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CASE REPORT

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Focused group analytic psychotherapy: An integration of clinical experience and research

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Abstract

Objective: Group-analytic psychotherapy is probably the most commonly used psychodynamic group therapy in Europe. This paper describes focused group analytic psychotherapy (FGAP), a new time–limited version of this therapy, based on clinical experience and research.

The therapy/suitability of patients: It is relatively structured and individually oriented, and designed for patients with a certain ability to tolerate internal and external stress, without decompensating or developing serious behavioral disturbances (they should have a limited degree of personality pathology). Patients entering FGAP should establish a circumscribed therapy focus ahead of therapy, based on some dysfunctional patterns of interpersonal problems, conflicts, and/or symptoms related to a psychodynamic hypothesis/case formulation.

Selection/preparation: The paper describes patient selection and preparation, the evolvement of the group process, and how therapist and other group members interact/intervene.

Clinical material/vignettes: Central elements in the evaluation and aspects of the therapy are described and illustrated with an extensive case description and clinical material and vignettes from the group process.

KEYWORDS

group analysis, level of personality organization, psychodynamic, therapy focus, time-limited

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1 | INTRODUCTION

The objective of this paper is to present a new group therapy, focused group analytic psychotherapy (FGAP), a time-limited therapy based on psychoanalytic and group analytic theories. The main elements of the therapy follow from integration of clinical experiences and results of systematic research. Essential research findings and theoretical underpinnings supporting the construction of FGAP are presented, followed by a description of the most important elements of the therapy and a rich case illustration.

1.1 | Research on group-analytic psychotherapy

Efficacy/effectiveness of group psychotherapy is well established for a variety of mental disorders (Burlingame & Strauss, 2021) and individual and group formats are by and large equally effective in promoting change. Only a small part of the studies in these meta-analyses are on therapies with a psychodynamic orientation (Blackmore et al., 2012; Lorentzen, 2006). Much knowledge can, however, be transferred from research on brief groups with other theoretical backgrounds *and* from short-term psychodynamic *individual* psychotherapy. Messer (2001) underlines six important principles for selection of patients to a time-limited psychotherapy: a certain quality of the patients' interpersonal relationships, establishment of an individual interpersonal focus, a fixed duration of therapy, active therapist techniques (questioning, confrontation/interpretation), setting goals for the therapy, and giving priority to the termination phase.

An *observational study* of 69 outpatients treated in three slow-open groups demonstrated that group analysis (GA) was an effective treatment for about 80% of the patients, showing improvement on symptoms, interpersonal problems, and psychosocial functioning. The patients had mixed diagnoses (anxiety and depressive disorders; 48% with personality disorders, mostly avoidant). GA is a long-term therapy, and the patients had to a certain extent influence on decisions of treatment length in this study (range 6–84 months), leaving some doubt if some patients might not have managed just as well with a shorter therapy (Lorentzen & Høglend, 2004; Lorentzen et al., 2002). The results evoked an interest in studying the *impact of therapy duration* on outcome, and in a subsequent clinical trial 167 outpatients were randomized to *manualized* short- or long-term group-analytic psychotherapies (20 or 80 weekly sessions, that is, approximately 6 and 24 months). The manuals (Lorentzen, 2014) were mainly based on group-analytic theories (Foulkes, 1986; Foulkes & Anthony, 1984) and theory from time-limited, mostly *psychodynamic* therapies (e.g., Piper et al., 2001).

For the "average patient," there were negligent differences in outcome between the two therapies 3 years after baseline (Lorentzen et al., 2013). More important for FGAP, was that patients with *less personality pathology*, on average, seemed to be sufficiently helped in the short-term therapy, while patients with more personality pathology did significantly better in long-term groups. Also, patients with less personality pathology did not seem to change further after 6 months, in the long-term groups (Fjeldstad et al., 2016; Lorentzen et al., 2015).

The therapy presented below, FGAP, is a *revised* and *expanded* version of the approach described in *the original manual for the short-term therapy* (Lorentzen, 2014, pp. 39–73). FGAP emerged as a *new therapy*, having integrated the clinical and research evidence that resulted from the randomized clinical trial (RCT) mentioned above *and* the approach described in the manual. Since the literature on this specific therapy is sparse, a brief review of the theoretical background and the framework of the therapy is offered, as well as requirements for patient suitability and how these are evaluated.

