The role of attachment dimensions in reducing interpersonal problems in training group analysis

A naturalistic effectiveness study

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*A naturalistic effectiveness study*

*I was not the composer who wrote the music, but the conductor who interpreted it, the conductor who brought it to light. I remember saying to my colleagues: ‘I feel like a conductor but I don’t know in the least what the music is which will be played’.*

S. H. Foulkes, 1948
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Abstract

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Title: The role of attachment dimensions in reducing interpersonal problems in training group analysis
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Background: Research has suggested that therapists differ in their effectiveness (e.g., Baldwin & Imel, 2013); however, less is known about favorable therapist characteristics, especially for group therapy outcomes. The current study is part of a larger project investigating the personal and professional development of trainees that undergo group-analytic training including participation in experiential groups at the Institute of Group Analysis and Group Psychotherapy (IGA) in Oslo. A description of the larger project is given in a separate report (Leitemo & Vestbø, 2017). In this larger study we found a significant reduction in trainee self-reported interpersonal problems over a training period of 10 months.

Objective: The aim of the current study was to explore whether measures of attachment dimensions (i.e., anxiety and avoidance) in the trainer (group analyst), the trainees and in the group, as well as measures of therapeutic relationships quality in the group, could explain the change in trainee interpersonal problems found earlier. Of interest were both direct effects of attachment dimensions as well as possible interactions between the participants’ attachment dimensions on change in interpersonal problems.

Method: In total, 53 candidates and 8 trainers involved at the IGA training program participated in the study. The participants completed the Circumplex of Interpersonal Problems at the beginning and at the end of the study period, the Group Questionnaire at the beginning of the study period and the Experiences in Close Relationships just prior to the study period. Due to the hierarchical nature of the data, we used multilevel modeling in order to analyze the impact of attachment dimensions on change in trainee interpersonal problems.

Results: We found that lower attachment anxiety in the trainer group analyst and in the group (modelled as the group members’ average level) predicted a reduction in trainee interpersonal problems. Furthermore, we found a significant interaction effect suggesting that trainees with higher levels of attachment anxiety benefitted from participating in a group with higher average level of attachment avoidance. Measures of the quality of group relationships were insignificant predictors of trainee outcome.
Conclusion: Our findings support the use of attachment theory as a valuable framework to understand differences in group therapist and group effectiveness and as a promising avenue for future group psychotherapy research.

Keywords: attachment; group psychotherapy training; therapeutic factors; therapist factors; group factors; group composition
Preface

We are indebted to the Institute of Group Analysis and Group Psychotherapy (IGA) for their warm and generous attitude towards our initiation of this project. As one of the first training institutions of analytic psychotherapy to let researchers examine their practice, they state an example for serious training institutions that want to validate their practice and education. We are in particular indebted to Anna Benkø, Synnøve Ness Bjerke, Christian Hjort and Diana Schart. IGA has generously paid both for postage and NOK 20,000 to one of the authors (HSBV) for scoring the questionnaires. We are further grateful to all of the participants in the project which diligently and generously responded to the many questionnaires they were given. We hope that the insights gained in the present study made their contributions worthwhile.

I (KL) would also like to take this opportunity to thank Paul Moxnes and Leif Braathen for encouragement and inspiration for becoming a psychologist and a group analyst, which has filled my life with increased spiritual and deeper meaning.

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1 Introduction

What is important for psychotherapeutic change? In today’s discourse and debate around evidence-based practice, one might be lead to believe that the answer lies in the specific psychotherapy method (e.g., cognitive-behavioral, psychodynamic, interpersonal etc.). However, research suggests that the choice of psychotherapy method in itself explains comparatively little of the variability in psychotherapy outcome for the general patient population. In a meta-analysis conducted by Wampold and Brown (2005), variations in treatment methods were found to explain less than 2% of the variability in therapy outcome. In contrast, the psychotherapy literature has provided evidence that therapists differ significantly in their effectiveness (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Kim, Wampold, & Bolt, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Bolt, 2006). Although the magnitude of ‘the therapist effect’ varies somewhat from study to study, meta-analyses show that the effect of therapists in general accounts for between 5-7% of the outcome variation (Baldwin & Imel, 2013; Benish & Imel, 2008; Laska, Gurman, & Wampold, 2014). A growing body of research has been conducted in order to identify the personal characteristics of effective therapists. This study joins in the ranks of this research literature, and extends previous findings by examining possible group therapist factors.

The purpose of the present study was to examine whether and how the attachment dimensions of the trainer group analyst, the group, and the individual trainee in group-analytic training groups affect the outcome of training measured as change in trainee interpersonal problems. Attachment theory was created by Bowlby (1969/1982) to describe how the bonds between an infant and its caregivers provide a system that is activated when the infant needs safety from threats - a safe harbor - which also acts like a safe base from which to explore the world. How well the caregiver is able to satisfy such needs influences what kind of working model the infant and the later grown up will internalize (Bowlby, 1973). As proposed by Bowlby, these working models procedurally and implicitly prescribes how individuals will handle threats by relying, or not relying, on close relationships. Group psychotherapy involves the likely activation of the attachment system as both the interpersonal interactions and the material dealt with can create anxiety in both the group therapist and the group’s members. The ways in which the therapist and the members handle such anxieties can be predictive of how much of a safe base the group provides for therapeutic explorations.
The present study is part of a larger project initiated and led by the authors investigating the personal and professional development of candidates at the Norwegian Institute of Group Analysis and Group Psychotherapy (IGA) in Oslo. The ultimate goal of this larger project is to provide knowledge about favorable group therapist characteristics, and whether group-analytic training might facilitate these characteristics.

This dissertation is organized as follows. The first part presents a review of the group psychotherapy research literature and its expected healing mechanisms. This provides a needed background to understand the setting of the present study. Before we present attachment theory and the associated empirical evidence for its significance in both individual and group therapy, we present a review of how the literature has related therapist characteristics (factors) to favorable group therapy outcomes. Finally, we present our research questions about the role of attachment dimensions and relationships quality in influencing the outcome of group analytic training. The study is then described and its methodology is presented along with the results. Finally the findings and their implications are discussed.

In the following, we use the term ‘trainer group analyst’, ‘trainer’ or ‘conductor’ when referring to the leaders of the training groups, whereas the members constituting the group-analytic training groups will be referred to as ‘trainees’ or ‘candidates’. Moreover, when we use the term ‘aggregated group members’ we refer to the average level of the group members’ scores on a given measure.

1.1 Group psychotherapy

Group psychotherapy shares many aspects with individual psychotherapy. This includes the goals of therapy of both intrapersonal (i.e., symptom reduction and increased well-being) and interpersonal (i.e., reductions in interpersonal difficulties and improved relationships) nature, and the establishment of an open, facilitative and safe environment in which problems can be explored. However, the ways of establishing such an environment in group and individual therapy, respectively, may be different. There are a number of reasons for this. A plain fact is that group therapy involves more patients than individual therapy, and the group leader or conductor has to intervene at several group levels as described by group systems theory (Agazarian, 2001). At the intrapersonal level, the leader has to address the individual in the group, by either supporting, drawing out or blocking individual interactions. At the interpersonal level, the leader has to address interactions in the group, by modeling, linking (increase awareness of how the topics discussed are relevant for others in the group) and
facilitate feedback among members. At the group level, the leader has to address the group-as-a-whole, reframing and providing alternative viewpoints, using self-disclosure, and encourage reflection on (or processing of) what is going on in the “here and now” of the group (Luke, 2014). A good conductor employs such skills effectively within the frame of his or her own personal qualities. In this sense, one might say that the group therapist must have a wider set of qualities or skills compared to the individual therapist. Also, the relative importance of each skill may be expected to be different in the two therapy formats, as some qualities are likely to be more important in individual therapy and others in group therapy.

The group members (including the therapist) are both influenced and affected by, as well as influencing and affecting each other. Each member may exhibit actions that are more or less therapeutic for the other members as well as actions that are meant to elicit help from the others. Hence, each member of the group is both in the role of a therapeutic agent and a patient. The group therapist’s task is therefore not only to help each member (which corresponds to the individual therapist’s task) but also to help the group and its members to help themselves in the group - that is, to facilitate the establishment of a therapeutic climate in the group-as-a-whole. In this sense, the role of the group therapist may be compared to that of a (musical) conductor that trains and facilitates his or her orchestra to play together (Foulkes, 1948). The musical conductor works sometimes with the individual musician, sometimes with subgroups in the orchestra but most often with the orchestra as a whole to “... bring out the harmonies and discords” (Schlapobersky, 2016, p. 302). Whereas the comparison to the musical conductor is relevant, conducting a group often involves more improvisation than orchestration as the work is done without a score (Schlapobersky, 2016). In working with the group, a good conductor facilitates the use of group members’ ego or personality functions for the benefit of the group and its individuals in such a way that group analysis becomes “ego training in action” (Foulkes, 1964, p.82).

1.2 What makes group psychotherapy effective?

The question of what makes group psychotherapy effective and which mechanisms and experiences that are involved in promoting a favorable group therapeutic outcome, has been addressed by several researchers (see Kivlighan & Kivlighan, 2014, for a review). Yalom, Tinklenberg and Gilula (1968) provided evidence of 12 therapeutic factors in group therapy: interpersonal learning (input and output), catharsis, cohesiveness, self-understanding, existential factors, universality, instillation of hope, altruism, corrective reenactment of family
dynamics (i.e., identifying and changing the dysfunctional patterns or roles one played in the primary family), guidance and identification. Subsequent research has suggested a rank ordering of these and other therapeutic factors in different groups (Kivlighan & Holmes, 2004). Whereas acceptance, catharsis and interpersonal learning seem to be more important in affective insight groups, acceptance, instillation of hope and universality seem to be more important in affective support groups. In this sense, the therapeutic factors related to a good group therapy outcome might depend on the particular type of group conducted. It is reasonable to hypothesize that the realization of these factors stem, in part, from the therapist’s characteristics and skills in activating them.

Psychometric investigations suggest that group therapeutic factors load on a smaller number of latent factors (e.g., Dierick & Lietaer, 2008). MacNair-Semands, Ogrodniczuk and Joyce (2010) developed a short form of the Therapeutic Factors Inventory (TFI-S) and found four underlying therapeutic factors: Instillation of hope, Secure Emotional Expression, Awareness of Relational Impact, and Social Learning, which correlated in the small to moderate range with measures of therapeutic outcome.

Another strand of group therapeutic research builds on the results from individual therapy showing that the quality of the therapeutic relationship is an important predictor of change. The group questionnaire (Krogel et al., 2013) conceptualizes the therapeutic relationships in a group therapeutic setting to both the leader, to the other members and to the group itself. Several aspects of the therapeutic relationship are assessed: positive bonding and negative relationship as well as working relationship operationalized as an understanding of the aims and tasks of therapy. One of the concepts measured by the member’s bonding to the group - cohesion - has been found to be a consistent predictor of therapeutic outcome in group therapy (Burlingame, McClendon, & Alonso, 2011). The concept usually refers to a group atmosphere where the members feel a sense of belonging and commitment (Burlingame, Fuhriman, & Johnson, 2002). In their meta-analysis, Burlingame et al. (2011) found a significant relationship between group cohesion and outcome measures ($r= .25$) corresponding to about 6% of the outcome variance.

Different therapy schools teach different techniques and treatment methods to promote or activate usually a subset of the above mentioned or other therapeutic factors (e.g., intrapersonal insight into conflicts and transference) and mechanisms (e.g., the resolution of transference). For the group-analytic approach, Lorentzen (2014) has provided a manualized description. However, for the purpose of our study, the literature reviewed here is restricted to
the characteristics associated with an effective therapist in order to promote a good group therapeutic outcome.

1.3 Therapist Factors in Group Therapy

The need to understand why some therapists seem to perform better than others in terms of effectiveness, has been emphasized in several studies, especially in the individual therapy research literature (e.g., Baldwin, Wampold, & Imel, 2007; Dinger et al., 2008; Kim et al., 2006; Nissen-Lie, Monsen, & Rønnestad, 2010). Less is known about favorable therapist characteristics for group therapy outcome. However, Lieberman, Yalom and Miles (1973) represent an important starting point in this type of research. Their study represents an attempt at identifying group therapist characteristics (or functions) across different types of groups, and is thus an important contribution to the common factor approach. They identified four important characteristics: Caring, executive function, emotional stimulation and meaning-attribution. Caring includes the concern of the well-being of their group members and their investment in their own skills and interventions used. Executive function refers to how effective the group leader is in establishing boundaries, expectations and group norms. Emotional stimulation refers to the leader’s effort to facilitate members’ expression of themselves. Finally, meaning-attribution refers to the manner in which the group leaders promote not only members’ understanding of themselves but also understanding of others. Lieberman et al. (1973) concluded that high levels of meaning attribution and caring, and moderate levels of executive function and emotional stimulation were associated with the best outcome.

