Working With Groups

Selection and Composition Criteria in Group Psychotherapy

Robert Unger

This article reviews the literature on the selection of members for and the composition of psychotherapy groups. Viewpoints on inclusion-exclusion criteria, as well as theories on group composition, are discussed.

The purpose of this article is to discuss the literature of the past several decades, regarding two facets of psychotherapy groups: the selection of patients for such groups and group composition. A review of the literature reveals a great diversity of opinion about selection and group composition, which highlights the fact that group therapy is quite a different entity from individual therapy, one that calls different parameters of understanding and diagnosis into play. The types of interactions that take place in group therapy and their resultant effects are highly subtle and complex and can be much more difficult to understand than those seen in individual therapy. These factors first appear in the selection and group formation processes that are the foundation for the group experience. Understanding the processes of selection and formation helps one to gain some insight into the unique nature of group therapy.

The literature on group composition and patient selection is dominated by a few themes. As might be expected, much is written about inclusion and exclusion criteria. This work is based somewhat on theoretical and experimental grounds but more largely on "seat of the pants" experience.

In its beginning section, this article looks first at the literature on selection criteria for exclusion of individuals thought not suited to be members of therapy groups. Next it reviews work on diagnostic or interactive selection criteria, moves on to consider interpersonal and behavioral criteria, and concludes its review of writings on selection with an examination of those that relate selection criteria to overall treatment context and to individual personality.

The second section of this article considers writings that treat the controversial issue of homogeneity versus heterogeneity in group composition—how alike or unlike members should be. The article concludes with a discussion of the implications of the literature it has reviewed, focusing particularly on group environment. It takes up the question of whether or not there may be said to be an optimal environment for a given patient, or for the majority of members in any therapy group, discussing this question in terms of the two issues raised in the literature of degree of homogeneity and appropriate amount of interpersonal conflict.

INCLUSION-EXCLUSION CRITERIA

Who is an appropriate candidate for group psychotherapy? There are widely varying opinions on this subject. Corsini noted in 1957 that there is little agreement as to who benefits from group therapy and who does

Robert Unger is a doctoral student in counseling, the University of Colorado, Boulder and he is also in private practice.

not, and this still seems to be essentially the case. In a study conducted at the 1959 annual meeting of the American Group Psychotherapy Association, Rosenbaum and Hartley (1962) polled 92 group therapists and found among them considerable overlap between clients considered appropriate and those considered inappropriate for group therapy, suggesting much confusion in this area.

Generally, writers have focused more on exclusion than upon inclusion criteria. In surveying early writers, Bach (1954) notes that among them there is greater agreement on contraindications than indications for group therapy. Earlier writers such as Slavson (1955) tend to be more exclusive, while more recent writers such as Hawkins and White (1978) are deeming more people suitable for group therapy, as understanding of the curative factors in the group process increases. Hawkins and White feel that the list of contraindications has been decreasing largely because some of those previously thought not to be amenable to group treatment are now being treated in specialized groups.

Writers tend to define inclusion-exclusion criteria in either diagnostic or interactive terminology. Yalom (1985) notes that psychopathic, paranoid, hypochondriacal, drug or alcohol-addicted, acutely psychotic, sociopathic, and brain-damaged individuals are poor candidates for group psychotherapy. Woods and Melnick (1979) add borderline adjustment, schizoid withdrawal, and somatization to this list. Slavson (1955), considered by many to be the father of modern group psychotherapy, eliminated obsessive-compulsives, disturbed psychotics, full-blown anxiety neurotics, cyclothymic personalities, suicidals, active homosexuals, compulsives, hypochondriacs, and true hysterics from group treatment.

In contrast to the above diagnostically oriented categories, other authors have the impression that interpersonal or behavioral measures, although less commonly used, are more appropriate in the selection process. Horowitz (1976) states that diagnostic categories are useless and that the most important criterion is the patient's capacity to stay with treatment. Kadis, Krasner, Winick, and Foulkes (1963) note that the importance of diagnostic categories recedes when the group is viewed in its totality. Woods and Melnick (1979) state that the standard diagnostic interview is not a particularly useful way to select patients for groups, and that given the interpersonal nature of group treatment, it is surprising that behavioral and interpersonal measures for group selection are not used more frequently.

Other authors have commented on diagnostic procedures for selection criteria. A study done by Piper and Marrache (1981) found that the dyadic interview method was at best an indirect way to find out about interpersonal behavior, and that psychiatric interview variables were poor predictors of therapy behaviors. Friedman (1976) feels that indications for group psychotherapy are somewhat different than for individual therapy, so that standard diagnostic procedures must be modified. It is Yalom's impression that the standard intake interview has little value in predicting group behavior. Berne (1966) thinks that reading a patient's chart should not be taken too seriously.

