

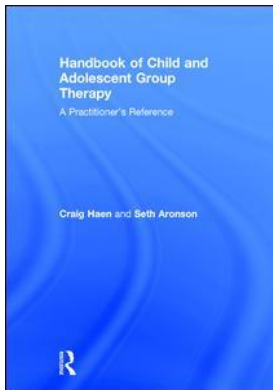
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Identifying, Screening, and Selecting Group Members

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3

IDENTIFYING, SCREENING, AND SELECTING GROUP MEMBERS

*Andrea Grunblatt*¹

Introduction

Group therapy is known as an effective therapeutic intervention for individuals who are experiencing a wide range of psychological symptoms. To provide maximal therapeutic gains, careful consideration of group membership is essential. A mismatch between an individual and a group can lead to negative consequences, including premature termination by the individual member (Gans & Counselman, 2010), open aggression between members or toward the leader, and possible dissolution of the group. The group therapist is responsible for making informed decisions regarding group membership.

Different types of groups require different considerations. For example, identifying, screening, and selecting group members for ongoing groups differs from time-limited or topic-specific groups. Process-oriented groups also have different needs than content-oriented ones. Experience has taught me the importance of paying attention to these details. Years ago I ran an adolescent group and, after two young people terminated, it became clinically necessary to add more members. One 15-year-old patient, Guy, whom I treated individually, seemed like an ideal candidate. He had issues with peers and often felt misunderstood in social situations. Guy joined the group without having been properly screened. During the first session, he began to viciously verbally attack two girls. Despite the girls' protests, he was unable to control himself, even with strong intervention from me.

Before the second session, we met individually to discuss his behavior in group. Despite this intervention, during the second group session, Guy's provocations continued. He was clearly unable to control himself, and subsequently was asked to leave the group. Eventually, he dropped out of individual treatment as well. Thus, Guy was not only an inappropriate referral for group membership, but my miscalculation about his appropriateness for group undermined and prematurely ended our therapeutic relationship.

What could have been done differently? Is there a way to predict this kind of behavior in a group setting? The decision to add Guy to group therapy was based solely on his one-on-one interactions with his individual therapist. While an individual session can be used as a clinical screening interview for group therapy, it is not enough. Alone, individual sessions cannot account for how potential members interact with peers, only how they interact with an adult therapist. Clearly a more thorough screening process is required to determine a child's or adolescent's appropriateness for a group, and to maximize therapeutic gains.

Screening requirements for child and adolescent group membership differ from those for adult groups in several ways. With adult groups, the leader may strive for homogeneity (Northen, 1988), but in groups for children and adolescents too much homogeneity can lead to dull play or interaction, and members may not learn from one another (Rose & Edleson, 1987). Varied opinions exist

regarding how much homogeneity or heterogeneity should be created in a group. Questions of gender, diversity, degree of age difference, and the inclusion or exclusion of various diagnostic categories are some of the issues that theorists have tried to address. Yalom and Leszcz (2005) recommended that, in children's groups, there should be at least two members of the same diagnostic category, also known as the *Noah's Ark Principle*.

Group Composition

Group composition theory has evolved over the years. While historically the parameters for inclusion/exclusion were rigid (Dwivedi, 1993), these ideas have shifted and now support a more fluid and inclusive approach to selecting members (Malekoff, 2014). Despite this shift, early theorists offered significant insight into group dynamics. One consensus among them was that the basic criterion for a group member is that he or she needs to be attracted to social interactions. Ginott (1961) coined the term *social hunger* to describe a child who, in infancy, had enough of his or her needs met to create a desire for recognition and approval by others. Slavson and Schiffer (1975) expanded on this concept, and framed it as a child's or adolescent's basic potential social capacity.

Ginott (1961) emphasized the therapeutic significance of reciprocity, which, he believed, was not possible in the one-to-one therapeutic relationship. He argued that mutual stimulation of ideas and feelings in groups could foster insight. Thus, group was believed to augment the opportunity for reality testing and provide an opportunity for children to learn more adaptive interpersonal skills. By contrast, Slavson and Schiffer (1975) described social hunger as a form of faulty adjustment. In their perspective, these maladjustments were largely due to character structure. As a child's ego is strengthened through the group, and as the child grows more secure and gains self-confidence, the child was thought to be able to relate more constructively to other people and identify with them.