Burlingame et al. (2002) and Burlingame, MacKenzie and Strauss (2004) found that group leaders who exhibited warmth and caring had better therapeutic outcomes than group leaders who exhibited less. Furthermore, higher levels of group leader empathy have been found to predict stronger alliances (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Marziali, Munroe-Blum, & McCleary, 1997) as well as more supportive relationships with group members (Burlingame, Strauss, & Johnson, 2008; Dies, 1994). Some evidence suggests that a group leader who provides structure (i.e., establishing boundaries, expectations and group norms) may be related to subsequent higher levels of group member involvement (Dies, 1994; Schimmel & Jacobs, 2011). Such involvement seems to be predictive of the development of group cohesion (Johnson, 2010). A passive leadership style (DeLucia-Waack,
or one that includes aggressive or untimely confrontations may cause disengagement and dissatisfaction among members (Schimmel & Jacobs, 2011; Dies, 1983; 1994).

Taken together, evidence suggests that therapist competencies such as the capacity for empathy and the concern of the group members’ well-being are related to better group therapeutic outcomes, whereas aggressive or untimely confrontations may cause disengagement among the members. As the group therapist has to intervene at several group levels, handling the combined emotional states presented through the members’ intrapersonal and interpersonal dynamics, it could at times be emotionally challenging for the therapist to contain the group’s anxieties and insecurities. The therapist’s and the group’s ability to handle these anxieties might be dependent of how much safety that has been internalized through prior relationship experiences. A useful framework, within which to understand whether and how prior relationship experiences can facilitate such safety in the therapist as well as the group, is that of attachment theory.

1.4 Attachment theory

Attachment theory is a developmental theory of interpersonal relationships, which offers a valuable framework within which to explore therapeutic processes (Bowlby, 2008). According to attachment theory (Bowlby, 1988), primary caregiver relationships in early childhood lay the foundation for adult attachment strategies and internal working models of self and others. If caregivers are reasonable consistent in their responsiveness to the child’s needs, the child will develop positive models of the self and others. In contrast, inadequate caregiver responsiveness may lead to the development of insecure attachment involving negative models of self, or of others, or both. These early attachment patterns influence future relationships and the attachment styles seen in adulthood (Bowlby, 1988; Sroufe, Egeland, Carlson & Collins, 2005).

Building on the initial work applying an attachment perspective to adults (e.g., Hazan & Shaver, 1987; Main, Kaplan, & Cassidy, 1985), Bartholomew (1990) systematized Bowlby’s definition of attachment representations into a four-category classification of adult attachment. According to Bartholomew’s (1990) model, attachment can be considered in terms of two dimensions: attachment anxiety, which reflects the degree of fear of abandonment and interpersonal rejection; and attachment avoidance, which reflects the degree of discomfort with interpersonal closeness and intimacy.

These dimensions have also been conceptualized in terms of models of self and others
From this categorization, four prototype attachment patterns have been derived: secure; preoccupied; fearful; and dismissing. Securely attached individuals are characterized both by an internalized sense of self-worth and comfort with intimacy in close relationships. Preoccupied individuals have a negative model of the self and a positive model of others; they are preoccupied with their attachment needs and motivated to validate their precarious self-worth through excessive closeness in personal relationships, and are often overly dependent on others. These efforts to elicit others’ involvement through controlling responses, as well as attempts at minimizing distance to others are often referred to as *hyperactivating* attachment strategies (Mikulincer, Shaver, & Pereg, 2003). Fearful individuals both have a negative model of the self and others; they are highly dependent on others for the validation of their self-worth, but avoid intimacy due to fear of rejection. Dismissing individuals have a positive model of the self and a negative model of others; they tend to avoid closeness with others because of negative expectations and maintain their high sense of self-worth by defensively denying the value of close relationships, and stressing the importance of independence (Bartholomew & Horowitz, 1991). Dismissing individuals typically display *deactivating* attachment strategies, which include efforts to keep relationships to others as distant. The four prototype patterns for adult attachment are illustrated in Figure 1.

![Figure 1. Bartholomew’s (1990) model](chart.png)
Although attachment patterns are hypothesized to be self-perpetuating, there is evidence suggesting that attachment patterns can be stable across significant proportions of the lifespan yet remain open to changes, in either a positive or negative direction, as a result of life stressors and changes in key relationships (Waters, Hamilton, & Weinfield, 2000). Individuals typically seek therapeutic help at times of interpersonal distress. As the attachment system is activated in these situations, the system is thought to play a central role in guiding the therapeutic relationship.

There is a growing recognition that there is a positive relationship between client attachment security and better working alliances as well as more favorable treatment outcomes (Berant & Obegi, 2009; Diener & Monroe, 2011). Although an increasing number of studies have emphasized the effect of therapist attachment on alliance and outcome, these studies have been conducted in an individual therapy setting. To our knowledge, no previous studies have investigated the group leader’s attachment dimensions and how they influence group therapy outcome. However, as Agazarian (2001) has emphasized, the individual focus (i.e., the intrapersonal level) is an important part of group therapy. Thus it might be useful to look at the individual therapy research literature, as findings regarding the impact of therapist attachment dimensions in individual therapy might matter for the group therapist as well.

### 1.5 The impact of the therapist’s attachment dimensions

Transferred to psychotherapy, Bowlby (2008) suggested that the role of the therapist is to act as an attachment figure by creating a secure base for the distressed client, providing clients with space and safety to explore themselves and their interpersonal environment as well as providing a corrective emotional experience to disconfirm insecure working models. More recent research indicates that clients can develop more secure attachments as a result of both individual (Taylor, Rietzschel, Danquah, & Berry, 2015) and group therapy (Kirchmann et al., 2012; Kinley & Reyno, 2013; Maxwell, Tasca, Ritchie, Balfour, & Bissada, 2014).

Mikulincer and Shaver (2007) argue that an individual’s ability to function as a caregiver can be related to his/her own experiences with attachment figures; therapists who have experienced a rejecting or neglectful caregiver may find it more difficult to create feelings of security in the therapeutic relationship and to behave in ways that will help clients to challenge their attachment patterns. This idea has led researchers to examine the effect of therapist attachment on alliance and outcome, with mixed findings.

Whilst there is some evidence that therapist attachment security influences therapist
and client evaluations of the working alliance (Black, Hardy, Turpin, & Parry, 2005; Bruck, Winston, Aderholt, & Muran, 2006; Dunkle & Friedlander, 1996), particularly when treating more distressed patients (Schauenburg et al., 2010), there is also evidence that shows no direct association between therapist attachment security and alliance, when rated by clients (e.g. Petrowski, Nowacki, Pokorny, & Buchheim, 2011). However, in relatively inexperienced therapists, evidence suggests that therapist attachment anxiety is linked to poorer client-rated alliance (Dinger, Strack, Sachsse, & Schauenburg, 2009), particularly over time (Sauer, Lopez, & Gormley, 2003).

The evidence regarding therapist attachment and outcome is also mixed. In their longitudinal study, Bruck et al. (2006) found that therapist attachment security correlated with reduced interpersonal problems and target complaints following therapy. Furthermore, the same study found that therapist attachment anxiety was related to worse patient-reported global functioning and psychiatric symptoms, and therapist attachment avoidance was related to reductions in patient-reported global functioning and greater interpersonal problems (Bruck et al., 2006). However, other studies have failed to find a direct association between therapist attachment and outcome (Schauenburg et al., 2010; Tyrrell, Dozier, Teague, & Fallot, 1999; Wiseman & Tishby, 2014).

The absence of consistent findings regarding the effect of therapist attachment on alliance and outcomes might be explained by findings of significant *interactions* between therapist and client attachment patterns to produce a combined influence on the alliance and outcomes. Tyrrell et al. (1999) found that clients with a more avoidant attachment style formed stronger alliances and achieved better outcomes with therapists who were less avoidant, and vice versa. Similarly Bruck et al. (2006) found that the greater the dissimilarity between client and therapist attachment styles, the better the client’s treatment outcome. Furthermore, Petrowski et al. (2011) found that clients, with a more insecure attachment style with highly preoccupied and disorganized features, evaluated the alliance as more satisfying with a therapist that was more avoidant rather than anxiously attached.

Taken together, some studies suggest that matching therapists and patients with dissimilar attachment styles (i.e., avoidant or anxious) might enhance the therapeutic relationship and foster more positive therapeutic outcomes. However, contrary to these findings, other studies have found a beneficial outcome of similarity between client and therapist attachment (Wiseman & Tishby, 2014), while some studies have failed to find interaction effects between therapist and client attachment styles (Romano, Fitzpatrick, &
Janzen, 2008). Thus, the literature does not provide consistent conclusions regarding the interaction between therapist and client attachment styles in terms of effects on alliance and outcome.

1.6 Attachment in group psychotherapy

In contrast to a relatively large amount of literature applying attachment theory to individual psychotherapy (Levy, Ellison, Scott, & Bernecker, 2011), research on group psychotherapy and attachment has been sparse (Markin & Marmarosh, 2010). Given that attachment dispositions affect people’s cognitive and behavioral processes, it follows that attachment dimensions affect how members engage with one another in groups. Securely attached group members are likely to perceive group relationships as positive, and will act in an involved, open and engaged way (Mikulincer & Shaver, 2007). Members higher in attachment anxiety are likely to perceive the group and the other members positively but see themselves as unworthy of the support of the group to a greater extent. They will often monitor the others for signs of rejection, and constantly seek support and reassurance from the group. Members high in attachment avoidance are likely to perceive the group and the others more negatively, and tend to be reluctant to involve and engage in the group. Evidence from empirical studies supports these theoretical considerations: greater discrepancy between self-rated cohesion to the group and the group’s rating of the individual’s cohesion has been found for anxiously attached individuals (Gallagher et al., 2014b). Moreover, lower rates of self-disclosure, more negativity towards others (Shechtman & Dvir, 2006), and less engagement (Illing, Tasca, Balfour, & Bissada, 2011) have been found for avoidant members.

Overall, studies investigating the relationship between attachment patterns in the group members and group therapy outcome have not been consistent. While some studies suggest a positive influence of member’s attachment security on outcome (e.g. Meredith, Strong, & Feeney, 2007; Meyer, Pilkonis, Proietti, Heape, & Egan, 2001), others suggest an advantage of attachment avoidance (Fonagy et al., 1996) or attachment anxiety (Sachse & Strauss, 2002, as reported in Marmarosh, Markin, & Spiegel, 2013). As suggested by Kirchmann et al. (2009), the lack of consistent results might be explained in terms of different mediating variables (e.g., composition of the group in terms of attachment status) and the type of group therapy.

Over the past 10 years, research by George Tasca and his research group have made significant contributions regarding the type of group therapy as a moderating variable on the
relationship between client attachment and therapy outcome. In one of their first studies, Tasca et al. (2006) found that level of individual attachment anxiety differentially predicted treatment outcome in two different group therapies for binge eating disorder, Group Psychodynamic Interpersonal Psychotherapy (GPIP) and Group Cognitive- Behavioral Therapy (GCBT), respectively. Whereas GPIP led to better outcomes for members higher in attachment anxiety, GCBT led to better outcomes for those lower in attachment anxiety. Furthermore, they found that group cohesion helped explain the positive relationship between attachment anxiety and outcome in GPIP. From a theoretical point of view, it is reasonable to infer that individuals with greater attachment anxiety require an increasing sense of security (i.e. engaged group climate and cohesion) in the group to benefit from the treatment. In support of this, Tasca, Balfour, Ritchie, & Bissada (2007) found that anxiously attached individuals who received GPIP reported an increasing alliance to the therapy group as sessions progressed. In the same line, a recent study by Gallagher, Tasca, Ritchie, Balfour, and Bissada (2014a) found a significant interaction between cohesion and outcome in short-term groups for binge eating disorder, but only for members with high levels of attachment anxiety. For members lower in attachment anxiety, cohesion was not related to outcome.

With regard to attachment avoidance, Tasca and colleagues have found that individuals with higher attachment avoidance had greater rates of dropping out of group-based treatments (Tasca et al., 2006; Tasca, Taylor, Ritchie, & Balfour, 2004). Moreover, those with higher attachment avoidance did also report a decreasing alliance to the group as the group therapy progressed (Tasca et al., 2007). These results indicate that unlike more anxious group members, members higher in avoidance might feel uncomfortable with the pull to engage and self-disclose in the group, and are at higher risk of dropping out of the group (Shechtman & Dvir, 2006; Tasca et al.,

The growing clinical and empirical literature applying attachment theory to psychotherapy has emphasized the importance of the attachment dispositions of group members to the process and outcome of group therapy. The literature reviewed in this section has suggested that securely attached group members are more likely to be able to engage in productive in-group behaviors such as acting involved, open and engaged (Mikulincer & Shaver, 2007). Those who are high on attachment anxiety might be especially sensitive to interpersonal feedback and thus require an increasing sense of cohesion to the group to benefit from the treatment (Gallagher et al., 2014a; Tasca et al., 2007). Those who are high on attachment avoidance might struggle with the pull to engage and self-disclose in the group, and are at higher risk of dropping out of the group (Shechtman & Dvir, 2006; Tasca et al.,
However, much less is understood about the group leader’s attachment dispositions and how they influence the outcome of group therapy. We are not aware of any previous empirical studies addressing this question. This study might be the first to address the impact of attachment dispositions in the group therapist/analyst on group therapy outcome.