There is some general agreement about behavioral and situational factors that are causes for exclusion from group therapy. Many writers such as Yalom (1985) and Horowitz (1976) believe that people in crisis situations are not appropriate candidates for group therapy, since their inclusion causes the energy of the group to be mobilized in solving an external crisis. Sociopaths and others displaying impulse-motivated antisocial behavior are also considered by many writers, such as Yalom (1985) and Corsini (1957), to be poor candidates for group therapy, as their impulsiveness can evoke reality-based fears in other people. Hawkins and White (1978), however, indicate that impulsive people can be treated in homogeneous groups.

Inclusion criteria for groups tend to be more behavioral descriptive and less diagnostic in focus. Slavson (1955) sets four general criteria for inclusion into groups:

(1) the patient must have experienced minimal satisfaction in his or her primary relations sometime during childhood, (2) a minimal degree of sexual disturbance, (3) a moderate ego strength, and (4) minimal superego development. He also notes as positive indicators people with character disorders, people who use projection as a defense mechanism, compliant personalities, and schizoid types.

There are some general behavioral and personality characteristics that are noted by several writers as positive indications for group treatment. Motivation and preparation are often cited as the most important criteria for successful group participation. Berne (1966) feels that any patient can be introduced to a group after proper preparation, and that exclusion of a type of person from a group usually represents a conscious or unconscious snobbishness on the part of the therapist. Woods and Melnick (1979) and Yalom (1985) also list motivation as a primary ingredient for inclusion in a therapy group. Friedman (1976) notes that group therapy is indicated for people who define their problems as interpersonal or emphasize the interpersonal aspects of their problems, although Yalom notes that many noninterpersonal problems have interpersonal roots.

Yalom (1985) also notes that, since the standard diagnostic interview and standard psychological testing both fail to yield predictions of group behavior, attempts are being made to define behaviors that might be relevant for predicting functioning in groups. Some possibilities are dogmatism, preference for high or low structure, social avoidance, locus of control, and interpersonal trust.

Most authors believe that patients must have some basic social skills to participate in and benefit from group therapy. Mullan and Rosenbaum (1962) emphasize relatedness as a general requirement and state that the patient must have reality contact and be able to be related to interpersonally. They feel that the person who has experienced minimal gratification in early interpersonal relationships will need to have individual therapy to prepare him or her for inclusion in a group. Horowitz (1976) cites the ability to withstand frustration, particularly in the early phases of group, as important, since group therapy is initially more frustrating than individual therapy.

Other writers cite indications for group therapy in terms of interpersonal behavior. Friedman (1976) lists commitment to change interpersonal behavior, willingness to become susceptible to influence of the group, willingness to report subjective experience of benefit to the group, and willingness to be of help to others in the group setting as desirable qualities for group inclusion. Corsini (1957) feels that the therapist needs to understand the nature of the patient's authority problems, his or her ability to reveal himself or herself to a peer group, and his or her ability to express aggression and to maintain tolerance for others' expression of hostility, before referring him or her to a group. Although self-disclosure is often cited as a positive indication for group inclusion (Yalom, Houts, Zimberg, & Rand, 1967), excessively high vulnerability (Bond & Lieberman, 1978) or extremely high self-disclosure (Woods & Melnick, 1979) are considered poor indications.

Some writers consider the overall context of treatment, as well as the personality of the candidate when determining inclusion-exclusion criteria. Bond and Lieberman (1978) state that most studies of group selection have focused on the characteristics of the person rather than of the situation. They note that, although dropouts are usually viewed as a failure of treatment, dropping out might be beneficial for the client, if the group is an improper one. Mullan and Rosenbaum (1962) feel that careful attention must be paid to the personality of the therapist, and Friedman (1976) notes that the competence of the group leader is an important consideration when assessing how a patient might do in

a group. Yalom (1985) notes his belief that, if the therapist has dislike for the patient, he or she probably will not do well in a group. Woods and Melnick (1979) note that the client-therapist conceptual style of relating and problem solving will be related to a successful group outcome for the client.

Although according to writers such as Yalom (1975), social deviants do not do well in groups, deviance itself must be viewed relative to the context of the particular group (Bond & Lieberman, 1978). The makeup of the group is thus important in determining inclusion and exclusion criteria. Bach (1954) notes that a person must have at least one other member to identify with, in order to participate successfully in the group.