1.2 | Theoretical background of FGAP

The theoretical basis for FGAP consists of group-analytic and psychoanalytic theories, applied in a structured, short-term manner. This entails a need for thorough evaluation of patients to diagnose problems that realistically can be

addressed in a brief group therapy and resources that ensure that patients are able to manage the relatively structured framework and therapeutic tasks of FGAP. These include opening up early, disclosing vulnerable parts of themselves, taking feedback from others, and focusing on work in the here and now.

Group analytic theories were developed in England in the late 1930s by S.H. Foulkes, a German immigrant, psychiatrist and psychoanalyst. His theories were strongly influenced by his interest in social psychology and sociology, and he saw how the individual was formed by their social-cultural heritage, a "luggage" he called foundation-matrix, which each person brings into the group. In addition, the group develops its own *dynamic matrix* through multilateral interactions and communications between members, which combined constitutes Foulkes' ideas of *the group-as-a-whole*, clearly summarized by Pines (1994). FGAP shares Foulkes' understanding of the group-as-a-whole, as a gestalt comprised of all its members, their transactions and communications, collectively constituting more than the sum of what each member represents. Furthermore, FGAP, like GA, also carries the idea that all communications in the group affect all members on a conscious and unconscious level. In a reciprocal way, each individual influences other members and the group, creating a two-ways' effects of conscious and unconscious processes (Hopper, 2003; Thygesen & Aagaard, 2002).

Psychoanalytic theories constitute a basis for both GA and FGAP. While Foulkes was trained in ego-psychology, later group analysts put more weight on theories that focus on interpersonal relatedness in psychological development, emphasizing that all humans need to be seen and confirmed to develop and grow (e.g., Behr & Hearst, 2005; Schlapobersky, 2016). FGAP leans heavily on Kernberg's object relations theory which integrates psychoanalytic theories of drives, personality structure, and the self into one object-relations theory (Kernberg, 1975, 1980). The theory explains how a person develops in relation to early significant others and gradually builds an internal world of perceived or fantasized representations of relationships with consequences for self-perception, attachment, cognition, affect tolerance/control, and overt behavior. Object relations refer to the individual's system of internal representations of the self in relation with others, including the predominant effects associated with these representations. The theory encompasses the patients' resources, as well as pathology (dysfunctional, irrational perceptions, and behaviors), and explains how aspects of the internal world appear as transference-counter transference reactions, both in the initial interviews and in the group situation. The phenomenon of transference refers to the patient's experience of or relation to the therapist as reflecting aspects of internal object representations (i.e., as though the therapist represents a parent). Countertransference, reflecting the therapist's emotional states associated with the patient, may involve the therapist's reaction to the patient's transference or to a dissociated aspect of the patient's experience (i.e., the patient's disavowed effect is evoked in the therapist's emotional field). The theory also describes a dimensional model of five levels of personality organization (normal, neurotic, and high, medium and low borderline levels), based on the degree of development (integration) of a selection of central structural *domains of personality*, like identity/sense of self, quality of object relations, affect tolerance/control, maturity of defense mechanisms, and moral values (Caligor & Clarkin, 2010; Caligor et al., 2018). More elaboration on this follows, under evaluation.

1.3 | FGAP

1.3.1 | Definition

FGAP is a time-limited clinical approach that aims to relieve mental suffering, contribute to resolving internal psychic conflicts, and/or change dysfunctional interpersonal behavior. Patients suited for FGAP have relatively circumscribed problems and a limited degree of personality pathology (moderate to high level of personality organization). A treatment focus should be established ahead of therapy, consisting of symptoms, one or more internal conflicts, and dysfunctional relationship patterns. These are activated in the group, enabling therapist and group members to explore them in the here-and-now mode. The goal is for patients to change dysfunctional

behaviors, or at least initiate a *change process* that, urged on by increased understanding of underlying factors acquired during therapy, can continue after termination. The therapy takes place in a closed group with one therapist and up to eight patients who start and end at the same time. The group consists of 20 weekly sessions, each 90 min.

