

When It Is Not a Good Fit: Clinical Errors in Patient Selection and Group Composition in Group Psychotherapy

David Kealy, John S. Ogrodniczuk,
and William E. Piper
University of British Columbia

Carlos A. Sierra-Hernandez
Simon Fraser University

Group psychotherapy provides unique opportunities for clinical errors in the selection of patients and composition of therapy groups. This article introduces some of the difficulties and complexities that can be associated with group composition and patient selection errors. Clinical vignettes from psychodynamic/interpersonal psychotherapy groups are used to illustrate three variations of group composition and selection errors. The first vignette depicts an error in selecting a disruptive patient into a fledgling group. The second vignette portrays an unsuccessful integration of a withdrawn, inhibited patient into an active, exploratory group. The third scenario illustrates challenges associated with poor quality of object relations in homogeneous group composition. Although research on group therapy composition and patient selection is limited, relevant empirical literature is integrated in our discussion of clinical implications and recommendations.

Keywords: group psychotherapy, clinical errors, patient selection, group composition

In group psychotherapy, the selection of patients and the composition of groups are issues that go hand in hand. Therapists' decisions about the composition of a group will significantly inform and influence decisions about which patients are selected to participate. The selection of individual patients will then ultimately determine the combination of interactive styles and behavioral idiosyncrasies represented in the group's make-up. The selection and composition decision-making process presents opportunities for clinical errors that have somewhat unique implications compared with other mistakes in psychotherapy. Errors in patient selection and group composition may have deleterious effects not just for an individual patient, but also for the experience and therapeutic progress of other group members. Indeed, misjudgments in selection and composition can in some cases impair the overall climate and work of a group (Gans & Counselman, 2010; Marmarosh, Markin, & Spiegel, 2013). These errors easily lend themselves to therapists' defensive nonacknowledgment of their existence: it may be all too easy to "blame" the patient or the group for the consequences of an injudicious enrollment of a patient. Moreover, these clinical errors—if recognized—can sometimes be particularly difficult for therapists to rectify.

Composition in group psychotherapy refers to the blend of personal characteristics among individual group members (Rutan, Stone, & Shay, 2014; Yalom & Leszcz, 2005). Composition is

usually discussed in terms of the relative homogeneity or heterogeneity of group members' characteristics. These range from concrete variables—such as age, sex, and diagnosis—to abstract features like interpersonal relationship patterns or capacity for reflective functioning. Composition can be adjusted to serve the objectives of a group, with more specific aims typically calling for greater homogeneity among members. A short-term group to relieve symptoms of postpartum depression, for example, will have a greater degree of homogeneity (sex, diagnosis, recent natal experience) than a long-term exploratory/interpersonal group. The selection of patients for a group, in terms of the characteristics they possess, will thus be greatly influenced by decisions regarding the group's optimal composition. An error at this stage of planning a group will only be reinforced as patients are selected to reflect the desired composition. In other words, patient selection can have a compounding effect on a flawed group design. For example, a group intended to address narcissistic difficulties might be designed with a narrowly defined homogeneous composition. The subsequent selection of members with equally high levels of narcissistic grandiosity could conceivably impede the objective of the group. In this case, some degree of between-member variance in grandiosity may be more likely to foster exploration of shame and vulnerability than a group where all members vigorously defend against it. A common group composition error is the omission altogether of careful consideration for the combination of members' characteristics. Such concern may be regarded as almost irrelevant in some resource-strapped public mental health settings, where cost-saving and efficiency measures result in patients being indiscriminately enrolled on a first-come, first-served basis.

Even when group composition is carefully deliberated, the process of patient selection introduces considerable potential for clinical error. To some extent, the literature describing "the difficult patient" in group therapy (Motherwell & Shay, 2005; Yalom &

David Kealy, John S. Ogrodniczuk, and William E. Piper, Department of Psychiatry, University of British Columbia; Carlos A. Sierra-Hernandez, Department of Psychology, Simon Fraser University.