Other attempts have been made to define individual selection criteria in a group interactive context. Bach (1954) states that a selection criteria should be employed that will avoid excessive tension and anxiety for all group members. Mullan and Rosenbaum (1962) state that a suitable client has sufficient flexibility to be able to heighten or lower intergroup tensions. These ideas reflect the importance of considering the person in the context of overall group functioning. Yalom (1985) contends that group success is only partially related to the efforts of a therapist and that the critical variable is some unclear blending of group members.

The irony of the above indications for group therapy is what Woods and Melnick (1979) described as the syndrome of "the rich get richer" (p. 171). That is, many of the positive indicators for group therapy seem to necessitate the very skills that the group would help the patient to gain. Hawkins and White (1978) note that lack of the specific skills needed to do well in group therapy is usually why people are referred in the first place. Friedman (1976) suggests that generally, the least disturbed patients will do better in group therapy, although some of the writings on homogeneous groups cited below contradict this. It is thus important to understand group composition in context of how groups might be able to help the greatest number of people.

GROUP COMPOSITION

The structural parameter most frequently cited in group therapy literature is that of homogeneity versus heterogeneity. Corsini (1957), in fact, notes this as the most controversial issue in group composition. Most writers see homogeneous and heterogeneous groups as two essentially different types of groups that are suited for different kinds of patients. Several different aspects of homogeneity and heterogeneity are discussed, the most common concerning diagnosis. Also mentioned, however, are demographic characteristics such as age, sex, race, and socioeconomic status.

Homogeneous groups are generally thought of as being useful for treating certain specific problems or diagnostic categories. They have been thought to be an alternative approach for patients considered inappropriate for standard mixed-group therapy (Woods & Melnick, 1979). Frances, Clarkin, and Marachi (1980) point out that they are especially useful for people who experience their condition or disorder with embarrassment or feelings of uniqueness or isolation, and who can benefit from sharing with others of the same experience. Homogeneous groups have been recommended by Hawkins and White (1978), Kadis et al. (1963), and others for treatment of organic disorders, psychosomatic problems, substance abuse, and general problems of impulse.

Several writers have outlined advantages to homogeneous groups. Frances, Clarkin, and Marachi (1980) state that the sense of commonality and of jointly fighting a shared problem provides immense support and self-validation. Cabral (1981) conducted a study in which a computer model was used to analyze symptom alleviation in three therapy groups. Results showed that the homogeneous group improved the most quickly. Citing some benefits of homogeneous groups, Yalom (1985) notes that they jell more

quickly, offer more immediate support, are better attended, contain less conflict, and provide rapid relief of symptoms.

Homogeneous groups are also considered by many to have limitations. Frances, Clarkin, and Marachi (1980) note that homogeneous groups generally avoid uncovering psychological interpretations and tend to be abreactive, inspirational, role models, or advice giving. Such groups can also be inflexible, dogmatic, mystical, and not to everyone's taste. According to Frances et al. (1980), the depth of interaction in a homogeneous group might be more superficial, with less opportunity for multiple transferences and with reality testing hampered by a restrictive range of inquiry and self-disclosure.

In contrast, heterogeneous groups are composed of a variety of types of people, with different diagnostic and demographic characteristics. Although heterogeneity can be considered in terms of such demographic attributes as age, socioeconomic status, and education, the area of heterogeneity most commonly considered by writers on group selection is presenting problem or diagnosis.

Heterogeneous groups are generally thought to foster a different type of group process than do homogeneous groups. Harrison and Lubin (1965) feel that heterogeneous groups are valuable in providing alternate perceptions and ways of behaving needed for optimal growth. Frances, Clarkin, and Marachi (1980) note that the variety of interactions and transferences available in a heterogeneous group affords the member the opportunity to correct perceptual distortions about others, to understand how others regard him or her, and to alter maladaptive patterns, and that both symptoms and character structures are likely to be affected.

The nature of heterogeneous groups presents some problems. Furst (1952) and Frances, Clarkin, and Marachi (1980) note that identification with the group and symptom alleviation are generally thought to be slower than with homogeneous groups. Treatment will usually take longer, resulting in greater time commitment and cost to the patient. Furst (1952) also notes that problems of interaction become intensified, creating greater difficulties for the therapist. It is Rosenthal's (1985) impression that heterogeneous groups take longer to obtain cohesiveness, although they usually go to greater depth, an opinion shared by several other writers.