1.7 The purpose of the present study: Objectives and Research Questions

The purpose of the present study was to examine whether and how the attachment dimensions of the trainer group analyst, the group, and the individual trainee in group-analytic training groups affect the outcome of training as measured by change in trainee interpersonal problems. We had previously established that the level of interpersonal problems among the trainees had been significantly reduced over the study period (Leitemo & Vestbø, 2017). Because previous research in psychotherapy points to relationship factors as important predictors of outcome (Norcross, 2011; Burlingame et al., 2011), we wanted to investigate the effects of attachment dimensions over and above the quality of the therapeutic relationships in the groups as measured by a group relationship measure (Krogel et al., 2013).

Based on the research reviewed in the previous sections, we anticipated that attachment dimensions (i.e., anxiety and avoidance) of the trainer group analyst would be contributors to their effectiveness. However, because no previous studies (to our knowledge) have examined the impact of therapist attachment style on client outcome in group therapy, we did not formulate specific hypotheses regarding the direction of the possible relationship.

Moreover, based on the literature review suggesting that the group may be regarded as a therapeutic agent itself, we anticipated that the average level of attachment dimensions in the group itself could influence the trainee outcome. The ‘group as the therapist’ opens the possibility that any individual therapist factor found in the literature also could function as a group factor in group therapy.

In addition to the therapist and the group, we anticipated that the initial level of attachment dimensions of the individual trainee could influence how the trainee would benefit from the group-analytic training. Furthermore, based on findings from the individual therapy research literature showing a beneficial effect of client-therapist dissimilarity in attachment dispositions, we anticipated that such interaction effects could be found both between the therapist and the trainee as well as the group and the trainee. Hence, the present study investigated the following set of research questions:
1. Are there relationships between trainees’ self-reported reduction in interpersonal problems and the self-reported initial level of attachment anxiety of the trainer group analyst; the aggregated group members; and/or the trainees?

2. Are there relationships between the trainees’ self-reported reduction in interpersonal problems and the self-reported initial level of attachment avoidance of the trainer group analyst, the aggregated group members, and the trainees?

3. Do the attachment dimensions (i.e., anxiety and avoidance) of the individual trainee interact with the attachment dimensions of the trainer group analyst and/or the aggregated group members in such way that it contributes to the reduction in trainees’ interpersonal problem?

4. How does the quality of the therapeutic relationships in the group influence the reduction in interpersonal problems among the trainees?
2 Method

2.1 Design and setting

The current study is a naturalistic process-outcome study investigating and analyzing the development of trainee interpersonal problems over 10 months as they participated in the group-analytic training program at the Norwegian Institute of Group Analysis and Group Psychotherapy (IGA) in Oslo. The group-analytic training program covers a period of maximum five years. The first part of the program is an introductory course, which spans the initial year of training. The second part, spanning the second and third year, consists of an advanced course, which leads to the attainment of the title ‘IGA Group Therapist’. The third and final part spans the fourth and fifth year and is a qualifying course, which leads to the attainment of the title ‘Group analyst’. Each part of the program may be completed independently of each other. The training program is available for medical doctors, psychologist, nurses and other professions that include a minimum of 3-year training in Health and Social Services at high-school level.

The program is organized into five blocks of training each academic year, starting in September, and continuing in November, February, and April with the final block meeting in June. Each block meeting spans three days (Thursday, Friday and Saturday) and is held at the same conference hotel in the city of Oslo. The training program contains small and large experiential groups in group analysis, didactic theory groups and clinical case or supervision groups. This is similar to the elements of a standard group psychotherapy training program (see Berman, 1975). On a yearly basis, the participants have completed 30 (45h) sessions of ‘small group experiences’, 15 (15h) sessions of ‘large group experiences’, 15 (15h) theory sessions and 15 (20h) sessions of group supervision.

There are 8-11 participants including the trainer group analyst in each experiential small group. These groups allow the trainees to experience the group-analytic approach to group psychotherapy as clients as well as to observe an experienced (trainer) group analyst in action. Each participant attends the same small group throughout the whole training period (which can last up to five years). For that reason, the small groups consist of members from different training levels. In contrast, the theory and supervision groups consist of participants from the same level of training. The present study investigated the qualities and processes within these small groups as the possible predictor variables of trainee development.

In addition to the training blocks, the participants meet with fellow participants in
collegial supervision (‘intervision’) groups between each block meetings in order to discuss theory and receive intervision. Moreover, the participants are expected to read assigned theoretical literature in preparation for each block meeting, and participants in the qualifying part of the program are expected to run their own group-analytic group for a minimum of two years.

2.2 Participants

All trainees (n=90) and training group analysts (n=10) as well as students graduated in the prior year (n=20) were invited to participate in the study. Of the potential participants, 54 (60%) of the trainees, 8 (80%) of the training group analysts and 13 (65%) of the graduated trainees accepted the invitation. Only one trainee dropped out of the study during the 10 months study period. Due to the relevance of the stated research questions in the present study, only data from the trainees and the trainer group analysts were used.

Of the trainee participants, there were 16 (30%) men and 38 (70%) women. The age of the participants ranged from 27 to 64 with a mean age of 44.5 (SD=9.5). In terms of occupation, there were 20 (37%) psychologists, 9 (17%) medical doctors, 12 (22%) nurses. The remaining 12 (22%) participants reported belonging to other professions. Numbers of years working as individual therapists ranged from zero to 30 with a mean of 10.5 (SD=7) years, whereas number of years working as group therapists ranged from zero to 25 with a mean of 4.8 (SD=5) years. The distributions were heavily skewed to the left and the 50 percentiles for work experience as individual and group therapists were about 8 and 3 years, respectively. Demographic data on the training group analysts were not collected due to the concerns of anonymity which might have been violated because of the small sample size.

2.3 Procedure

In the preparation of our study, and as a part of the larger project, we chose self-report scales intended to measure therapist qualities (e.g., empathy, emotional competence, and self-esteem, for an overview of all measures, see Appendix 1). Before making the final decision of which scales to include, we discussed our choice of measures with our supervisor, Helene A. Nissen-Lie, who is familiar with the literature on therapist factors. Next, one of the authors (KL) contacted the respective scale developers and requested the permission to use their scales in the current study. All of the contacted scale developers generously gave us
permission to use their scales. Inventories that existed in English versions only were translated into Norwegian by one of the authors (HSBV) and examined by the other author (KL) as well as our supervisor. Any disagreements regarding the translations were discussed until consensus had been reached.

In August 2015, the letter of invitation (see Appendix 3) was submitted to the potential participants together with a declaration of consent (see Appendix 4) and the first of a total of four collections of self-report questionnaires. The participants were asked to return the questionnaires well in advance of the first block of meeting in September.

The second ‘wave’ of questionnaires was submitted after the first block meeting in September with a request to return the questionnaires well in advance of the second block of meetings in November. The third wave of questionnaires was submitted after the fourth block of meetings in April 2016 with the request to return the questionnaires well in advance of the fifth meeting in June. Finally, the fourth wave of questionnaires was submitted to all participants in August 2016 with a due date well in advance of the start of another cycle of training in the new academic year. The inventories used in the present study, which are specified below, were a subset of the questionnaires that were collected at the first, second and fourth waves.

For all waves (i.e., measurement points), participants who had not completed and returned the questionnaires by the due date received an e-mail reminding them about responding to the questionnaires. If the questionnaires still remained unregistered after two weeks, the participants received a phone call from either of the authors with a request to return the questionnaires.

2.4 Measures

In this section we present the three inventories used in the current study. The Experiences in Close Relationships Questionnaire (ECR-R-18; Wongpakaran & Wongpakaran, 2012) was distributed as part of the first wave of questionnaires to both the trainees and the trainer group analysts. The Circumplex of Interpersonal Problems (CIP; Pedersen, 2002) was distributed as part of the questionnaires in the second and fourth waves, to the trainees only. Finally, The Group Questionnaire (GQ; Krogel et al., 2013) was distributed to the trainees as part of the second wave of questionnaires.
2.4.1 Circumplex of interpersonal problems (CIP)

As an outcome measure we used The Circumplex of Interpersonal Problems (CIP; Pedersen, 2002) which is a 48-item Norwegian version of Alden, Wiggins, & Pincus’ (1990) Inventory of Interpersonal Problems – Circumplex (IIP-C) assessing current interpersonal problems. CIP measures the same eight interpersonal problem areas as IIP-C: Domineering, Vindictive, Cold, Socially avoidant, Non-assertive, Exploitable, Overly nurturant, and Intrusive, and uses the same 5-point Likert scale. Each item is rated from 0 (“not at all”) to 4 (“extremely”). Higher scores are indicative of higher levels of interpersonal problems. In our study we chose to use a 9-point scale, where each item was rated from 1 (“not at all”) to 9 (“extremely”) in order to better differentiate between the participants responses. Before analyzing the results, we converted the responses back to a 5-point scale, for reasons of comparisons.

As in the original IIP-C, the CIP contains two types of items: 27 items follow the phrase “It is hard for me to…” and the remaining 21 items describe “Things that you do too much”. A global interpersonal distress score is calculated from the mean of the CIP. The CIP global score has been shown to correlate .99 with the IIP-C global score (Pedersen, 2002). The internal consistency of the CIP global score has been demonstrated to be good (α = 0.91; Pedersen, 2002). In the current study, the Cronbach alpha coefficient for the global CIP score was α = 0.93.

The CIP has been used extensively in Norwegian clinical studies and is both sensitive to psychotherapeutic interventions and correlated with other descriptions of personality functioning, distress scores and measures of quality of life (e.g., Antonsen et al., 2017, Lorentzen, Ruud, Fjeldstad, & Høglend, 2013). Pedersen (2002) provides average and standard deviations of global CIP scores in a Norwegian non-clinical but rather small sample (n=153). The questionnaire used in this study is shown in Appendix 5.

2.4.2 Experiences in Close Relationships (ECR-R-18)

In order to measure attachment dimensions we used the short version of the revised Experiences in Close Relationships Questionnaire (ECR-R-18; Wongpakaran & Wongpakaran, 2012), which is an 18-item self-report questionnaire, designed to measure attachment dimensions - feelings and experiences in close relationships. Half of the items measure attachment anxiety (i.e. the degree of fear of abandonment and interpersonal rejection), and the remaining half measure attachment avoidance, (i.e. the degree of
discomfort with interpersonal closeness and intimacy). An example of an item representing anxiety is “I worry a lot about my relationships” and an example of an item representing avoidance is “I prefer not to show a partner how I feel deep down”. Respondents use a 7-point Likert scale ranging from 1 (“disagree strongly”) to 7 (“agree strongly”) to rate how well each statement describes their typical feelings in close relationships. Higher scores are associated with higher levels of anxiety or avoidance, conceptualized as dimensional rather than categorical constructs. This means that the ECR-R-18 does not place individuals in fixed attachment categories.

In developing the ECR-R-18, Wongpakaran and Wongpakaran (2012) used exploratory factor analysis and revised and shortened the Experiences in Close Relationships - Revised (ECR-R; Fraley, Waller, & Brennan, 2000). ECR-R is a 36-item questionnaire based on the original Experiences in Close Relationships (ECR; Brennan et al., 1998). In the development of the original ECR, Brennan et al. used responses from more than 1000 U.S. undergraduates and pooled 323 items obtained from existing measures of adult attachment and subjected them to a factor analysis. A two-dimensional orthogonal factor structure emerged; an anxiety subscale and an avoidance subscale. The 18 highest loading items were chosen for each subscale.

The ECR-R-18 has been found to have good criterion validity (Wongpakaran & Wongpakaran, 2012). The anxiety subscale correlated positively with the Perceived Stress Scale-10 (PSS-10) and the UCLA Loneliness Scale, and negatively with the Rosenberg self-esteem scale (RSES). The avoidance subscale correlated positively with the UCLA, but did not reveal any relationship with the RSES and PSS scales in Wongpakaran and Wongpakaran’s study. The ECR-R-18 has been found to have a fair to good internal consistency (α = 0.84 for a nonclinical group and 0.75 for a patient group), and the test-retest reliability was found to be satisfactory (ICC = 0.75). The ECR-R-18 has to our knowledge not been applied in other published papers. In the present study, the Cronbach alpha coefficients for the two subscales anxiety and avoidance scale were .836 and .835, respectively. The ECR-R-18 was used in the present study, translated into Norwegian by the authors, see Appendix 6.

