conclusions being made about whether observed changes in participants can be attributed to the intervention. The very small number of clients and groups limits the variance between groups and increases the chance of a Type 2 error (i.e., not detecting a true difference between groups). With only one group analyst conducting all groups, it was impossible to determine whether the large ESes were due to therapist effects or the manualized treatment per se, limiting the generalizability of study results. On the other hand, with one group analyst, it was possible to control for the therapist factor when testing for the group-level and client characteristics. Treatment fidelity was not checked, making it impossible to test therapist adherence, competencies, and consistency across groups. The groups spanned five years, which may have introduced cohort effects. However, the group had stable organizational conditions, all groups were conducted according to the same principles (Lorentzen, 2014), and client and treatment characteristics were not related to the year of treatment ($ps > 0.10$). The lack of a structured diagnostic interview, including an interrater reliability check of psychiatric diagnosis, weakens conclusions about whether PM and OPD-LSIA better predict outcomes than psychiatric diagnoses.

All three outcomes were self-reported, potentially introducing self-report bias. In only assessing PM and OPD-LSIA at pretreatment, we did not account for changes in PM and OPD-LSIA throughout treatment. Finally, results may be restricted to counseling settings and student counseling clients from a Danish cultural background with severe distress and personality difficulties. While there were some individual differences in participants' cultural backgrounds (e.g., immigrant status of the participant or their parents) and other social identity variables (e.g., sexual orientation), these differences were sufficiently small among a largely homogenous sample that they were unable to be analyzed statistically in the present study.

These limitations have implications for further research. First of all, the results point to further evaluation of PM and OPD-LSIA as selection tools in assessment for short-term group psychotherapy. Ideally, future studies must include a control condition to investigate whether this manualized focused short-term group analysis is more effective than other treatments. Preferably, several group therapists should participate in future studies, making it possible to investigate whether the treatment effect can be attributed to therapist variables or the treatment itself and to include more than nine groups to increase the power to detect between-group effects. Studies should also be conducted in other settings, such as community mental health or hospital-based settings with a more diverse patient population and outside of Denmark. Such studies could also include structured diagnostic interviews to increase internal validity.

In conclusion, this study found good outcomes for 66 relatively disturbed clients in short-term group analytic psychotherapy, conducted by a skilled therapist according to prespecified guidelines. As hypothesized, PM and personality structure measured by the OPD-2 predicted good outcomes, indicating that these client variables can be used as selection criteria for short-term group analytic psychotherapy. However, more research is needed, and the lack of randomization and control prevents cause and effect conclusions.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

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