Correspondence concerning this article should be addressed to David Kealy, Department of Psychiatry, University of British Columbia, 420 – 5950 University Boulevard, Vancouver, BC V6T 1Z3. E-mail: david.kealy@ubc.ca

Leszcz, 2005) attests to this, as presumably the extent of the patient's vexing characteristics was not sufficiently considered by the assessing clinician before enrollment in the group. Selection errors can alter the composition of the group from a combination that works to one that does not, veering a group off its intended course and potentially interfering with individual members' treatment.

In this article, we present three vignettes from the first author's clinical practice to illustrate some of the particular difficulties that emerge when clinical errors occur in the selection of patients and composition of therapy groups. The examples that follow are taken from various long-term psychodynamic/interpersonal therapy groups conducted over several years.¹ In the tradition of Yalom (Yalom & Leszcz, 2005) and Rutan and Stone (Rutan et al., 2014), these groups involved relatively heterogeneous membership, an emphasis on exploration rather than education, and a focus on addressing longstanding characterological and interpersonal difficulties.

Selecting a Disruptive Patient

Ron was a middle-aged man who suffered significant blows to his self-image after a major career setback and a period of profound depression. Having previously enjoyed a position of authority and prestige in his professional life, Ron was now surviving on disability benefits and orienting his schedule around numerous medical and psychological appointments. Ron's individual therapist referred him for additional treatment in response to Ron's persistent anger and frustration at having made insufficient progress with individual psychotherapy and psychopharmacological treatment. During the assessment, Ron confirmed his feelings of bitterness and pessimism about the potential benefits of further psychological treatment. Nevertheless, he agreed to enroll in a new long-term interpersonal group that was being put together.

Within moments of the group's commencement, Ron began expressing his contempt for the therapists and exerting his dominance over the group process. Any effort on the part of the group therapists to establish boundaries and norms for the group was met by Ron expressing derision. For example, Ron insisted that sessions end not at an established time, but according to group consensus. He proclaimed that group members should feel free to hug one another despite our guidance to talk about, rather than act out, emotional responses. Indeed, Ron regarded the therapists' efforts to promote safety, sharing, and exploration as feeble attempts to hide our incompetence. Interpretative comments—including those made to other group members—were often greeted by a sneering retort about the uselessness of professionals' psychobabble. Our fledgling group seemed to be on course for a major collision, as various group members began to miss sessions here and there—ostensibly for practical, external reasons. Efforts to discuss group members' reactions to Ron's behavior or the group process overall were fruitless. Indeed, although other group members were essentially deprived of opportunities to use the group for their own exploratory work, outwardly there appeared to be nothing but support for Ron as the de facto leader of the group. Eventually, Ron effected his own solution to having been poorly matched to this group: he left. Unfortunately, he did so with his feelings of bitterness intact—and perhaps intensified. Immediately

following his departure, several group members declared that an error had likely been made in selecting Ron for the group:

Morris: *What a relief that's he's gone. it felt like he had hijacked the group.*

Tanya: *I hope Ron gets the help he needs. He's clearly struggling. But I do not think this group was a good fit for him. Will he be getting any more support?*

Therapist: *Yes, we will ensure that he will be linked with further services. It would be interesting to hear more about your reactions to Ron leaving the group . . .*

Kerry: *Now we can actually get some work done. I feel for the guy, but he was like a bulldozer in the group. He really let you guys [group therapists] have it. Maybe he's just not ready . . .*

Following this exchange, group members proceeded to bring forth material pertaining to their own issues, with little further reference to their experience of Ron's involvement in the group. The therapists were somewhat surprised and dismayed that group members who expressed relief at Ron's departure had indeed supported him in his criticism and devaluation of the group's structure and leadership. The fledgling nature of the group, however, had likely precluded exploration of this dynamic. Lacking a sufficient sense of safety or cohesion, group members may have felt afraid of challenging Ron's dominance. As well, their concern for his well-being might have allowed them to tolerate his behavior, even at the expense of their own therapeutic progress. Under ideal circumstances the therapists' efforts to contain Ron's behavior might have been bolstered by the input of other group members. Furthermore, the therapists could have leveraged the group's reflective abilities to explore what function Ron's actions might have served for the group overall.