2.4.3 Group Questionnaire (GQ)

In order to control for the quality of group therapeutic relationships we used the Group Questionnaire (GQ; Krogel et al., 2013) which is a 30-item self-report measure that assesses
the quality of the therapeutic relationship in group treatment by measuring quality across three structural dimensions of the relationship: member-member, member-leader, and member-group. Based on Johnson et al.’s (2005) three-factor model of the group relationship, three different aspects of the therapeutic relationship are measured: Positive Bonding, Positive Working and Negative Relationship. The positive bonding relationship factor encompasses the constructs cohesion, engagement, and emotional bond; the positive working relationship factor encompasses the agreement on therapeutic tasks and goals; and the negative relationship factor includes elements of conflict and empathic failure (Johnson et al., 2005). Respondents use a 7-point Likert Scale ranging from 1 (“not at all true”) to 7 (“very true”), and item scores are compiled to produce the three subscales scores: Positive Bonding (13-items; e.g., “I felt that I could trust the group leaders during today’s session”), Positive Working (8-items; e.g., “The other group members and I agree on what is important to work on”), and Negative Relationship (9-items; e.g., “There was friction and anger between the members”). The GQ has showed good construct validity (Thayer, Burlingame, & Marcus, 2014) and good internal consistency, with reliability estimates (Cronbach’s alpha) of the three subscales of .92, .90, and .80, respectively (Krogel et al., 2013). The internal consistencies for the subscales measures across the three structural dimensions, are found to be .82 for Positive Bonding Member (PBM), .83 for Positive Bonding Leader (PBL), .88 for Positive Bonding Group (PBG), .87 for Positive Working Member (PWM), .86 for Positive Working Leader (PWL), .61 for Negative Relationship Member, .66 for Negative Relationship Leader, and .76 for Negative Relationship Group (Thayer et al., 2014).

In the present study, the Cronbach’s alpha reliability for the Positive Bonding score was .88, .92 for Positive Working, and .79 for Negative Relationship. For the subscales measure across the structural dimensions, the alphas was 0.76 for PBM .72 for PBL, and .77 for PBG, .82 for PWM, .84 for PWL, .67 for NRM, .56 for NRL, and .89 for NRG. With regard to the subscales NRM and NRL, the alpha values were found to be below .7, which is not unusual for scales with fewer than ten items. In such cases, Briggs and Cheek (1986) recommend to check the mean inter-item correlation for the items, and suggest an optimal range for the inter-item correlation of .2 to .4. With our sample, we found that the mean inter-item correlations of the NRM and NRL scales were .42 and .28, respectively, which indicate that the items within each scale do measure the same underlying construct. The GQ was used in the present study, translated into Norwegian by the authors, see Appendix 7.
2.5 Ethical considerations

Permission to collect personal information from the participants in our study was given by the Norwegian Social Science Data Services (NSD; Norsk samfunnsvitenskapelig datatjeneste AS) (see Appendix 2). Due to the participants not being traditional patients seeking help, but rather trainees and teachers in a post-graduate training program, the project did not need to apply for permission from the regional ethical committee (i.e., REK).

2.6 Data Analyses

Due to the hierarchical (nested) nature of our data in which repeated measures (Level 1) were nested within the individual participants (Level 2), who were nested within groups (Level 3), a multilevel random effects growth model was employed using the SPSS software Linear Mixed Models (SPSS, version 24.0, 2016). A requirement for the standard linear regression model to have unbiased, consistent and efficient coefficients, is that the stochastic part of the model (i.e., the error term) is independently and identically distributed. Since individuals and groups may work differently, and hence different random variations in outcome may be induced depending on the group the individual participates in, the assumption of independence of the error terms may be violated. The linear standard regression model may hence not produce efficient estimates. A multilevel random effects model, accounting for the dependence of the errors, is thus more appropriate for the present study design. For the purpose of our study, the three-level multilevel random effects model allowed both the individuals and the groups to have separate influences on the development (growth rate) of interpersonal problems, both directly through an intercept random effect, and indirectly through influencing the coefficients on the (fixed) explanatory or predictor variables. In other words, it allowed deviations from an “average model” through the use of random effects at both the individual and the group level. For the sake of simplicity and due to the lack of observations in the study, we limited the number of parameters to be estimated by excluding the possibility that there were random effects influencing the coefficient associated with the predictor variables.

In order to avoid problems with reversed causation, the initial values of the interpersonal problems were obtained after the first block meeting (wave 2) together with the measures on the Group Questionnaire. Hence, the group relationships measured were obtained at an early stage in the ‘group life’, just after the group had been established with
newly added members. This ensured that the measure of the quality of early therapeutic relationships was not influenced by any changes in interpersonal problems among the trainees in the study period (between wave 2 and 4).

Our general prediction model with both random effects at the individual and the group level and both direct and interaction fixed effects is given by

\[
\begin{align*}
\text{Level 1: } CIP_{ij} &= \pi_{0ij} + \pi_{1ij} \text{time}_{ij} + \epsilon_{ij} \\
\text{Level 2: } \pi_{0ij} &= \beta_{00j} + \beta_{01j} CIP_{ij} + \tau_{0ij} \\
&= \beta_{10} + \beta_{11} \text{AA}_{0ij} + \beta_{12} \text{AV}_{0ij} + \sum_{s=1}^{4} \rho_{1sj} \text{GQ}_{s,ij} \\
\beta_{00j} &= \gamma_{000} + \gamma_{001} CIP_{ij} + \nu_{00j} \\
\beta_{10j} &= \gamma_{100} + \gamma_{102} \text{AA}_{0ij} + \gamma_{103} \text{AV}_{0ij} + \gamma_{104} \text{AX}_{0ij} + \gamma_{105} \text{AV}_{0ij} \\
\beta_{11j} &= \gamma_{110} + \gamma_{112} \text{AA}_{0ij} + \gamma_{113} \text{AV}_{0ij} + \gamma_{114} \text{AX}_{0ij} \\
\beta_{12j} &= \gamma_{120} + \gamma_{121} \text{AA}_{0ij} + \gamma_{122} \text{AV}_{0ij} + \gamma_{123} \text{AX}_{0ij} \\
\rho_{1sj} &= \gamma_{1(s-1)j} \quad \text{for } s = 1, \ldots, 8. 
\end{align*}
\]

which predicts the level and change over time in CIP (interpersonal problems) in the trainees. Both the change and the level of CIP are functions of the level of attachment dimensions in the trainer group analyst, the trainee and the aggregated group members as well as interpersonal problems of the trainee and the aggregated group members. Following recommendations for multilevel modeling of small groups proposed by Tasca, Illing, Joyce and Ogrodniczuk (2009), the dependent variable (i.e., interpersonal problems) at both the individual and the group levels was used only as a predictor variable for the level and not the change of interpersonal problems in the trainees. Time \( t \) is located as the first, the individual (trainee) \( i \) as the second, and the group \( j = \{1, \ldots, 10\} \) as the third of the three subscripts on the variables. CIP is modelled over two periods \( t=\{1, 2\} \) referring to the second and fourth wave respectively. A time subscript of zero \( (t=0) \) refers to the first wave where the attachment dimensions of the participants were measured. For the random part of the model, it is assumed that \( \epsilon_{ij} \sim N(0, \sigma^2_{\epsilon}) \), \( \tau_{0ij} \sim N(0, \sigma^2_{\tau}) \) and \( \nu_{00j} \sim N(0, \sigma^2_{\nu}) \), i.e., that they are normally distributed around zero with constant variances.
Equation (1) represents Level 1 of the model where CIP is modelled as a function of time and fixed and random factors interacting with time ($\pi_{ti}$) (i.e., slope-coefficient), a set of random and fixed explanatory (and predictive) factors ($\pi_0$) pertaining to the group and the individuals as of time ($t=0$), and an error term ($\epsilon_{ti}$) with a constant variance.

Equations set (2) represent Level 2 of the model and describe the individual predictor variables explaining the average level (2a) and the change (2b) in CIP over the study period. Equation (2a) states that the average level of interpersonal problems is predicted by the initial ($t=0$) level of CIP as well as a random factor $r_{0ij}$ pertaining to the individual in addition to group-specific factors ($\beta_{00j}$). In addition to the eight measures of relationship quality in the Group Questionnaire (GQ), equation (2b) states that that trainee attachment anxiety (AAX) and attachment avoidance (AAV) are predictors of change over time. For convenience, variables AAX and AAV are collectively denoted as attachment dimension predictors (ADP).

Equations set (3) represent Level 3 of the model and describe how group-specific factors (i.e., factors that are identical to all the trainees in the same experiential small group) influence both the average level and the change of the trainees’ interpersonal problems. Such factors may or may not interact with individual-level predictors. Equation (3a) describes that the level of the dependent variable over the two periods is influenced by a constant and a group-specific random factor ($u_{00j}$). Equation (3b) states that no group-specific factors are influencing the average level of CIP over the two periods. Equation (3c) describes the group-level predictor variables for the change in the trainees interpersonal problems over time, that is, the ADPs for the aggregated group members and the trainer group analyst (i.e., conductor), denoted by superscripts g (group) and c (conductor), respectively. The two ADP variables pertaining to the aggregated group members were computed as the average ADPs among the group members, i.e., $ADP_{0ij}^g = (\sum_{s=1}^{n_j} ADP_{0sj})/n_j$ where $n_j$ is the number of members of group $j$. Thus, the aggregated group measure does not include the trainer group analyst whose attachment dimensions are treated separately as independent predictor variable. Since we only have observations on eight of the ten trainer group analysts, the missing observations on the trainer group analysts were imputed by the average of the ADPs of the other eight trainer group analysts.

Equations (3d) and (3e) in the model state how the average group members’ and trainer group analyst (i.e., group-level) ADPs interact with trainee attachment anxiety and avoidance, respectively, in influencing the growth rate of the trainees interpersonal problems.
Equations (3f-m) state that group relationships quality is assumed to be unaffected by any interaction with group-level variables.

In further accordance with recommendations in Tasca et al. (2009), all individual-level fixed variables (i.e., predictors) were centered around its small group mean (group mean centered) and all group-level fixed variables were centered around the grand mean, across all trainees.

### 2.6.1 Estimation strategy

The model described by the equations (1-3) contains a high number of explanatory variables and together with a relatively small number of observations, the model cannot be estimated and tested all at once due to too few degrees of freedom. A broad set of the predictor variables in the estimation are nevertheless preferred since the inclusion of many potentially significant predictive variables reduces the probability that the model is misspecified and therefore yields biased coefficient estimates. This bias might lead us to erroneously conclude that some variables are insignificant when they in fact are not (Type II error).

In order to strike a balance between the need for degrees of freedom and protection from Type II errors, we proceeded in the following way:

1. First, all individual-level variables either explaining the average level or the change over time in CIP as well as the eight group process measures in addition to the average group members CIP were included in the estimation of the model. No interaction terms (except variables interacting with time (slope)) were included at this stage. The least significant variable (i.e., according to the student t-test) was removed from the model and the model was re-estimated, and again the most insignificant variable was removed and the model re-estimated etc. The procedure was repeated until all of the variables in the reduced model reached a $p$-value of less than 5 percent. This estimation and model reduction procedure can be denoted as a “backward” modeling and testing strategy.

2. The model was then expanded with group-level (aggregated group member and trainer group analyst) ADP variables explaining the level and change over time. Terms including the interaction of individual ADP variables with group-level ADPs were also included at this stage. The backward estimation procedure was then employed again.
3. The eight group process measures were once again added to the model and the backward estimation procedure employed.

4. Robustness check: The penultimate model was re-estimated for the sample excluding one trainee which reported an exceptional large reduction in interpersonal problems. Insignificant variables were removed and the model re-estimated on the full sample.

2.7 Results

An overview of the descriptive statistics including the means, standard deviations, number of

Table 1. Descriptives of trainee and trainer group analyst variables

<table>
<thead>
<tr>
<th>Trainee variables</th>
<th>Wave (time)</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>$CIP_1$</td>
<td>$W2$ ($t=1$)</td>
<td>1.17</td>
<td>0.43</td>
<td>54</td>
<td>0.42</td>
<td>2.22</td>
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<tr>
<td>$CIP_2$</td>
<td>$W4$ ($t=2$)</td>
<td>1.09</td>
<td>0.45</td>
<td>53</td>
<td>0.32</td>
<td>2.19</td>
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<tr>
<td>$AAV_0$</td>
<td>$W1$ ($t=0$)</td>
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<td>0.62</td>
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<td>4.75</td>
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<td>$GQ_{PWL,1}$</td>
<td>$W2$ ($t=1$)</td>
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</tr>
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<td>$GQ_{NRL,1}$</td>
<td>$W2$ ($t=1$)</td>
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<td>0.92</td>
<td>54</td>
<td>1.00</td>
<td>5.00</td>
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</table>

<table>
<thead>
<tr>
<th>Trainer group analyst (conductor) variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>$AAV_0^C$</td>
</tr>
<tr>
<td>$W1$ ($t=0$)</td>
</tr>
<tr>
<td>$AAV_0^C$</td>
</tr>
<tr>
<td>$W1$ ($t=0$)</td>
</tr>
</tbody>
</table>

Note. $AAV_0$ = attachment anxiety at $t = 0$, $AAV_0$ = attachment avoidance at $t = 0$, $CIP_1$ = interpersonal problems at $t = 1$, $CIP_2$ = interpersonal problems at $t = 2$, $GQ_{PBL,1}$ = positive bonding leader at $t = 1$, $GQ_{PWL,1}$ = positive working leader at $t = 1$, $GQ_{NRL,1}$ = negative relationship leader at $t = 1$, $GQ_{PBM,1}$ = positive bonding member at $t = 1$, $GQ_{PWM,1}$ = positive working member at $t = 1$, $GQ_{NRM,1}$ = negative relationship member at $t = 1$, $GQ_{NRG,1}$ = negative relationship group at $t = 1$, $GQ_{PBG,1}$ = positive bonding group at $t = 1$. 
observations and range of the trainee and trainer variables used in our study is presented in Table 1. A paired sample t-test suggested a significant ($t=2.312$, $p=0.025$) reduction in interpersonal problems among the trainees as measured by the CIP over the ten months study period. Moreover, the mean and the standard deviation of both trainer attachment anxiety ($M=2.30$, $SD=0.96$) and trainer attachment avoidance ($M =2.45$, $SD=1.02$) were higher than were those of trainer group analyst attachment anxiety ($M =2.11$, $SD =0.73$) and trainer group analyst attachment avoidance ($M =2.01$, $SD =0.54$).