1.3.2 | The framework

Key FGAP framework factors are the *time limit*, *theoretical background*, dimensions of the *group format* (structure, process, and content), *interventions*, and the *objectives* and *focus* of the therapy. All aspects contribute in shaping criteria for selection of suitable patients and their preparation for the group, thus impacting group composition, treatment techniques, implementation of change, and indirectly—therapy outcome.

1.4 | Evaluation/preparation

1.4.1 | How to evaluate?

All relevant information can be collected through clinical and psychodynamic interviews, starting with actual complaints and problems and followed by the patients' developmental history, description of their personality, and information on close relationships over the years. Patterns of transference-countertransference may also be inferred from the person's description of close relationships, by the interviewer attuning emotionally to the patient and persons involved in the relationship narratives. It is also important to involve patients in exploration of "distortions" in the interactions during the interviews as these may reflect irrational attitudes, representing potential links between "there-and-then" and "here-and-now" events. This also offers opportunities for assessing the patients' ability to observe themselves, to reflect on psychological phenomena, and to see connections between inner states and overt behavior in self and others (mentalization).

1.4.2 | What should be evaluated?

It must be emphasized how important it is to diagnose degree and type of personality pathology (*level of personality organization*) for each patient, to find a central *therapy focus* based on a *psychodynamic case formulation*, and to establish a clinical diagnosis.

1.4.3 | Level of personality organization

Degree of personality organization has been *dimensionally* ranged from one to five on the following levels: n*ormal*, *neurotic*, *and high*, *medium*, *and low borderline* (Caligor et al., 2018). *Only patients assessed to be on the levels of normal, neurotic, and high borderline personality organization (levels 1–3) are found to be suitable for FGAP*. Level of personality organization is decided based on assessment of several individual structural domains of personality: *Identity* encompasses three dimensions: (i) *Capacity to invest* (in school/work/spare time, *how effective* the person is, and how much *satisfaction* these activities entail). (ii) *Sense of self*, both how *coherent* it is and if there is a feeling of *continuity* over time. (iii) *Sense of others* is checked by asking the patients to describe the most important person in their life, in detail. *Object relations* are evaluated based on the *number of friends*, and the *quality* and *stability* of friendships. Information about romantic partnerships is especially important; whether there is intimacy and sex in

combination, whether the patients are dependable or whether they have a tendency to drop friends and partners. *Maturity of defenses* is determined by the presence of higher-level defenses like *sublimation*, *humor*, and *anticipation* of stress; all defenses leading to coping and less rigidity of the personality. Lower level defenses can be tendency to *idealize/devaluate* others, *externalization*, *black and white* thinking (splitting) or suspiciousness of the motives of others. *Aggression* may be absent or out of control. It can be *directed towards the self*, for example as neglect of physical health, high-risk behavior, or a tendency to self-mutilation. When *directed towards others*, aggression may vary from irritation to loss of temper; the patient may feel bad when others succeed, enjoy other people's suffering, or have a tendency to cause psychical or physical harm to others. *Moral standards* may be more or less important in directing a person's actions. Do persons feel guilt when they do something wrong, or only when caught in the act? Some may do *immoral* things if the chances of being caught are small, others may be *too strict* towards themselves, and some may engage in criminal acts and enjoy *deceiving others*. It may also be useful to add *pathological narcissism* as a sixth dimension, a phenomenon that affects several of the domains mentioned. It is often manifested as chronic conflicts and disruptions in intimate and social relationships, by persons having a sense of self that is highly dependent on admiration from others, and by having strong feelings of envy of or preoccupation with comparisons with others.

Evaluation of personality domains gives the therapist an estimate on degree of personality pathology *and* offers leads for choice of treatment targets, which for example could be conflicts around self-esteem, specific attitudes affecting relationships negatively, or lack of tolerance for own aggression, which is acted out in covert ways. Readers with less experience in evaluating personality can be referred to Caligor et al.'s (2018, p. 552) clinical anchors for characterizing personality domains across the range of severity levels (from 1 = normal to 5 = most impaired). Lorentzen (2022; appendix) is also useful, presenting the same clinical anchors, plus eight detailed case stories of patients rated on six different personality domains.

There also exist several systems for diagnosing level of personality organization, see f. ex. Operationalized Psychodynamic Diagnosis OPD-2 (OPD Task Force, 2008), Psychodynamic Diagnostic Manual (PDM-2; Lingiardi & McWilliams, 2017), or section III within the Diagnostic and Statistical Manual-5 (American Psychiatric Association, 2013).