The degree of heterogeneity of a group also appears to be largely related to the amount of conflict that will appear in the group. According to a number of writers, the more heterogeneous the group, the greater the possibility that conflict between group members will occur. Harrison and Lubin (1965) see value in this phenomenon, stating that groups in which conflict is built-in stimulate members to deal effectively with people different from themselves. They also note that the optimum amount of conflict is not clear, nor is the optimum amount of time spent in conflict, and they add that things do not have to come out all right at the end, the residue of conflict perhaps having a more lasting impact. Yalom (1985) notes, however, that the intensity of conflict cannot exceed the members' tolerance for it, if it is to be useful to the group. He also thinks that a group can contain elements of homogeneity and heterogeneity and suggests that groups can ideally be heterogeneous in patients' conflict areas and patterns of coping, and at the same time homogeneous as to patients' degree of vulnerability and capacity to tolerate anxiety.

Furst (1952) presents some general guidelines for choosing between homogeneous and heterogeneous groups. He believes that homogeneous groups would be chosen when: (a) the interview type of therapy is preferred, (b) a less profound and nonintensive type of therapy is utilized, (c) the therapist is not trained or prepared for deep therapy, and (d) time and expense are important. According to Furst, heterogeneous groups should be utilized when: (a) deep levels of therapy are desired, (b) modification of character structure is desired, (c) training and experience of the therapist is adequate, and (d) time and expense are less important.

DISCUSSION

The literature reviewed in this article suggests some interesting implications of group selection and composition processes. Concerning inclusion-exclusion criteria, it is interesting to find that the prevailing feeling in the literature is that traditional diagnostic categories are of little use in determining appropriateness for group treatment. Also of note is the finding that there are such widely diverging opinions on who should, and who should not, be included for group treatment. This suggests the possibilities that group treatment is still a discipline in its infancy with some basic parameters yet to be established, and that group therapy is a highly complex specialty that does not readily lend itself to the traditional diagnostic categorizations typically utilized.

The above findings raise the question of the type of environment most suited to help a particular patient. This is a difficult issue because an individual patient, while ideally needing the "right" environment—one which helps to resolve that patient's difficulties as they are expressed interpersonally—is also ideally a part of what one hopes is the "right" environment for the other patients in the group. Thus group formation has to be a considerable compromise for everyone, owing to still limited knowledge about group formation and the logistical constraints on forming an "ideal" group. This by itself is not tragic, since a person's social and familial environment is always a compromise from the ideal, but it still presents the question of what might be the best group environment for the most people, or at least the one that is necessary to enable the group to reasonably progress.

It appears that the issues of homogeneity and heterogeneity and of group conflict as discussed by the writers cited above best address this question. As was noted, most writers feel that the degree of homogeneity in groups generally determines the possibilities for cohesion and identification. While there is a belief that individuation and depth is somewhat limited in homogeneous groups, relatively quick symptom-relief can take place. Heterogeneity in groups is thought to result in greater difficulties in group identification and to produce both more conflict among members and greater hardships for the leader. In this type of group, however, there exists possibilities for greater individuation and more in-depth work, largely through the resolution of conflicts that arise from the widely varying characteristics of the members.

This is an important factor in group structure and is reminiscent of some basic aspects of developmental theory. The difficulties in progressing from narcissistic states, where identification is primarily with like objects, to more object-related states, where one must experience the pain and frustration of being essentially differentiated from others is well known. It seems that the heterogeneous-homogeneous facets of group therapy address this conflict, and both have their merit. Of the literature reviewed, Yalom most clearly addressed this issue, suggesting that the combination of heterogeneous and homogeneous elements can, and perhaps should, occur in a given group.

If group therapy is to help one prepare for the everyday realities of life, it seems ultimately desirable to emphasize its heterogeneous aspects. Since people are constantly confronting situations that call for viewpoints different from their usual views, identifications, and experiences, the group should help them to prepare to confront that reality.

It is also possible that in a given moment any group can be viewed as essentially heterogeneous or homogeneous. A skilled group therapist would therefore be able to bring out the similar or disparate qualities of the members, depending on the needs of the group. When it appears that cohesiveness and mutual identification are needed to manage the group tension level or to protect the egos of members, the group can be treated more homogeneously, with interventions made to emphasize common aspects or themes. When the group is in a relatively comfortable state and needs to move ahead, the leader can intervene in a way that will

allow heterogeneous or conflicting situations to arise between members. The leader must be able to modulate this situation to deal effectively with conflict, so that the group members are protected (Unger, in press). Discussion of the techniques to accomplish these goals is beyond the scope of this article, but it is this kind of flexibility on the part of the group leader that can provide the most powerful therapeutic experience for group members.

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