Much of the difficulty that ensued on Ron's admission to group therapy might have been anticipated at the selection stage. Although his history of interpersonal difficulties was comparable in severity with other group members, Ron held particularly negative opinions of treatment providers in the wake of having suffered significant narcissistic injuries. His behavior in the group may be understood as a form of projective identification (Steinberg & Ogrodniczuk, 2010), whereby the shame and enfeeblement he had experienced but disavowed was being evoked in the group therapists. Exposing such feelings in a group setting was likely intolerable, and he instead sought safety by attempting to wrest control of the group. The "difficult patient" in group therapy usually has accomplices: group dynamics influenced by therapists and other group members often coalesce with the individual's problematic behavior to coconstruct the difficulty (Gans & Alonso, 1998). In this case, group members may have been unconsciously relying on Ron to do the "storming" (Tuckman & Jensen, 1977) work on their behalf, expressing their collective anxieties with an aggression that may have felt somewhat empowering. Moreover, the newness of

¹ Case descriptions have been disguised by either providing an amalgam of different cases, or by changing name, gender, age, occupation, and other identifying features.

the group was an additional, compounding factor: Ron's antagonistic behavior had been given a prime forum owing to the lack of sufficiently established norms and safety. It is conceivable that Ron could have profited from a referral to a mature group composed of seasoned group members. A group with a stable composition and an established working culture would likely be better equipped to convey a sense of safety to a narcissistically threatened patient, and better able to contain and empathically confront paranoid projections. Indeed, sometimes the selection of a somewhat disruptive patient can invigorate a group and stimulate members to work on difficult interpersonal dynamics that might otherwise lay dormant.

Pathological narcissism is a formidable clinical issue to address in group psychotherapy. Research involving group therapy patients has found high levels of narcissism to be associated with domineering, vindictive, and intrusive interpersonal behaviors (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009). Moreover, patients with narcissistic features tend to drop out of group therapy prematurely (Ogrodniczuk et al., 2009). Ideally, patients like Ron who disrupt group treatments and prematurely drop out should be identified at the assessment and selection stage, and referred for alternate treatment. However, establishing strict exclusion criteria regarding narcissistic and paranoid features would prevent some individuals from obtaining much-needed treatment that could provide significant benefit. In other words, disruptive potential by itself is not necessarily a sufficient exclusion issue for group therapy in general. Group clinicians are thus left to weigh multiple factors—including patient characteristics and the nature of the group's composition and maturity—in deciding whether to admit such patients to a particular therapy group. Should considerable difficulties arise that create serious threats to the group, as in our example, therapists are advised to be proactive (Yalom & Leszcz, 2005). Rather than waiting for the patient to leave under a cloud of resentment or dejection, the therapist should consider "owning" the selection error and recommending to the patient a treatment that would be more suitable (Motherwell & Shay, 2005). This should be done with tact and sensitivity to other group members' anxieties about being arbitrarily removed from the group.

The Immobilized Patient (in a Group That Moves)

Delores was a 40-year-old married woman who was referred to an existing interpersonal group after an extended series of consultations regarding persistent depression. She had previously taken part in brief psychoeducational interventions, and she continued to work with a psychopharmacologist in an ongoing effort to find the right combination of medicines to abate her gloomy feelings. Although never suicidal, Delores evinced a longstanding lack of zest. She described herself as easily overwhelmed—tending to retreat to her bedroom to avoid being stressed by external stimuli—and often troubled by somatic symptoms. Despite these difficulties, Delores impressed the assessing clinician as being conscientious and eager to connect, as she had long felt lonely and isolated. She was enrolled in group psychotherapy with the goals of alleviating depressive symptoms, addressing chronic poor self-esteem, and enhancing her capacity to engage with others.

Delores was warmly welcomed by the members of what was by then a mature group. Group members disclosed the difficulties that had brought them to therapy, and reassured a nervous-looking

Delores that they too had once felt anxious about engaging in group treatment. This helped Delores reveal some of her struggles. She seemed to feel validated in discovering that others had also suffered from depression, with similar stories of multiple and frustrating treatment efforts. However, the group members also described in detail their childhood traumas, interpersonal disappointments, and maladaptive efforts to cope with developmental adversity. The group had also developed to the point where members could examine here-and-now interactions in the group in the context of their individual patterns. Accustomed to new members needing time to catch on to this way of working, the group patiently and gently attempted to help Delores develop an exploratory perspective. Delores, however, seemed dazed and stunned into silence. She stared blankly for much of each session. When invited by comembers to speak, she responded with reports of her symptoms or medication updates. Minute slivers of information about her marriage or her former work would seep out at a glacial pace. Group members became increasingly aware of Delores' need to develop more of a bond with the group—even growing frustrated at the work of having to extract her minimal involvement.