1.4.4 | Inventory of interpersonal problems (IIPs), self-report

It is also valuable to include the patient's *self-report* of their interpersonal problems based on their scores (from 0 to 4) on 64 statements about interpersonal transactions they have difficulties doing or do too much, resulting in eight sub-groups of typical behaviors (sub-scales): dominant, vindictive, cold, social avoidant, nonassertive, exploitable, overly-nurturant, and intrusive. Based on interpersonal theory and sophisticated geometric methods it has been shown—using the IIPs—that the best model for capturing people's distinctive features is a two-dimensional circle (circumplex) (Alden et al., 1990), with sub-scales positioned circularly around two orthogonal dimensions. One is dominance versus non-assertiveness (agency) and the other overly-nurturance versus coldness (affiliation). A graph of the different sub-scales offers detailed information on how the patients perceive their habitually behavior, which may suggest central interpersonal goals for treatment.

1.4.5 | Treatment focus

The brief duration of FGAP requires that patients have a relatively circumscribed and emotionally charged therapy focus. This is obtained by choosing central symptoms, dysfunctional interpersonal patterns, and/or conflicts that are connected by a psychodynamic hypothesis, derived from a case formulation. Aspects of the IIP-profile may also be included in this focus. This profile expresses the patient's *conscious perception* of herself, but exploration of such patterns often activates covert aspects of conflicts the patient may want to change.

2 | CASE ILLUSTRATION

One patient, Emily, who is considered to be suitable for FGAP will be described in more detail, and information on *presenting problems* and *life story* are parts of the case formulation/psychodynamic hypothesis given below. This hypothesis, in concert with aspects of the presenting problems, details from the evaluations of personality domains, and information from the self-report on interpersonal problems (IIP-C), should as far as possible be reflected in the patient's "therapy focus." Some clinical material also appears under the description of the group process, when sequences of interactions between Emily and three other group members are described.

Emily is a 28-year-old accountant who has been living with a male partner for 1 year. There are no children. She was referred for anxiety connected to leaving home, entering shops, or traveling by bus. She usually controls her anxiety but suffers occasional panic attacks with palpitations and difficulties in breathing. Diagnoses: Axis 1—panic disorder with mild agoraphobia. Axis 2—mixed PD, with a few paranoid, dependent, and obsessional traits.

2.1 | Psychodynamic case formulation

Problem areas (symptoms, interpersonal problems): Increasing anxiety in crowds the last year; similar symptoms in puberty and a few years ago after a break-up with a partner. Obsessed with thoughts that her boyfriend wants to leave her. Emily often feels unfairly treated and gets angry, which easily leads to conflicts with others. She usually thinks she has the right to speak up, but sometimes feels that *she* gets too angry and unfair with others. Often she feels that colleagues do not do their job, which leaves more work for her. A frequent complaint is that her cohabitant does not support and confirm her enough, and she is less sexually attracted to him than in the beginning of their relationship. It is difficult for her to express warm feelings, both to her partner and friends. *Stressors*: Emily has a demanding job within banking with deadlines and a shortage of staff, which "forces" her to work more. She is also obliged to pay regular visits to a cousin with severe mental problems, to make sure she is well and follows up her treatment. *Predisposing factors* (development/vulnerability): Emily is number two of three siblings and was early told that the birth of a brother strongly affected her; she regressed in behavior, cried a lot for a period, and alternated between clinging to and rejecting mother. Her father was often strict and had an unpredictable temper, she being so ashamed for this, that it was difficult to bring friends home. Her mother was shy and timid, and although she was more caring, Emily felt she let them down by trivializing father's behavior. Mother cared for a sick nephew and some old people in their neighborhood, making Emily feeling jealous and neglected. She did well at school and in sports, but her parents rarely followed up on her activities. She was good-looking and always surrounded by boys. She liked attention, but although she had a couple of short romances, the boys seemed less important to her than the other girls in her class, or the group of girls she shared a flat with, when she started studying economy at the university. Her parents divorced when Emily was 15, allegedly under pressure from her mother. Emily felt a relief, but did experience her first onset of panic attacks, shortly after this. *Psychodynamic hypothesis*: Some object representations are colored by anger/dominance (father) and emotional distance (mother), and some self-representations seem less integrated, representing more needy, lonely parts of her. Existence of some good friendships indicate, however, that she has experienced early closeness. She easily feels victimized but fights against "becoming as timid as mother was in her relation to father." It is better to "hit back" and "demand respect" when others behave unjustly. She resents colleagues at work "who don't do their job or who skive." She often sees people in "black or white"; some are OK, while others are completely reprehensible. She tries to suppress longings and control anger, or "transform" such feelings into activity through exercise and hard work. Her anger often seems activated when underlying longings for closeness and care are not met, which again may be a "trigger mechanism" associated with her panic attacks. Emily's reactions to her "loss of mother" when a brother was born, indicate a vulnerability for feeling abandoned. She seems to have an impaired ability for intimacy and empathy, as demonstrated by lack of concern for boyfriends and her cohabitant. Her ambivalence towards him and suppression of thoughts about leaving him may, via projection manifest itself as