The correlations between the trainee variables are presented in Table 2. According to Cohen’s (1988) guidelines for the strength of correlations there were strong correlations between the outcome variable at time $t=1$ and $t=2$. Trainee attachment anxiety was strongly positively correlated with trainee interpersonal problems ($r =.58$, $p<.001$). Trainee attachment anxiety and trainee attachment avoidance were only weakly and non-significantly correlated with measures of the quality of group relationships (see Table 2), suggesting no significant problems of multicollinearity. However, the intercorrelations between the subscales of the Group Questionnaire ranged from being non-significantly different from zero to $r=.9$ and highly significant at $p<0.01$, which could pose a multicollinearity problem and thus produce difficulties in differentiating between the subscales in predicting trainee outcome. Not reported in the table is the intercorrelation between trainer group analysts’ ($n=8$) attachment anxiety and avoidance which was $r=.05$ and insignificantly different from zero.

Table 2. Correlations between trainee variables

<table>
<thead>
<tr>
<th></th>
<th>$AA_{0}$</th>
<th>$AA_{0}$</th>
<th>$CIP_{1}$</th>
<th>$CIP_{2}$</th>
<th>$GQ_{PBL,1}$</th>
<th>$GQ_{PWL,1}$</th>
<th>$GQ_{NRL,1}$</th>
<th>$GQ_{PBM,1}$</th>
<th>$GQ_{PWM,1}$</th>
<th>$GQ_{NRM,1}$</th>
<th>$GQ_{PBG,1}$</th>
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<tbody>
<tr>
<td>$AA_{0}$</td>
<td>– .195</td>
<td>.578**</td>
<td>.551**</td>
<td>.055</td>
<td>-.003</td>
<td>.026</td>
<td>.012</td>
<td>-.016</td>
<td>.005</td>
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<td>$AA_{0}$</td>
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<td>.195</td>
<td>-.017</td>
<td>-.039</td>
<td>-.004</td>
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<td>-.118</td>
<td>.037</td>
<td>-.231</td>
<td>-.172</td>
</tr>
<tr>
<td>$CIP_{1}$</td>
<td>.578**</td>
<td>.152</td>
<td>-.834**</td>
<td>-.009</td>
<td>.113</td>
<td>.141</td>
<td>-.061</td>
<td>.067</td>
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<td>.834**</td>
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<td>-.017</td>
<td>.169</td>
<td>.042</td>
<td>-.058</td>
<td>.127</td>
<td>.029</td>
<td>.039</td>
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<td>-.009</td>
<td>-.019</td>
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<td>-.449**</td>
<td>.599**</td>
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<td>$GQ_{PWL,1}$</td>
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<td>-.017</td>
<td>.411**</td>
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<td>.175</td>
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<td>.700**</td>
<td>.176</td>
<td>-.464**</td>
<td>-.175</td>
</tr>
</tbody>
</table>

Note. $AA_{0}$ = attachment anxiety at $t = 0$, $AA_{0}$ = attachment avoidance at $t = 0$, $CIP_{1}$ = interpersonal problems at $t = 1$, $CIP_{2}$ = interpersonal problems at $t = 2$, $GQ_{PBL,1}$ = positive bonding leader at $t = 1$, $GQ_{PWL,1}$ = positive working leader at $t = 1$, $GQ_{NRL,1}$ = negative relationship leader at $t = 1$, $GQ_{PBM,1}$ = positive bonding member at $t = 1$, $GQ_{PWM,1}$ = positive working member at $t = 1$, $GQ_{NRM,1}$ = negative relationship member at $t = 1$, $GQ_{PBG,1}$ = negative relationship group at $t = 1$. **Correlation is significant at the 0.01 level (two-tailed). *Correlation is significant at the 0.05 level (two-tailed).
2.7.1 Multilevel model analysis

The estimation of the model was carried out through the use of multilevel modelling techniques. It turned out that the low number of observations was insufficient for the estimation of the individual-level or group-level random factors. Subsequently they were set to zero. The loss of the estimation of the random factors implied that we were unable to consider between-group analysis of the data. The results of the multilevel modeling analyses are presented in Table 3.

Table 3. Results of multilevel modeling analyses.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficients</th>
<th>SE</th>
<th>t-value</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>Intercept</td>
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<td>0.018</td>
<td>3.491</td>
<td>0.001</td>
</tr>
<tr>
<td>$time \cdot AAX_0^{G}$</td>
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<td>0.050</td>
<td>2.067</td>
<td>0.041</td>
</tr>
<tr>
<td>$time \cdot AAX_0^{C} \cdot AA V_0^{G}$</td>
<td>-0.088</td>
<td>0.031</td>
<td>-2.819</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Note. $CIP_1$ = interpersonal problems of the trainee at time $t=1$. $CIP_1^{G}$ = interpersonal problems of the aggregated group members at $t=1$, $AAX_0^{C}$ = level of trainer group analyst attachment anxiety at $t=0$, $AAX_0^{G}$ = level of attachment anxiety in the aggregated group members at $t=0$, $AA V_0^{G}$ = level of aggregated attachment avoidance in the aggregated group members at $t=0$, $time \cdot AAX_0^{C} = $ direct effect from attachment anxiety in trainer group analyst on the change in interpersonal problems in the trainees, $time \cdot AAX_0^{G} = $ direct effect from attachment anxiety in the aggregated group members on the change in interpersonal problems of the trainees, $time \cdot AAX_0 \cdot AA V_0^{G} = $ interaction effect between trainee attachment anxiety and aggregate group members level of attachment avoidance on the change in interpersonal problems in the trainees. The variance of the residual term was estimated to be 2.8%.

2.7.2 The research questions investigated

Research question 1: Are there relationships between trainees’ self-reported reduction in interpersonal problems and the self-reported initial level of attachment anxiety of the trainer group analyst; the aggregated group members; and/or the trainees?

Trainer group analyst attachment anxiety was a significant predictor of change in trainee interpersonal problems ($time \cdot AAX_0^{C} = 0.06, p<.001$) where higher group analyst attachment anxiety was associated with less reduction in trainee interpersonal problems. The
trainer group analyst effect is illustrated in Figure 2 where we for illustrative purposes have divided the trainees into those with a trainer group analyst with a level of attachment anxiety above (high) and below (low) average and plotted their associated change in interpersonal problems.\textsuperscript{1}

The aggregated level of group members attachment anxiety was a significant predictor of change in trainee interpersonal problems \((\text{time} \times \text{AAX}_G = 0.10, p < .005)\) where higher group attachment anxiety was associated with less reduction in trainee interpersonal problems.

Trainee attachment anxiety did not predict the change in trainee interpersonal problems \((t = 1.534, p = 0.128)\). The statistics reported in this and the following parentheses represent the \(t\)-value and the associated significance level \((p\text{-level})\) of a test of the slope coefficients associated with the respective variable (i.e., \(\text{time} \times \text{predictor variable}\)) as it was separately added as a potential predictor of change to the model reported in Table 3.

Figure 2. The effect of trainer group analyst attachment anxiety on the change in trainee interpersonal problems.

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{effects.png}
\caption{Effects of trainer group analyst attachment anxiety on change in trainee CIP.}
\end{figure}

Note. The change in trainee CIP are plotted conditional on the trainee participating in a group with a trainer group analyst with attachment anxiety either below or above the average level among the trainer group analysts.

\textsuperscript{1} Figure 2 and Figure 3 are made for illustrative purposes and do not reflect the outcome of model simulation.
Research question 2: Are there relationships between the trainees’ self-reported reduction in interpersonal problems and the self-reported initial level of attachment avoidance of the trainer group analyst, the aggregated group members, and the trainees?

Neither trainee attachment avoidance ($t=0.199, p=0.842$), trainer group analyst attachment avoidance ($t=-1.849, p=.067$) nor the attachment avoidance of the aggregated group members ($t=1.105, p=.272$) did significantly predict the change in trainee interpersonal problems.

Research question 3: Do the attachment dimensions (i.e., anxiety and avoidance) of the individual trainee interact with the attachment disposition of the trainer group analyst and/or the aggregated group members in such way that it contributes to the reduction in trainees’ interpersonal problems?

The interaction between trainee attachment anxiety and aggregated group attachment avoidance significantly predicted a change in trainee interpersonal problems ($time*AAX_0*AAVV_0 = -0.09, p<.005$) where trainees with higher (lower) attachment anxiety received a greater reduction in interpersonal problems when participating in a group with higher (lower) aggregated level of attachment avoidance. This interaction effect is illustrated in Figure 3 where the changes in trainee CIP are plotted conditional on the trainees either

Figure 3. The interaction between trainee attachment anxiety and aggregated level of group members’ attachment avoidance on the change in trainee interpersonal problems.

Note. The changes in trainee CIP are plotted conditional on the trainee either scoring below or above the average level of attachment anxiety and the trainee participating in groups which scored either below or above the average levels of group attachment avoidance.
scoring below or above the average level of attachment anxiety and the trainee participating in
groups which scored either below or above the average levels of group attachment avoidance.

We did not find any other significant interaction effects on the change in trainee
interpersonal problems. More specifically, no interaction effects were found between trainee
attachment anxiety on the one side, and training group analyst attachment avoidance \((t=\cdot .928,\ p=.356)\) or attachment anxiety \((t=.009,\ p=.642)\) or aggregated attachment anxiety of group
members \((t=-.075,\ p=.210)\) on the other. Furthermore, no interaction effects were found
between trainee attachment avoidance on the one side, and aggregated group member
attachment anxiety \((t=.014,\ p=.795)\) or avoidance \((t=.028,\ p=.5)\) on the other. Similarly, no
interaction effects were found between trainee attachment avoidance and trainer group
analysts attachment anxiety \((t=-.014,\ p=.47)\) or attachment avoidance \((t=\cdot .031,\ p=.17)\).

Research question 4: How does the quality of the therapeutic relationships in the group
influence the reduction in interpersonal problems among the trainees?

We found no significant relationships between either of the subscales on the group
questionnaire and the change in trainee interpersonal problems. More specifically, tests of the
slope coefficients yielded the following results: \(GQ_{PBL,1}\) \((t=1.506,\ p=.135)\), \(GQ_{PWL,1}\) \((t = \cdot
.089,\ p=.929)\), \(GQ_{NRL,1}\) \((t = -.782,\ p=.436)\), \(GQ_{PBM,1}\) \((t=1.195,\ p=.235)\), \(GQ_{PWM,1}\) \((t=\cdot .202,\ p= .840)\), \(GQ_{NRM,1}\) \((t = -1.698,\ p= .093)\), \(GQ_{NRG,1}\) \((t = .684,\ p= .495)\) and \(GQ_{PBG,1}\) \((t=.564,\ p=.574)\).
3 Discussion

The aim of the present study was to explore the role of attachment dimensions in reducing interpersonal problems among trainees in training group analysis. Overall, attachment dispositions were found to be highly relevant. Lower attachment anxiety among the trainer group analysts and in the group turned out to be beneficial for the trainees. Furthermore, trainees with higher attachment anxiety benefited by attending a group with a higher level of attachment avoidance. In contrast, the quality of group relationships turned out to be an insignificant predictor of trainee outcome. In the following sections these findings are discussed in more detail.

3.1 The impact of trainer attachment anxiety on trainee outcome

In accordance with previous research in individual therapy (Bruck et al., 2006; Dinger et al., 2009; Sauer et al., 2003), we found that higher attachment anxiety in the trainer group analysts exerted a negative influence on the trainees’ outcome. To our knowledge, our study is the first to establish this result in the group therapy research literature.²

Based on theoretical notions, one might infer that group therapists with higher attachment anxiety could influence the group process by avoiding conflict in order to be liked. As proposed by Dinger et al. (2009), it might be that the hyperactivating attachment strategies characteristic of anxiously attached individuals also take place in the professional therapeutic relationship. Following this, it might be that therapists with higher attachment anxiety display more undesirable therapist behaviors in terms of avoiding conflict and effort to control the clients in order to minimize distance. Such a preoccupation by the therapist’s own attachment needs would be likely to interfere with the therapist’s ability to remain emotionally present and respond therapeutically to the needs of his or her clients. Interestingly, Rubino, Barker, Roth, and Fearon (2000) found that therapists higher in attachment anxiety responded less empathically to their clients compared to less anxious therapists, suggesting that therapist attachment style can influence the therapist’s ability to empathize with clients. In emotionally charged situations, therapists with higher degrees of attachment anxiety might become too involved with their own fear of rejection and desire for closeness, which could lead to a reduced capacity to respond with true empathy to their clients’ needs. Given the link between

² In a non therapeutic setting, however, several studies have addressed the relationship between leaders’ abilities to serve as security providers and follower’ performance, feelings, health and adjustment (e.g., Davidovitz, Mikulincer, Shaver, Ijzak, & Popper, 2007; Richards & Hackett, 2012; Ronen & Mikulincer, 2012).
therapists’ capacity for empathy and psychotherapy outcome in both individual (Bohart, Elliott, Greenberg, and Watson, 2002) and group therapy (Johnson et al., 2005; Marziali et al., 1997), it is possible that therapists higher in attachment anxiety make less empathic responses and that this could be involved in explaining the negative impact of trainer attachment anxiety on trainee outcome found in our study.