Rhonda: *Delores, we haven't heard from you yet today [three-quarters into the session] and last week you barely talked. How are you doing?*

Delores: *I'm fine, I guess.*

Rhonda: *A few weeks ago you mentioned something about your husband being unsupportive . . .*

Delores: *Oh, it's okay now. He doesn't seem upset anymore[silence].*

Rhonda: *Well what happened?*

Delores: *Nothing. He's still frustrated that my new medication hasn't kicked in yet [silence].*

Tim: *Are you concerned there are deeper issues between the two of you? Maybe there's something there that might be contributing to your depression?*

Delores: *No [long silence].*

Susan: *It can be really hard to think about these issues, Delores, but we've all been there [long silence].*

Rhonda: *Do you and your husband talk about your feelings for each other?*

Delores: *Not really. I just do not see how this is relevant. I know you're trying to help, but I'm tired and these questions are giving me a headache.*

Occasionally, the group's efforts at prodding Delores to engage seemed to overwhelm her, and she would miss one or two subsequent sessions. On returning to the group, however, only a concrete explanation for the absence was provided, despite efforts to link her behavior to group activity. These absences eventually progressed to the point where she backed out of the group entirely, giving an explanation that she was too fatigued to regularly attend the clinic.

Compared with Ron, Delores had presented in a manner that seemed to make her a more reasonable candidate for group psy-

chotherapy. Nevertheless, some potential concerns at the selection stage might have been considered. Information available during the assessment suggested that Delores may have experienced emotional distress somatically, and that she tended to respond to her feelings with action (e.g., by withdrawal) rather than through reflection or discussion. In addition to her preoccupation with her symptoms, she had long been socially isolated and unaccustomed to participating in group activities. While many prospective group members may exhibit some of these characteristics, Delores possessed all of them at once. This combination, along with her high degree of anxiety and hypersensitivity, seemed to be particularly poorly matched to the level of functioning enjoyed by the existing group. Referral to a different group—perhaps one with greater variability in patients' emotional functioning—might have allowed Delores to feel more comfortable and less threatened. Alternatively, Delores may have been more suitable for a different kind of group altogether—perhaps involving a homogeneous membership—where a structured content could focus on symptom reduction and behavioral activation. An experience of success in a less-overwhelming group situation might help a patient like Delores feel better prepared for a group with a robust exploratory ethos.

What options exist for the group therapist who has selected a withdrawn, nonintrospective patient for a mature group? As with any patient who occupies the role of deviant group member, one should consider the broader group-level dynamics that may be contributing to reinforce the situation. For example, is it possible that Delores' comembers limited the degree to which they might have helped her adjust to the group, perhaps dreading to identify with her regressive state? Maybe Delores unwittingly reminded some group members of a sullen parent whom they once struggled in vain to enliven. Perhaps Delores herself was enacting a similar dynamic experience from her own history. Interpretations that seek to foster curiosity about such processes may help to bridge the gap between the frozen patient and the rest of the group, and can reduce the group's scapegoating of the silent member (Brown, 2008). In some cases, however—particularly with a patient lacking psychological mindedness (McCallum & Piper, 1990)—this may only slightly delay an inevitable departure from therapy with limited improvement. According to Yalom and Leszcz (2005), identifying a situation where this is likely is better done sooner rather than later. The group therapist should then take care to help the patient obtain alternate and more suitable treatment (Brown, 2008).

Asking a patient to leave an existing group should not be regarded as a routine intervention. Doing so risks the further demoralization of the individual, and may evoke members' fears about potentially being removed if not compliant with the therapist's wishes. Before deciding to recommend a member leave, the therapist should consider whether further efforts could foster a more productive engagement with the group. Moreover, the therapist should be alert to the potential weight of negative countertransference in arriving at such a decision: wishing to remove a patient out of a sense of frustration should not be confused with a sound clinical determination that the patient would do worse to continue in the group. Nevertheless, the failure to remove a poorly fitted patient is an error in itself, as the patient will be deprived of the opportunity to leave an ineffective treatment and find a viable alternative with the collaborative guidance of a professional.