obsessive fears of being abandoned. Her "demand" to be confirmed (sense of entitlement) and denial of a need for reciprocity, are narcissistic features that should be activated and explored further in therapy.

2.2 | Therapy focus

During the evaluation and through the therapist's exploratory questions, Emily "lets go of" her previous idea that her anxiety is only due to her fear of a panic attack. The therapist's hypothesis of a possible connection between panic attacks and suppressed anger, which may be activated when she feels let down, seems to have given her something to think about. She also seems to accept the idea that suppression of feelings of emptiness and pain may cause her to feel less empathy in close relationships. The focus in her therapy is therefore to explore what kind of strategies she uses to keep painful feelings away. She should also explore whether her frequent harsh remarks, sarcasms, and critical outbursts are in proportion to the events that triggered such reactions, and possibly start to work on finding more acceptable ways of conveying her anger and the boundaries she sets for herself. She was also encouraged to explore the reciprocity in her relationship with her cohabitant, and her ability/desire for closeness and intimacy. She was also given a behavioral task and was instructed to "practice empathy" by showing concern directly through comments when others disclose something painful, and to inform the group when she feels hurt, preferably in a socially acceptable way.

2.3 | Interpersonal problems

Emily's self-report on interpersonal problems indicates that she perceives herself to be more vindictive (focused on herself), domineering, and intrusive, but at the same time also less assertive, and slightly more exploitable and cold (reserved), than others. This profile may indicate *a conflict between self-images*, on the one hand feeling exploited and subdued/dominated, on the other hand perceiving herself as more cold, vindictive, and domineering than others.

2.4 | Personality pathology (level of personality organization)

She was evaluated to have a weakened *ego identity* and a shaky *self-esteem*, manifested as an impaired ability to give a coherent description of herself and others. She also has quite a few conflicts in her closest relationships (*object relations*). Some of her *defense mechanisms* are mature (suppression, reaction formation), but she has a moderate tendency of using projection and black and white thinking. She has more contact with anger than with loving and tender feelings, and she feels that she sometimes gets too angry. She has a strict, punitive *superego* and appears somewhat critical and judgmental, more towards others than herself. Pathological narcissism is slightly increased, she needs much confirmation from others and has a tendency of self-righteousness, feeling better than and that she deserves more attention than others. This indicates that she functions on a *high borderline level* of PO, based on the evaluation on the six personality domains described in more detail previously.

3 | THE COURSE OF TREATMENT (THE GROUP PROCESS)

A frequently reported experience is that closed groups have at least four relatively distinct and characteristic phases: engagement, differentiation, interpersonal work, and termination. Each phase represents specific challenges for the therapists, patients, and the group, which must be "solved" before the group/members can progress (Lorentzen, 2014). The *engagement phase* (lasting 2 to 4 sessions) is often colored by members' positive feelings of