Another way of understanding the relationship between higher trainer group analyst attachment anxiety and negative trainee outcome is possibly gained by considering the literature linking reflective functioning to attachment security. The relationship between reflective functioning - the ability to conceptualize, identify, and understand mental states in the self and others (Fonagy & Target, 1997) - and attachment security has been described as reciprocal, wherein higher reflective functioning facilitates the development of secure attachment, and secure attachment facilitates the development of reflective functioning in children (Fonagy & Bateman, 2006). Lower attachment anxiety may hence reflect better reflective functioning of the therapist and an improved ability to mentalize what is going on in the group. Such an ability may enhance group functioning. Better reflective functioning is also associated with a greater cognitive empathy (as opposed to affective empathy or emotional identification), which is referred to as the ability to construct a working model of the emotional states of others (Reniers, Corcoran, Drake, Shryane, & Völlm, 2011), which again has been associated with greater therapist effectiveness (Bohart et al., 2002).

A study by Cologon, Schweitzer, King, and Nolte (2017) found that higher reflective functioning moderated the relationship between therapist attachment anxiety and outcome. More specifically, higher therapist reflective functioning was found to enable therapists higher in attachment anxiety to actually outperform therapists with lower attachment anxiety, in terms of therapist effectiveness. The finding that reflective functioning might transform attachment anxiety from a negative to a positive therapist characteristic can be understood in light of the idea that higher mentalizing capacity provides a buffer against the detrimental effects of attachment insecurities (Eagle, Wolitzky, Obegi, & Berant, 2009).

As the group therapy setting examined in our study was part of a training context where the group members themselves were experienced health workers and therapists, one might speculate whether these members, as opposed to the typical patient seeking treatment, would be more affected by higher levels of attachment anxiety in the group leader. Perhaps trainees, because of a strong motivation to gain insight about themselves as well as group processes, would be more ready to explore interpersonal issues like anger and conflict, as
compared to the typical patient. If that is the case, a group leader higher in attachment anxiety could inhibit the exploration of issues like conflicts or possible ruptures due to his/her own fear of rejection.

On the other hand, the opposite could also be true. That is, that trainees, as opposed to the typical patient, would perhaps act more in a self-driven way in the group and thus would become less affected by the therapist’s attachment anxiety. Interestingly, a study by Schauenburg et al. (2010) found that therapist attachment security significantly impacted client outcome in individual therapy, but only when treating more severely impaired individuals. This finding corresponds to the idea that more well-functioning group members would be less affected by the therapist’s attachment insecurities. Our results may thus underestimate the possible impact of the group therapists’ attachment anxiety on groups with members of the typical patient population.

A possible interpretation of the finding of Schauenburg et al. (2010), which is also compatible with the finding in our study, is that attachment security allows the therapist to adjust his or her own behavior in order to meet the needs of interpersonally challenging clients. In the same way as clients presenting severe interpersonal difficulties might activate the therapist’s own attachment system, potentially leading to undesirable therapist behaviors, treating clients in a group therapy setting could be equally challenging to the therapist in terms of having to manage complex and potentially intense emotions between and within the respective group members. Conducting groups could thus be emotionally demanding even without severely disturbed patients. A securely attached group therapist, as opposed to a more insecurely attached one, would probably be better able to contain the group processes by providing security and stability in challenging situations. In contrast, a group therapist high in attachment anxiety would perhaps be more inclined to seek approval from the group and its members which could be interfering with the group process.

Given that attachment security has been associated with a host of psychological functions that may serve a therapist well, such as the capacity for empathy, reflective functioning, as well as the abilities needed to appropriately adapt to the needs of the client, therapist attachment security seem to be important for providing both a collaborative stance and shared focus with the client (Diamond & Blatt, 2017; Main, Goldwyn & Hesse, 2003; Main, Hesse, & Goldwyn, 2008), especially when the ‘going gets tough’.
3.2 The impact of average attachment anxiety in the group

Our finding that a higher level of aggregated attachment anxiety among the group members exerted a negative impact on the individual trainee’s outcome is both supportive of and reflects the idea that the group matters to therapy outcome. Furthermore, this finding raises interesting questions regarding group composition. In order to work constructively with relationship or mental health issues, a group should ideally be composed in such a way that the group members both support and challenge one another. Bernard et al. (2008) observed that if a group were composed entirely of avoidant or submissive group members, there would not be enough interpersonal tension in the group, leading to fewer opportunities for interpersonal learning among the members. Our study suggests a disadvantageous effect of higher aggregated level of attachment anxiety among the group members. One might hypothesize that a group predominantly with individuals higher in attachment anxiety would be characterized by avoidance of conflicts as a result of the members’ fear of rejection. Members who share the need for closeness and search for external sources of support, comfort, and safety may feel a sense of affiliation or connection with each other, and join together in an implicit agreement to soothe one another’s attachment anxiety. However, as the group progresses, these members’ attachment strategies might be amplified rather than challenged, and somewhat prevent the potential for interpersonal learning and the acquisition of insight into one’s own dysfunctional relationship patterns.

Another way of understanding our finding is by viewing the group itself as a therapeutic agent. In this sense, the member-group relationship can be compared to that of the member-leader relationship. An early study by Yalom (1985) found that almost half of the group members (42%) in a 12 month short time group therapy rated the other members, rather than the therapist, as ‘the most helpful agent’. In contrast, only 5% of the group members considered the therapist as ‘the most helpful agent’. This corresponds to the idea of the group as the healing agent, which is put at the very core of group-analytic psychotherapy (Foulkes, 1948; 1964). As Schlapobersky (2016, p.31) writes, “[T]he conductor calls this ‘community’ into the room where the group-as-a-whole becomes the therapeutic agent [...] [T]he conductor does nothing for people in the context of the group that they can do for themselves and one another.” As the group through a free-floating discussion internalizes the conductor, the group is weaned from its dependence on external agents. Increased autonomy, in group-analytic psychotherapy established within a social context, is indeed a therapeutic goal in dynamic therapies in general (cf: Gullestad & Killingmo, 2012).
When the aggregated level of attachment anxiety among the group members is high, the members’ ability to contain the anxiety evoked by the group processes may be more limited. Furthermore, the ability to reflect upon what is happening in the group would thus be expected to be lower, perhaps resulting in conflicting issues remaining unresolved. This explanation is seemingly at odds with a recent study by Kivlighan, Lo Coco, Gullo, Pazzagli, and Mazzeschi (2017), who found that higher aggregated level of attachment anxiety among the group members contributed to improved relationship quality both in terms of lower negative relationships and higher positive working relationship (as measured with The Group Questionnaire). However, the finding by Kivlighan and colleagues was contingent on the individual patient him- or herself having a lower level of attachment anxiety compared to the group-as-a-whole, suggesting that attachment heterogeneity in the group could increase the quality of group relationships. It should be noted, however, that their study did not consider therapy outcome.

### 3.3 Interaction between trainee anxiety and aggregated group avoidance

Interestingly, we found a beneficial interaction effect between the individual trainee’s attachment anxiety and the aggregated level of attachment avoidance among the group members. Trainees with higher attachment anxiety had better outcomes when participating in a group with higher aggregated level of attachment avoidance. In contrast, trainees with lower attachment anxiety had better outcomes when participating in a group with lower aggregated level of attachment avoidance. It could be useful for the remainder of this section to think of the group as a therapist or a healing agent. In doing so, our finding corresponds to previous results from the realm of individual therapy showing an advantageous effect of complementary attachment dispositions between the therapist and the client (e.g. Tyrrell et al., 1999; Bruck et al., 2006; Petrowski et al., 2011). The findings from these studies suggest that there is value in responding “against” the patient’s attachment style. As Bowlby (1980) suggested, an important task for the therapist is to disconfirm the client’s usual interpersonal and emotional strategies in order to facilitate corrective emotional experiences and interpersonal growth. In the same way as the caregiver needs to be able to provide a secure base for the child, the therapist must provide a safe space for the client, enabling the client to feel soothed and supported in the context of their treatment (Bowlby, 1988; Dozier, Cue, & Barnett, 1994). However, unlike children, whose emotion regulation strategies develop as a result of interactions with their caregivers, adult clients enter the therapy relationship with
interpersonal and emotional strategies developed in the context of other relationships. This leaves the therapist with the more difficult task of helping clients modify these strategies in order to facilitate more adaptive functioning. Following this, it is reasonable to infer that a “mismatch” between therapist and client attachment dispositions would make it easier for the therapist to challenge or disconfirm the clients' perceptions and expectations about relationships and emotions, thereby helping the client to modify his or her strategies for processing interpersonal information and for relating to others.

Another way of understanding our finding is that more avoidant group members might be perceived as being more able to contain, balance out and minimize the more anxiously trainee’s emotional distress. As proposed by Talia et al. (2014), an important task for the therapist treating clients high in attachment anxiety, is to help these clients to contain and regulate intense emotions. Members with higher attachment avoidance could perhaps serve such a function for the more anxiously attached members by modeling alternative ways of regulating distress and approaching interpersonal relationships (i.e., containing emotions and valuing the need for independence). Furthermore, a group higher in attachment avoidance might provide more space for the anxiously attached to work through their problems.

The group processes within a group with high overall attachment avoidance might be enhanced by having an anxiously attached trainee contributing to the process. The anxiously attached trainee may contribute to the process by providing more engagement so as to have the group work more effectively with him or her. In an interesting theoretical contribution, Ein-Dor, Mikulincer, Doron, and Shaver (2010) argued that there is an evolutionary advantage of having both anxious and avoidant members in a group. Whereas members high in attachment anxiety might act as ‘sentinels’ in the group, detecting danger and warning the other members of potential threats, members high in attachment avoidance might provide important functions to the group by acting as ‘catalysts’ to withdraw and escape from potentially dangerous situations. This interesting perspective might be applied to group therapy as well. It is possible that the members higher in attachment anxiety serve the function of pushing the group to explore issues such as dependency, self-hatred, and overwhelming emotions. These members may be the first to detect anger and conflict in the group and to perceive problems that are emerging in the group process. On the other hand, the members higher in attachment avoidance might serve important functions to the group in terms of pushing the group to explore issues such as denial, regression, as well as projection of unwanted parts of the self onto others. These members may be the first ones to express the
need to withdraw, thus pushing the group to handling and working with issues of autonomy and separation. These lines of thoughts might explain that the group-as-a-whole could benefit from having members with different attachment orientations.

3.4 The therapeutic relationship factors

Contrary to our expectations and perhaps surprisingly, we found no significant relationships between early measures of relationship factors (positive bonding, positive working, and negative relations) in either the member-member, member-group or member-leader constellations on the one side, and outcome, on the other. Although the group questionnaire is a relatively new measure and no validation studies exist, its construct validity has been thoroughly established by Thayer et al. (2014). So why was the therapeutic relationship seemingly less important for the trainees in our study?

One explanation may be that since the trainees are therapists themselves, they might to a greater extent understand that their perceptions of relationship quality is as much affected by themselves as they are by the other members, and that the perceived relationship quality reflects information about themselves and what they need to work with. Trainees might have better self-insight than the typical patient seeking treatment. Another explanation within this strand is that self-esteem and self-concept are more stable in the trainees than in typical patients and that the trainees’ ability to reflect about their own contribution in relationships might be expected to be more robust to deficient interactions in the group. In the terminology of self-psychology (Kohut, 1977), it could be that self-objects have been more robustly internalized by the trainees and that the trainees are less dependent on positive or negative interactions, i.e., identity and autonomy have been more fully established.

Another possible explanation might be that attachment dimensions could be among the determinants of the relationship quality and that controlling for these dimensions means that measures of relationships quality itself become redundant. A metaphor might be that of marital satisfaction as a predictor for the length of the marriage. Marital satisfaction might be a positive predictor of marital length, but once controlling for the determinants of a good marriage, it may cease to provide any incremental validity in predicting its length. If this is true, relationship quality is a mediator of attachment dimensions. A test of this hypothesis by excluding the three attachment predictors and testing the significance of the relationship variables is not recommended, however, since the model would then be misspecified (under the current model) and the parameter estimates would be biased.
A third explanation may be that the early measures of relationships quality were poor predictors of the continuing relationships over the year. The groups consisted of a majority of established trainees that had been in the same group together for at least a year as well as incoming first-year students that are replacing the students that graduated in the previous year. The groups were thus of a slow-open nature and not closed as many other groups studied have been. Furthermore, the group had completed the first block of training when they filled in the questionnaires. Thus the relationship quality could be reflecting temporary dynamics the recent change of members may have evoked. The loss and grieving of the old members might have stood in the way of the newcomers feeling welcome. The newcomers might be seen as poor replacement figures by the older members who may or may not miss their graduated members.