Yalom and Leszcz (2005) advise that this is best managed during an individual meeting with the patient in question, to reduce the individual's sense of shame and to avoid group members' counterproductive protestations over the decision. The subject should be broached with the patient as an opportunity to review and optimize his or her treatment. Often patients will be relieved when the therapist matter-of-factly indicates that having a poor fit with a group/therapist/therapy is a not-uncommon experience. The therapist can then impart a sense of hope and optimism regarding a more appropriate referral.

An Unproductive Mix

Following the planned departure of several members from an established group, Maggie and Irene were referred as prospective new members. Both women had been seen for individual psychotherapy regarding longstanding dysthymia, poor self-esteem, and interpersonal difficulties. Their therapists were recommending "something more" in the hope of accelerating changes that had been relatively slow in developing via individual therapy. In assessing the suitability of Maggie and Irene, the clinician was struck by certain similarities they shared. Both were middle aged and divorced, and were single mothers with stormy relationships with their children. Both had themselves suffered from abuse and neglect during their childhood. As adults, their relationships with partners had been fraught, and both women tended to view intimate relationships as inevitable power struggles that they were destined to be on the losing end of. Nevertheless, Maggie and Irene interacted in a pleasant manner during consultation interviews, and each seemed appreciative for the opportunity to join the group.

Maggie and Irene were welcomed by group members who had felt somewhat anxious about the unfilled chairs in the room following the departure of their comembers. After several sessions in which the group became acquainted with the new members, it appeared as though this group had renewed itself. All members—including Maggie and Irene—actively participated, and commented favorably on the sense of support they derived from the sessions. From the therapists' perspective, however, the group had stalled. What had once been a forum for examining here-and-now interactions had now become a venue for members to vent their various frustrations. Where intragroup and intrapsychic processes had previously been explored, the group's material now alternated between bitter complaints about those who had done members wrong, and applause for members' concrete and reactive responses to the problems in their lives. Although members got along well with and felt supported by one another, the level of empathic connection among them was fairly shallow. Rather than deeply resonating with one another's painful feelings, and attempting to tolerate potential feelings of vulnerability and impotence, group members instead provided brief validation before venting their own hurts and disappointments.

Sandra: *I had a date this weekend, but it went terrible . . .*

Irene: *I've pretty much decided to never go out with a man again. Nothing against the guys in this group—I just haven't had good experiences with men.*

Therapist: *Irene, perhaps the group can provide an opportunity to learn a little bit more about your experiences with men . . .*

Maggie: *My relationships with men have been awful too. But it's not about them being men—it's a power issue. The only way a relationship can work is if you're on top. You have to keep your eye on the other person 'cause they'll try to use you or control you.*

Therapist: *That's an interesting perspective that perhaps fits with some of your experiences. But I wonder if there could be other ways of understanding what happens in these relationships?*

Irene: *You know the saying, "it's a dog eat dog world"*

Sandra: *Getting close to someone just invites them to take advantage of you.*

Ted: *That's like my first wife, she nearly destroyed me, even after all I did for her.*

Maggie: *Just make sure you're in charge if you get into a relationship again—only you can look out for number one!*

Variations on the above sequence were repeated for a protracted period, during which the group seemed impervious to the therapists' various efforts to induce curiosity about intrapsychic and interpersonal themes.

On the surface, Maggie and Irene seemed to fit well into an established group that happened to be in need of additional members. Indeed, no one could be pinpointed as a "difficult patient." The clinician's assessment observation of Maggie and Irene's similarity is a clue to the problem in this scenario: the patients were too similar—both to one another and to the remaining group members. Both women could be classified at the lower end of the continuum known as quality of object relations (QOR; Azim, Piper, Segal, Nixon, & Duncan, 1991). In other words, both had histories of severe relational deprivation and disappointment, experiencing interpersonal relationships as fertile ground for hurt and hostility. This in itself does not make for a poor group therapy candidate. Indeed, group therapy can be an ideal method of ameliorating some of the interpersonal distress and self-image problems typically suffered by individuals with poor QOR (Piper, Rosie, Joyce, & Azim, 1996). The clinical error in this case was the lack of attention to the levels of QOR among the remaining group members. Much of what had helped this group become an insight-oriented entity in the past was the contribution of previous members' relatively higher QOR. In their absence, the members that remained had returned to a lower level of interpersonal and introspective functioning. Inviting two new members with similarly low levels of QOR had further contributed to the group becoming stuck.