"being in the same boat," but also by anxiety whether one will be accepted by the others or not. In the first session the therapist welcomes all patients and invites each to take turns introducing themselves and disclosing the therapy focus they have negotiated with the therapist. The therapist comments and asks clarifying questions, ties similar themes together and invite responses from the other patients. The uniqueness of the group and how it is different from other social situations is underlined, and thus the building of *boundaries* around the group and the development of an analytic culture has started. In the *differentiation phase* (2 to 4 sessions) the patients start to position themselves, wondering "who is important or not so important," and "will I be able to assert myself in the group?" Sometimes there is some friction when one or more members will establish their position by challenging the therapist. Bonding between members began at the start of the group and continues at this stage, when also strategies for reflecting back to others, for positioning, and for disclosing vulnerable parts of themselves, have to be developed. The therapist uses the characteristics of the different phases both as a back curtain for understanding the present dynamics in the group *and* to promote the progression of the group. The phase of *interpersonal work* is the longest (8 to 12 sessions). Although narratives are welcomed, most of the therapeutic work should take place in the here-and-now, where dysfunctional interpersonal patterns become manifest.

In the following some interactions between Emily and three fellow group members are presented. It was early in the *interpersonal phase* when someone commented that Emily seemed somewhat angry and hurt. Could she, please, tell what had happened? She answers irritably, that she had been interrupted by John in the middle of a sentence, when she just told about how she felt let down by her partner, who did not pay enough attention to her at home, and who often did not listen when she complained about how she was exploited at work. John is a young taxi driver who could often be rather intrusive and not so empathetic, and his therapy focus was to work specifically with aspects like empathy, being a more attentive listener, and trying to understand others better. John reacted with anger to her answer, and said he especially resented that she found him impolite when he addressed her. Anne, a middle-aged teacher sided with Emily, as she too had experienced John as rather insensitive. Fred, who has problems with aggression and easily reacts with submission or turning away when conflicts materialize and tension starts to increase, immediately started to insist that John had not interrupted at all, but had tried to tell about something positive he had achieved at work.

These sequences are typical of a free group discussion where four patients "comments on" each other, disclosing aspects of slightly dysfunctional, relational patterns that they happen to have included in the focus they have chosen to work within the group.

3.1 | Intervention-group work

The therapist who for a while quietly had observed the group, had noted how John brushed Emily away when she criticized her cohabitant. He also noticed how her slightly aggressive response recruited support from Anne and forced Fred to enter the arena to cover up signs of a conflict. It struck the therapist that John himself was left and let down by his *father* as a child, a father that was rather emotionally distant and eventually left mother and moved to another city, and how John ever since had stubbornly denied feelings of loss. The therapist wondered furthermore, if Emily's story had created imbalance in John's internal world, where painful feelings coloring self- and object-representations–tying father and John together–had earlier been repressed.

The therapist decided to explore this sequence, aware of the fact that persons involved might not be aware that parts of their treatment foci had been activated, but at the same time feeling that the group felt safe enough to work on these issues. The intervention could simply be: "Let's stop–I think something important is happening here!" All group members are then invited to explore the events which all had shared. The attention is now moved from the *manifest level* of the sequence of interactions, to the dynamic determinants of the relational patterns (*latent level*), which are more idiosyncratic and personal for each member. The sequence potentially offers an arena for learning by having a «corrective emotional experience» (Palvarini, 2010), an important event that in concert with other therapeutic factors in groups like for example interpersonal learning, group cohesion, and development of

socializing techniques, may impart enduring changes. By taking the actual sequences in the here-and-now as a point of departure and by defining the negative aspects of the squabble as attempts of communication, it may be possible to stimulate the members to explore and reflect, possibly leading to insight and new learning. Doing so would be in contrast to a typical escalation of conflicts and repetitions of formerly meaningless, destructive, and retraumatizing quarrels.

To initiate *the termination phase* (2 to 3 sessions) the therapists may have to remind the group that the end is approaching. The therapist tasks are now to bring the group to an ending and to evaluate the results of therapy, with *reference to planned focus*. The complexity of these tasks may vary, depending on group members. Most of them may report that many issues have been resolved, they have changed in specific areas, and/or entered a promising change process that will continue, after the end of therapy. Some may be more disappointed, feel helpless, or even angry because less than hoped for has happened. The therapist should empathetically contain such feelings, represent reality, and evaluate treatment outcomes according to therapy goals, and be alert to underlying feelings of separation and loss. Some patients may want to immediately continue in a second treatment, something that probably should be discouraged or postponed since constructive afterthoughts often appear in the months following a successful psychodynamic therapy.