Yet another explanation is more technical. It could be that the lack of significance is due to a collinearity problem which is the result of high degrees of intercorrelations between the subscales of the Group Questionnaire. The study would need more observations in order to differentiate between and establish the significance of the subscales if they actually do matter.

### 3.5 The lack of other associations

Besides the significant effect of the aggregated level of attachment avoidance in the group in moderating the effects of trainee attachment anxiety on outcome, we found no evidence of any direct effects of attachment avoidance in the trainer group analyst, the trainee or the group on trainee outcome. Attachment avoidance reflects the distrust of the relationship partner’s goodwill and the striving to maintain emotional distance from partners (Mikulincer and Shaver, 2017). Although this attachment dimension represents a barrier to engaging oneself in the process that group therapy represents, higher levels of attachment avoidance may also provide some needed space in which trainees can work with their emotional problems. The trainees investigated in our study are therapists themselves and involvement of both the trainer group analyst and the group, could easily be perceived as some form of over involvement and thus be interruptive to the trainees’ explorative processes. Thus, if the attachment dimensions of the leader and/or the group were slightly on the avoidant end of a continuum, this could benefit group work due to a “lack of congestion.” Such opposing forces could rule out any significant results at the level of avoidance observed in these groups.

The lack of association between attachment avoidance and outcome could also be
related to how avoidance was measured in our study - that is, from the stance of close or emotionally intimate (e.g., romantic) relationships as measured by the ECR-R-18. It might be that such a conceptualization of avoidance is less relevant for group therapy. We would nevertheless think that the negative aspects of avoidance would appear at particularly high levels of avoidance, something that would perhaps be observed in typical patient groups.

Furthermore, we did not find any effects of the initial level of the two attachment dimensions of the individual trainees on the trainee outcome. This was in contrast to our anticipations, as previous research have suggested a relationship between group member’s attachment dispositions and outcome in group therapy (Gallagher et al., 2014a; Shechtman & Dvir, 2006; Tasca et al., 2007). However, it is reasonable to assume that the trainees in our sample where more securely attached as compared to the typical patient population investigated in these studies, which might be an explanation for the lack of associations observed in our study.

3.6 Limitations

This study has a number of limitations that need to be addressed. First, the number of trainees and trainer group analysts participating in the study was small. Given that the number of observations per explanatory variable should be 10-15 (i.e., sufficient degrees of freedom) in order to protect reasonably well against overfitting\(^3\) (i.e., the model is fitted to the statistical noise rather than the underlying relationship), our model is on the limit of having too many explanatory variables. This restraints the use and testing of other potentially important predictive variables that might be suitable predictors of trainee development. We are not in doubt that there might be other group factors and therapist factors besides attachment anxiety that are important for change in trainee interpersonal distress, but many such factors are likely to be intercorrelated which would pose a rather large multicollinearity problem (see Belsley, Kuh, & Welsch, 1980). Such multicollinearity problems require even more degrees of freedom and power to be resolved for the predictive factors to be precisely estimated. Future

\(^3\) Overfitting occurs when the number of coefficients to be estimated is large relative to the number of observations. It can be illustrated in the extreme where there are only two observations and two coefficients (i.e., an intercept and an explanatory variable, in a linear model) to be estimated. In that case, there will always be a perfect fit - one relationship explains both observations and there is no error variance - irrespective of whether it has captured the underlying model or not. Thus, the model is (also) fitted to the noise. The lack of fit to the underlying statistical model becomes evident when making predictions with the model.
research on group therapist and group factors should aim to have enough observations to make a simultaneous test of all potentially significant factors possible.

The model reduction procedure makes several $t$-tests in order to arrive at the final model. This increases the probability of making Type I errors, that is, including predictors that in reality do not predict outcome (i.e., false positives). Bonferroni adjustment (Dunn, 1959) refers to a correction of the required significance levels in order to keep the probability of making Type I errors constant. If Bonferroni adjustments were invoked in our study, the least significant variable found (i.e., the aggregated level of attachment anxiety among the group members) would cease to be significant as a predictor of change. The other predictor variables are more protected from the adjustment of the required level of significance which Bonferroni adjustments represent. There is, however, an inconsistent use of Bonferroni adjusted significance levels in the literature. Bonferroni adjustments are controversial and few studies use them presumably because such adjustments increases the probability of making Type II errors - not finding significant predictors when they actually exist (i.e., false negatives). Nevertheless, our findings should be checked for robustness through replication studies. The impact of the aggregated level of attachment anxiety among the group members on the trainee outcome remains especially uncertain until further studies have supported its importance.

The lack of random effects in the estimated model due to the small number of observations is another limitation of the analysis. This effectively stops us from identifying and analyzing potential differences between groups which might be present in our data. The resulting heterogeneity in the random disturbances to the model not accounted for may furthermore bias our coefficient estimates. It is up to future studies to allow for more observations in all dimensions and to study the significance of random effects in group-analytic psychotherapy.

Yet another limitation to our study that should be mentioned is that we used self-report measures to assess the participant’s attachment dimensions, interpersonal problems and the therapeutic relationships in groups. As all self-report measures have the inherent disadvantage of being dependent on respondents’ characteristics such as awareness and self-insight, and perhaps also on aspects of social desirability, our results could be somewhat biased. Furthermore, self-report measures of attachment, such as the ECR-R-18, are not able to assess the participants’ unconscious state of minds regarding attachment and that the unconscious aspects might be more important for assessing avoidance than anxiety as attachment
dimensions. It should also be noted that the ECR-R-18 is adopted for tapping attachment in close or romantic relationships, and that it is not necessarily suitable as a measure of attachment in groups. An alternative, and perhaps more valid way of assessing attachment in future studies, could be by applying semi-structured interview methods such as the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996). AAI has been considered to be ‘the gold standard’ of adult dyadic attachment measures (Marmarosh et al., 2013). However, administering and scoring the AAI requires in-depth training and the interview itself is time consuming. Because both the AAI and self-report measures of attachment have been extensively used in the research and produced theoretically consistent findings, there are seemingly many credible ways of measuring adult attachment (see Daniel, 2006).

### 3.7 Implications

Given that a reduction of interpersonal problems among the trainees is an important goal of therapist training, the findings from our study have several implications. First, our findings support the use of attachment theory as a valuable framework to understand why some therapists and groups seem to be more effective than others in terms of facilitating therapeutic change.

Second, our study establishes that attachment anxiety matter for the trainer group analyst. This may have implications for which group analysts are selected for the position as trainers in the group-analytic training program. Given that our result can be generalized to patient care, our study might also have implications for the selection of group therapists as conductors for groups with psychiatric patients.

Third, our study suggests that it may be important for group therapists to gain insight into how they might be influencing the group process by for example avoiding conflict in order to be liked. This may have implications for the value of the group leader’s own personal therapy as well as supervision.

Finally, our study makes an important contribution to the literature on member-group matching, with implications for group composition. Although there are probably few clinicians that routinely assess their client’s attachment orientations, it could be of value to do so during the screening process in order to have a group composition that enhances the effect of the group.
3.8 Future research

The present study establishes attachment anxiety as trainer group analyst and group factors of treatment. It is unclear to what extent these results are generalizable to group-analytic psychotherapy or group psychotherapy within the ordinary psychiatric patient population. This could be addressed by future research. Assuming at the moment that the results do generalize, another question immediately arises: does group-analytic training itself contribute to reduced levels of attachment anxiety among the trainees? To date, there are only a small number of studies that have assessed the impact of psychotherapy on changes in attachment (Fonagy et al., 1996; Levy et al., 2006; Kinley & Reyno, 2013; Maxwell et al., 2014) with mixed results. In light of our findings, it seems even more important for future research to establish under which therapeutic conditions attachment security can be promoted.

While our study has been able to demonstrate how the group-analytic training program reduced interpersonal problems among the trainees, it did not address whether the level of interpersonal problems itself played any role as either a therapist or a group factor. We did, however, observe a strong correlation between attachment anxiety and interpersonal problems in the present study. To the extent that interpersonal problems can be seen as a factor influencing therapist effectiveness, this result may suggest that attachment safety may be a prerequisite for this and possibly other therapist factors. To provide further validation of the group-analytic training program examined in this study, future research may investigate the impact of the level of interpersonal problems on trainee outcome. Furthermore, future research could examine how group therapist factors may be mediators of attachment security on group therapy outcome.

3.9 Conclusion

Attachment theory might indeed be a promising avenue for future group psychotherapy research in order to understand whether and how some group therapist and group qualities contribute to healing and personal growth among the group’s members. Attachment theory may direct the conductor to practice with his or her group in such a way that great music eventually can be made.


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Unpublished manuscript, Department of Psychiatry, Stanford University, California.
Appendices

Appendix 1: The IGA Database.

Table A1. An overview of the different inventories collected at four different waves by Leitemo and Vestbø (2017).

<table>
<thead>
<tr>
<th>Inventories in the database</th>
<th>Waves and participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trainee candidates</td>
</tr>
<tr>
<td>The Questionnaire of Cognitive and Affective Empathy (QC-AE; Renssen, Corcoran, Drake, Shyane, &amp; Vollm, 2011)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Short Profile of Emotional Competence (S-PEC; Mikolajczak, Bresseur, &amp; Fantini-Haunel, 2014)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The short version of the revised Experiences in Close Relationships (ECR-R-18; Wongpakaran &amp; Wongpakaran, 2012)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Circumplex of Interpersonal Problems (CIP; Pedersen, 2002)</td>
<td>W = (2.4)</td>
</tr>
<tr>
<td>The Subjective Happiness Scale (Lyubomirsky &amp; Lepper, 1999)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Rosenberg Self-Esteem Scale (Rosenberg, 1965)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Meaning in Life Questionnaire (MIQ; Staggers, Frazier, Oishi, &amp; Kaler, 2006)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Sentence Completion Test of Ego Development (Loevinger, 1979), 24-item version</td>
<td>W = (1)</td>
</tr>
<tr>
<td>18-item version</td>
<td>–</td>
</tr>
<tr>
<td>Compassionate love for humanity scale (Spracher &amp; Fehr, 2005)</td>
<td>W = (1)</td>
</tr>
<tr>
<td>The Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky, D. E., &amp; Rommerted, M. H., 2005)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>Therapist Qualities (Nissen-Lis, 2015)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Balanced Inventory of Desirable Responding (Paulhus, D. L., 1988)</td>
<td>W = (1.4)</td>
</tr>
<tr>
<td>The Group Questionnaire, Krogel et al., 2013</td>
<td>W = (2.3)</td>
</tr>
<tr>
<td>GQ adapted for the trainer group analyst</td>
<td>–</td>
</tr>
<tr>
<td>The Group Climate Questionnaire - Short Form (GCQ-S; MacKenzie, 1983) (small groups/large groups)</td>
<td>W = (2.3)</td>
</tr>
<tr>
<td>GCQ-S adapted for ‘the large group’</td>
<td>W = (2)</td>
</tr>
<tr>
<td>The Therapeutic Factors Inventory – 19 (TFI-19, Joyce, MacNair–Semanda, Tasca, &amp; Ogrodniczak, 2011)</td>
<td>W = (2.3)</td>
</tr>
<tr>
<td>TFI-19 adapted for the trainer group analyst</td>
<td>–</td>
</tr>
</tbody>
</table>
Appendix 2: NSD Approval

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Helene Amundsen Nissen-Lie
Psykologisk institutt Universitetet i Oslo
Postboks 1094 Blindern
0317 OSLO

Vår dato: 26.06.2015
Vår ref: 43541 / 5 / MinM
Deres dato: 
Derers ref: 

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 21.05.2015. All nødvendig informasjon om prosjektet forelå i sin helhet 23.06.2015. Meldingen gjelder prosjektet:

43541 - En studie av utvikling av terapeutferdigheter og opplevelse av personlig utvikling blant kandidater og selverføringsgruppeledere i IGAs utdanningsprogrammer

Behandlingsansvarlig - Universitetet i Oslo, ved institusjonens øverste leder

Daglig ansvarlig - Helene Amundsen Nissen-Lie

Student - Kari Leitemo

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningssloven § 31. Behandlingen tilfredsstiller kravene i personopplysningssloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningssloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.


Personvernombudet vil ved prosjektets avslutning, 01.07.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Marianne Hegetveit Myhren

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.
Appendix 3: Letter of invitation to participate in the research project

UiO : Psykologisk institutt
Det samfunnsvitenskapelige fakultet

Til kandidater og lærere ved IGAs gruppepsykoterapiutdanning på Voksenåsen

Dato: 22. mars 2017

Invitasjon til deltakelse i forskningsprosjekt

En undersøkelse av profesjonell og personlig utvikling blant kandidater og lærere ved IGAs utdanningsprogrammer

Psykologisk Institutt ved Universitetet i Oslo har etablert et samarbeid med Institutt for gruppeanalyse og gruppepsykoterapi (IGA) for å undersøke effekten av IGAs utdanningsprogram i gruppepsykoterapi og gruppeanalyse. Dette skjer med bakgrunn i at også andre utdanningsinstitusjoner innen psykoterapifeltet enten er i gang med, eller står på trappene til, å vurdere sine utdanningsprogrammer.