Research on group composition has found that the mixture of members' levels of QOR makes a difference. In a comparative trial of short-term group therapy for complicated grief, Piper and colleagues (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007) found that groups composed of a greater number of high-QOR patients produced greater improvement for their members, regardless of the members' individual level of QOR. In other words, the

presence of patients with high QOR influenced the group sufficiently to benefit those with lower levels of relational functioning. This finding underscores the need for careful attention to the composition of groups. In our example, the selection of Maggie and Irene added to the homogeneity of low-QOR patients whose in-group functioning had been previously enhanced by group members with higher QOR. Had Maggie and Irene been placed into differently composed groups, a different group process may have unfolded. Selection based on the mixture of group members' QOR levels is optimally done at the commencement of a group or as new members join a group. Once a group is underway it may be difficult to identify particular patients whose presence impedes group process, and therapists may lack an acceptable rationale—in the eyes of group members—that would justify removing some patients in an effort to even out the QOR mixture. While research has yet to directly investigate this question, a sluggish group might instead benefit from the prudent addition of higher-functioning new members at appropriate intervals. Otherwise, a group may plod along as therapists attempt to leverage any tiny window of opportunity to expand the group's empathic and introspective functioning. Fortunately, in the case of Maggie's and Irene's group, a protracted period of primitive interaction eventually gave way to a more mature group process—thus averting premature termination or other negative outcomes.

Therapist: *There has been a lot of discussion about painful relationship experiences, and the struggle of trying to protect against them. Yet I'm not sure we're talking much about what you really want from a close relationship. Maybe it feels too vulnerable to go there . . .*

Irene: *It would be nice to be held—for someone to be there when things are rough, to let you know they're in it with you. I want to feel like I matter to a man too, like he'd really want to be with me.*

Sandra: *How do you meet someone like that?*

Irene: *I do not know—I've had my guard up for so long. Maybe I've got a sign on me warning men to keep away . . .*

Maggie: *I miss being able to share things with someone.*

Irene: *How do we find that without being hurt?*

The above sequence illustrates the therapist's attempt to generate interest in the nuances of relational experiences. As in Maggie's and Irene's group, therapists should not expect such interventions to produce an immediate effect in a homogeneous, low-QOR group. Object relations theory suggests that patients with considerably impaired relational functioning may require an extended period of using the environmental aspects of therapy before venturing into exploratory terrain. For such patients, lower-level defenses such as splitting and projective identification often stand in the way of reflective functioning (Clarkin, Lenzenweger, Yeomans, Levy, & Kernberg, 2007). Group members under the sway of such defensive forces may need the group to serve as a container for the expression of dread, fear, and aggression. At the same time, therapists' persistent and tactful invitations to reflect may eventually promote group members' curiosity about a broader

and more complex array of emotional experiences (Yeomans, Levy, & Caligor, 2013).

Conclusion

The above examples represent a mere fraction of the various ways in which clinical errors in patient selection and group composition can manifest in group psychotherapy. Many selection and composition difficulties may not be judged as errors until an outcome is ultimately realized. Some patients, for example, who seem at first to be poorly suited may eventually get a hold of the group process and become ardent collaborators in their own—and the group's—therapeutic work. Others, unfortunately, may be on course for a negative outcome owing to a complex interplay of their own unique characteristics and the particular composition of the intended group. The best intervention for the latter scenario is prevention. Careful attention in advance to problematic patient characteristics, group composition features, and the developmental stage (MacKenzie, 1997) of the group under consideration will likely have a greater impact than any intervention attempted by a clinician after a selection error has occurred.