3.2 | The therapist

In FGAP, the therapist is more active, directive, and transparent than in longer therapies. It is convenient if the therapist also has been the one who evaluates and selects patients to the group, both to establish bonding as early as possible, and to ensure that he/she has first-hand knowledge of the patient when the group starts. The patient should both be willing to and have the ability to work on change from the start of therapy, and it is promising when someone demonstrates an increased interest in self-exploration and constructive use of cues from the therapist during evaluation. This was the case with Emily when she was confronted with conflictual self-images, feeling both exploited and subdued, at the same time seeing herself as more vindictive, cold, and dominating than others. Similarly, John started to give up his self-sufficient attitude during the preparation period, which made it possible for him to start working on his formerly suppressed longings for intimacy, once the therapy started. Therapists should *stimulate* and *moderate* the development of relationships between group members from session one and be *models* for wished-for interpersonal transactions, thus starting to build a constructive group culture. An important objective of FGAP is for members to get some distance from *and* understand more of their central personal, *dysfunctional* interpersonal patterns (obtain *insight*) and preferably change some of these. A main therapist task is therefore to *uncover meaning* by exploring latent determinants of individual behavior and interactions, particularly conflictual ones. Interventions meant to effect *activation/confrontation* or *support* should be balanced according to the needs of the group and single patients. Therapists are usually more active in the beginning or if the group stalls but should step back when group members work well. Other main tasks are to maintain the group's structure, remind patients of their therapy *focus* and to work in the *here-and-now*.

4 | OUTCOME AND PROGNOSIS

4.1 | What happened to Emily?

Emily had already during the evaluation sessions understood that her anxiety was related to underlying feelings of aggression, emptiness, and longings, activated when she felt neglected. In the group, she learned that she had a tendency of projecting feelings of incompetence and weakness (sadness, helplessness) onto others, while she warded off such feelings by restless activity and hard work. Consequences of harsh comments to fellow group

members were explored in the group, and she gradually became more proactive by recognizing wishes for support in herself, sharing these with the others. After termination, she rated herself as less cold and vindictive, less exploitable, and more nurturant (warm), than before therapy, and she also reported that she gradually had become less critical of her cohabitant. At follow-up, 2.5 years later, she reported that she missed the group and experienced grief for a period after termination. She had not experienced any more anxiety attacks, she could still at times see herself as too domineering and somewhat sarcastic at work, but her relationships with colleagues were strongly improved. She rated herself as less cold and more nurturant on the IIP-circumplex. Her relationship to her cohabitant was further improved and they had recently planned to have a baby.

5 | CLINICAL PRACTICE AND SUMMARY

5.1 | Who can benefit from FGAP?

The main assertion in this paper is that patients with a mild to moderate degree of personality pathology will more likely profit from FGAP than those with more serious pathology, who may need more time to change. Presence of this criterion and identification of interpersonal problems and symptoms rooted in latent internal conflicts (e.g., between opposing self-images or contrasting wishes for autonomy or dependency), that the patient is interested in exploring, are often better prognostic signs than a descriptive clinical diagnosis (DSM or ICD). Evidence that supports this idea springs from the formerly cited RCT comparing change in group therapies of different lengths (Fjeldstad et al., 2016; Lorentzen et al., 2015). In other words, compared to patients with severe personality pathology, patients having a normal, neurotic, or a high level of borderline personality organization are more likely to benefit from FGAP. They should also be able to be content after being helped with a limited number of problems. Patients with a tendency of *acting out* may also benefit from FGAP even if they have a moderate degree of personality pathology, if the impulsive behavior has been identified and explored thoroughly as a potential threat ahead of start, possibly even been selected as *the* focus for the treatment. This means that FGAP will be suitable for many patients with both symptom neuroses and limited areas of personality pathology, but also patients with mild to moderate personality disorders, all patients who are referred to university consulting centers, public out-patients clinics, day care centers, and private-practice. Patients with severe personality disorders, psychosis, drug/alcohol addiction, and organic conditions are not suited for this therapy.

It is important to remind the reader, however, that the amount of research on this specific new treatment is scarce, and it is possible that more patients could be included in these groups, if this treatment to various degrees was combined with use of medication, individual consultations and/or family therapy.

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