Hovedfråstillingen for prosjektet er:

1) hvorvidt og hvor mye utdanningsprogrammet bidrar til utvikling av terapeutferdigheter og
2) hvordan utdanningsprogrammet påvirker deltakernes opplevelse av personlig utvikling


Datainnsamlingen vil foregå ved at utdanningskandidatene og lederne av selvutvåringssamfunnene (lærerne) fyller ut selvrapporteringsskjemaer. Fire ganger i løpet av det kommande året. Det første av de fire skjemaene finner du vedlagt i denne foretaksbokken sammen med tilhørende fraandede undervisningsværktøy. Skjema (to og tre) blir først og fjernere tilgjengelig, mens det fjerdde og siste skjema(ene) vil bli sendt ut i august neste år. Skjema (to og tre) er betydelig kortere enn de to andre.

Deltakelse er frivillig. Dersom du ikke deltager, ber vi deg undersøge vedlagte samtykkeerklæring og returnere denne sammen med utfylte spørreskjemaer i vedlagte spørresvarekonventt innen 10. september.

Dersom du ikke ønsker å delta, behøver du ikke å foreta deg noe. Din deltakelse og evaluering som utdanningskandidat/lerer i programmet påvirkes ikke av om du deltar i undersøkelsen eller ikke, og heller ikke av dine svar. Du som enkeltperson vil ikke kunne identifiseres i forskningspublikasjonene.

Postadresse: Postboks 1004 Blindern, 0317 Oslo
E-post: ekspedisjonen@psykologi.uio.no
www.sv.uio.no/psa/
Som det fremgår av samtykkeerklæringen, er dette en avidentifisert bestvarelse og du skal ikke påføre navn. Det er kun forskningsgruppen (som består av Kai Leitemo og Hanne Vestbo) som har tilgang til nøkkelens som knytter en identifikator (som allerede er utfykt) til navn. Nøkkelen oppbevares i et låst skap og er ikke tilgjengelig for andre enn forskningsgruppen.

Om det lar seg gjøre, vil utvalgte resultater fra forskningen bli presentert på en av kurssamlingene i 2016/2017.

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Hanne Vestbo
Universitetet i Oslo

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Kai Leitemo
Universitetet i Oslo

-----------------------------------------------

Helene A. Nissen-Lie
Universitetet i Oslo

-----------------------------------------------

Jan Vegard Bakali
Lovisenberg DPS

-----------------------------------------------

Christian Hjort
Instituttbestyrer, IGA

-----------------------------------------------

Synnøve Bjerke
Undervisningsleder, IGA

Vedlegg:

- Spørreskjema til utfylling
- Samtykkeerklæring til undertegnning
- Svaravvalutt
Appendix 4: Declaration of Consent

UiO: Psykologisk Institutt
Det samfunnsvitenskapelige fakultet

Dato: 20. august 2015

Samtykke til deltakelse i forskningsprosjektet:
En undersøkelse av profesjonell og personlig utvikling blant kandidater og lærere ved IGAs utdanningsprogrammer

Bakgrunn og formål
Psykologisk institutt (PSI), Universitetet i Oslo skal i samarbeid med Institutt for gruppeanalyse og gruppepsykoterapi (IGA) gjennomføre en studie av utvikling av terapeuterferdigheter og opplevelse av personlig utvikling blant kandidater og lærere i IGAs utdanningsprogrammer. Prosjektet innrører en del av en professorhovedoppgave til Hanne Vestbo og Dr. Polit. Kai Leitemo, begge professorstudenter ved PSI, og vil kunne bli utvidet til en mulig doktorgradsprosjekt i fremtiden. Prosjektet veiles av psykologspesialist og forskeramened Nils Håkon Aamandsen Nissen-Lie (Ph.D), PSI, og psykologspesialist Jan Vegard Bakali (Ph.D), Lovisenberg DPH.


Hva innebærer deltakelse i studien?

Hva skjer med informasjonen om deg?


Postadresse: Postboks 1044 Blindern, 0317 Oslo
E-post: ekspedsjonens@psykologi.uio.no
www.sv.uio.no/psf/

63
**Frivillig deltakelse**
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger bli avidentifisert og ditt navn fjernet fra nekkelen som forbinder besvarelserne med deltakernes navn.

Dersom du har spørsmål til studien – eller ønsker å trekke deg, ta kontakt med Kai Leitemo på telefon 46410785, eller Helene A. Nissen-Lie (kun prosjektinfo) på telefon 22845949.

Studien er meldt til Personvernombudet for forskning. Norsk samfunnsvitenskapelig datatjeneste AS.

**Samtykke til deltakelse i studien**

Jeg har mottatt informasjon om studien, og er villig til å delta.

_____________________________________
(Signert av prosjektdeltaker, dato)
Appendix 5: The Norwegian version of Circumplex of Interpersonal Problems (CIP)

<table>
<thead>
<tr>
<th>Uttrykk</th>
<th>Valg</th>
<th>Ikke valg</th>
<th>Valg</th>
<th>Ikke valg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. gi direkte uttrykk for mine følelser overfor andre</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. holde ting hemmelig for andre mennesker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. la en annens behov komme foran mitt eget</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. vise andre mennesker at jeg er glad i dem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. være en person om å slutte å plagne meg</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. føle sinne overfor noen jeg liker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. delta i grupper</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. krangle med en annen person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. være å blande meg i andres saker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. støtte en annen persons mål med livet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. gi gave til en annen person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. være trygg på meg selv når jeg er sammen med andre mennesker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. sette grenser overfor andre mennesker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. omgås andre mennesker på en selskapelig måte</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. være sint på andre mennesker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. glede meg over et annet menneskes lykke</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. forpliktte meg overfor en annen person for lang tid</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. ta hensyn til mitt eget beste når en annen person blir kreverende</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Veldig uenig</td>
<td>Både/og</td>
<td>Veldig enig</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
<td>---------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>19. …virkelig bry meg om problemer som andre mennesker har.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. …la andre mennesker få vite når jeg er sint.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. …være bestemt når jeg trenger å være det.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. …stole på andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. …si &quot;Nei&quot; til andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. …viser at jeg er sint når situasjonen gjør det nødvendig.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. …føle nærhet til andre.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. …føle at jeg elsker en annen person.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. …presentere meg for nye mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vurder utsagn om hvordan du er eller gjør for mye overfor andre:**

<table>
<thead>
<tr>
<th></th>
<th>Veldig uenig</th>
<th>Både/og</th>
<th>Veldig enig</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Jeg holder folk for mye på avstand.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Jeg er for mistenksom overfor andre.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Jeg er for redd for andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Jeg stoler for mye på andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Jeg er for åpen overfor andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Jeg argumenterer for mye med andre.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Jeg føler meg for ofte flau overfor andre mennesker.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Veldig</td>
<td>Både</td>
<td>Veldig</td>
</tr>
<tr>
<td>---</td>
<td>--------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>35. Jeg lar meg for lett overtale av andre mennesker</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Jeg lar for ofte andres behov gå foran mine egne</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Jeg prøver i for høy grad å forandre andre mennesker...</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Jeg ønsker for mye å bli lagt merke til</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Jeg krangler for mye med andre mennesker</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Jeg er overdrevent sjenerøs mot andre mennesker</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Jeg prøver for sterkt å kontrollere andre mennesker.!</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Jeg lar i for høy grad andre mennesker utnytte meg</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Jeg prøver for sterkt å behage andre mennesker</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Jeg manipulerer andre for mye for å oppnå det jeg vil...</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Jeg forteller for mye om personlige ting til andre</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Jeg er for aggressiv overfor andre mennesker</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Jeg lar for lett en annen persons elendighet gå inn på meg</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. Jeg troller og tøyer for mye</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nedenfor finner du en rekke påstønder som handler om hvordan man kan føle seg i nære forhold. Her er vi interessert i hvordan du opplever forholdene dine generelt, ikke bare hvordan du opplever det i ditt eventuelle nåværende forhold. Dersom du ikke har hatt noen kjæreste, tenk på personer som har stått, eller står deg nær.

<table>
<thead>
<tr>
<th>Stemmer ikke i det hele tatt</th>
<th>Både/og eller nevtral</th>
<th>Stemmer helt</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Jeg foretrekker å ikke vise min partner hvordan jeg føler meg innerst inne………………………………………………………………………………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Jeg bekymrer meg ofte for om min partner virkelig er glad i meg….…………. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Jeg føler meg komfortabel når jeg deler mine private tanker og følelser med min partner……………………………………………………………………………. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Når partneren min og jeg er borte fra hverandre, bekymrer jeg meg for at han/hun kan bli romantisk interessert i noen andre…………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Jeg synes det er relativt lett å komme nær partneren min…………………. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Min partner gjør at jeg tyler mer på meg selv…………………………………... 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Jeg diskuterer vanligvis mine problemer og bekymringer med partneren min…………………………………………………………………………………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Jeg bekymrer meg en god del over å miste min partner………………………. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Jeg stoler generelt på deg, jeg har vært og er romantisk involvert med….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Jeg bekymrer meg mye for mine nære relasjoner…………………………….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Jeg forteller min partner om nært sagt alt…………………………………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Når jeg viser min partner mine følelser for ham/henne, er jeg redd for at følelsene ikke skal bli gjengjeld………………………………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Jeg synes det er relativt lett å komme nær partneren min…………………. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Noen ganger har mine tidligere eller nåværende partnere endret sine følelser for meg uten tydelig grunn………………………………………………………………………………………………….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Jeg snakker ut om ting med min partner………………………………………… 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Jeg bekymrer meg over at min partner ikke bryr seg like mye om meg som jeg bryr meg om ham/henne…………………………………………………………………………………………………………………………….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Det hjelper å gå til partneren min når jeg har det vanskelig…………….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Jeg bekymrer meg for at jeg ikke skal kunne måle meg med andre mennesker…………………………………………………………………………………………….. 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 7: The Group Questionnaire (GO). Norwegian version.

I lys av dine opplevelser i selvpplevelsesgruppen i løpet av den samlingen du akkurat har gjennomført, vurder følgende påstander:

<table>
<thead>
<tr>
<th>Nummer</th>
<th>Påstand</th>
<th>Stermer ikke i det hele tatt</th>
<th>Både/og eller nøytral</th>
<th>Stermer helt</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jeg følte at jeg kunne stole på gruppelederen under denne samlingen…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Jeg følte at jeg kunne stole på de andre gruppengledommene under denne samlingen…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Gruppelederen og jeg respekterer hverandre…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>De andre gruppengledommene og jeg respekterer hverandre…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Jeg opplever at gruppelederen bryr seg om meg selv når jeg gjør ting han/hun ikke synes noe om…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Jeg opplever at de andre gruppengledommene bryr seg om meg selv når jeg gjør ting han/hun ikke synes noe om…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Gruppelederen var varm og vennlig overfor meg…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>De andre gruppengledommene var varme og vennlige overfor meg…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Gruppelederen og jeg er enige om de tingene jeg trenger å fokusere på i denne gruppa…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>De andre gruppengledommene og jeg er enige om de målne jeg har for denne gruppa…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Gruppelederen og jeg er enige om hva som er viktig å jobbe med…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>De andre gruppengledommene og jeg er enige om hva som er viktig å jobbe med…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Gruppelederen og jeg har etablert en felles forståelse for hvilken type utvikling som vil være bra for meg…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>De andre gruppengledommene og jeg har etablert en god forståelse for den utviklingen som vil være bra for meg…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Gruppelederen og jeg jobber sammen mot mål vi har en felles enhet om…</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Stemmer ikke i det hele tatt</td>
<td>Både/og eller nevnever</td>
<td>Stemmer helt</td>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. De andre gruppendemlemmene og jeg jobber sammen mot et mål vi har en felles enighet om</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Det virket av og til som om gruppelederen ikke var fullstendig genuin og autentisk</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18. Det virket av og til som om de andre gruppendemlemmene ikke var fullstendig genuine og autentiske</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Det virket ikke alltid som at gruppelederen brydde seg om meg</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20. Det virket ikke alltid som at de andre gruppendemlemmene brydde seg om meg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Gruppelederen forstod ikke alltid hva jeg følte på innsiden</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. De andre gruppendemlemmene forstod ikke alltid hva jeg følte på innsiden</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Det oppstod spenninger og sinne mellom medlemmene i gruppa</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Medlemmene var fjerne og tilbaketrukne fra hverandre</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25. Det var spenning og angst mellom medlemmene</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26. Medlemmene brydde seg om og likte hverandre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Medlemmene følte at det som foregikk var viktig, og opplevde en følelse av delakelse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Vi samarbeider og arbeider sammen i gruppa</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>29. Selv om vi kan være uenige, opplever jeg gruppen som trygg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Gruppendemlemmene aktepterte hverandre</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

70