In our opinion, the nature of group psychotherapy requires group therapists to have a high degree of tolerance for making errors. An overly anxious or perfectionistic therapist will likely avoid taking calculated risks in developing lively and productive groups. Paradoxically, too much caution in the selection of group members may result in a composition error: a staid group with limited dynamic vigor that fails to capture the interest of its members. Moreover, being too selective may exclude many patients who could benefit from the power of group therapy to alleviate suffering and promote personal growth. Being aware of the potential—indeed, the inevitability—for errors in patient selection and composition may be the best protection against such errors becoming overly destructive. Maintaining this awareness alongside an acceptance of error potential can help clinicians make effective selection and composition decisions, and implement sensitive interventions on the discovery of a poor fit in group psychotherapy.

References

- Azim, H. F., Piper, W. E., Segal, P. M., Nixon, G. W., & Duncan, S. C. (1991). The quality of object relations scale. *Bulletin of the Menninger Clinic*, 55, 323–343.
- Brown, N. W. (2008). Troubling silences in therapy groups. *Journal of Contemporary Psychotherapy*, 38, 81–85. <http://dx.doi.org/10.1007/s10879-007-9071-z>
- Clarkin, J. F., Lenzenweger, M. F., Yeomans, F., Levy, K. N., & Kernberg, O. F. (2007). An object relations model of borderline pathology. *Journal of Personality Disorders*, 21, 474–499. <http://dx.doi.org/10.1521/pedi.2007.21.5.474>
- Gans, J. S., & Alonso, A. (1998). Difficult patients: Their construction in group therapy. *International Journal of Group Psychotherapy*, 48, 311–326.
- Gans, J. S., & Counselman, E. F. (2010). Patient selection for psychodynamic group psychotherapy: Practical and dynamic considerations. *International Journal of Group Psychotherapy*, 60, 197–220. <http://dx.doi.org/10.1521/ijgp.2010.60.2.197>
- MacKenzie, K. R. (1997). Clinical application of group development ideas. *Group Dynamics: Theory, Research, and Practice*, 1, 275–287. <http://dx.doi.org/10.1037/1089-2699.1.4.275>
- Marmarosh, C. L., Markin, R. D., & Spiegel, E. B. (2013). *In-depth clinical case studies: Attachment theory and group psychotherapy*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14186-000>
- McCallum, M., & Piper, W. E. (1990). A controlled study of effectiveness and patient suitability for short-term group psychotherapy. *International Journal of Group Psychotherapy*, 40, 431–452.
- Motherwell, L., & Shay, J. J. (2005). *Complex dilemmas in group therapy*. New York, NY: Brunner-Routledge.
- Ogrodniczuk, J. S., Piper, W. E., Joyce, A. S., Steinberg, P. I., & Duggal, S. (2009). Interpersonal problems associated with narcissism among psychiatric outpatients. *Journal of Psychiatric Research*, 43, 837–842. <http://dx.doi.org/10.1016/j.jpsychires.2008.12.005>
- Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology*, 75, 116–125. <http://dx.doi.org/10.1037/0022-006X.75.1.116>
- Piper, W. E., Rosie, J. S., Joyce, A. S., & Azim, H. F. (1996). *Two weeks in the life of the day treatment program*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/10208-006>
- Rutan, J. S., Stone, W. N., & Shay, J. J. (2014). *Psychodynamic group psychotherapy*. New York, NY: Guilford Press Publications.
- Steinberg, P. I., & Ogrodniczuk, J. S. (2010). Hatred and fear: Projective identification in group psychotherapy. *Psychodynamic Practice: Individuals, Groups and Organisations*, 16, 201–205. <http://dx.doi.org/10.1080/14753631003688225>
- Tuckman, B. W., & Jensen, M. A. C. (1977). Stages of small-group development revisited. *Group and Organization Management*, 2, 419–427. <http://dx.doi.org/10.1177/105960117700200404>
- Yalom, I. D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.
- Yeomans, F. E., Levy, K. N., & Caligor, E. (2013). Transference-focused psychotherapy. *Psychotherapy*, 50, 449–453. <http://dx.doi.org/10.1037/a0033417>

Received March 31, 2016

Revision received April 19, 2016

Accepted April 24, 2016 ■