Well-Functioning Groups

Groups that are composed well have greater chances of functioning smoothly. In these groups, members elicit healthy ego functioning in other members and thus help one another to grow toward improved mental health through the closeness of their relationship. Slavson and Schiffer (1975) referred to this process as the *supportive ego*, a concept echoed in Shechtman's (2007) notion of children helpers. The well functioning group, according to Redl's *law of optimum distance*, is one that provides a balance of enough homogeneity to ensure stability and enough heterogeneity to maintain vitality (Redl & Wineman, 1957).

The following is an example of a heterogeneous group in which the supportive ego worked. The members were placed in the group based on similar developmental stages. One group consisted of six girls (ages 10–15 years) who initially didn't seem to complement one other. One member was very anxious, while another had developmental issues and impaired cognitive processing. A third member had Asperger's syndrome and an expansive personality, and another member was shy and possibly psychotic. Every girl except one had admitted to being bullied in the past, but that seemed to be the only similarity between them. I chose these different members for the group in order to give them the opportunity to connect with each other in a reciprocal way that would increase each girl's capacity for socialization. The girls' complementary adaptive styles balanced each other. The expansive member and the shy member bonded, as did the other girls. The expansive member supported the shy girl in coming out of her shell. The anxious member drew in the member with cognitive processing issues. One of the girls tried to be a commanding leader, but the group wouldn't allow her to assert her power and instead reined her in. Together the group dynamics allowed for psychologically beneficial changes in all of the members, which were supported by emotional attunement among them (Schore, 1994).

Homogeneous groups can be made more heterogeneous by introducing a carefully selected new member whose presence may promote opportunities for positive change. In one instance, I added both a high-functioning boy with Asperger's syndrome and a well-behaved but hyperactive boy into a boys' group of aggressive 8- to 10-year-olds. Prior to the introduction of the new members, the group had played in the sandbox with army men who repeatedly killed each other. When the new members joined, the group's play started to shift to basketball and building castles out of boxes and blankets. This change provided an opportunity for one of the quieter children, who had previously been adjusting his play to accommodate the other members, to come out of his shell. It also offered an opportunity for the child with Asperger's syndrome to demonstrate how he tended to instigate other children and provoke them into ganging up against him. This member, Alan, could not resist using his power to make the other children wait, yet he did not understand how doing so incited anger. During discussion at the beginning and end of each group, the impact of Alan's delays upon the other boys became a central topic. Processing these dynamics and exploring how each of the children could have handled it differently helped each boy to think about how he also incites other children, the beginning of effecting behavioral change.

Identifying, Selecting, and Screening for Groups

Screening Interview

At minimum, most group therapists engage in a pre-group screening interview with the parents or caretakers and the potential group member. Therapists should be mindful that the selection process is a decision for all parties, and the time should be aimed at everyone involved getting the information needed to make an informed decision. During this time, the group therapist gathers clinical, historical, and relational information through either structured, semi-structured, or open dialogue with the family. In this section, various forms of screening will be presented, and the advantages and disadvantages of each will be outlined.

The pre-group screening is intended to promote comfort and familiarity for both parent and young person, and allows for observations of important parent-child verbal and nonverbal interactions. In addition to gathering information from prospective group members and their families, the clinician should also orient them to the group therapy process. Information given about the group is usually logistical (time and location of group meetings, number of existing members, fee arrangement) and procedural (length of time the group has been in existence, group norms, an explanation about what it is like to be in a therapy group). Discussion of confidentiality and the circumstances under which it can be broken is important, particularly for adolescents (see Hurster, Chapter 7, this volume).

It can be helpful for a prospective member to see the group room in order to relieve possible anxieties about the physical space. Observing the way the young person responds to information about the group can be very informative. He or she may feel overwhelmed by anxiety at the prospect of receiving feedback from peers or present as overly eager to join with no expressed concerns.

The screening interview should also be used to explore the child's potential to have successful peer relationships, as well as successful relationships with adults. Most children and adolescents are referred for treatment because of problems in relationships with others (parents, teachers, peers, siblings). Many have a history of abuse (physical, sexual, or emotional) or neglect, and have therefore come to expect rejection or ridicule from others. Understanding these relational issues can inform areas for intervention, as well as help determine not just whether a young person is appropriate for group, but more importantly, which kind of group. Group therapists can assume that the child or adolescent will show some of the same behavior that they engage in with their parents and siblings when interacting with the therapist and other group members. Therefore, a good understanding of these dynamics enables the therapist to anticipate problem areas and conceptualize potential corrective responses.

The selection of group members should be based on a complete review of the child's or adolescent's developmental history, including a detailed description of the complaints and symptoms for which the young person was referred, and assessment of his or her level of maturity, typical modes of reaction to frustration, adjustment to school and peers, and characteristic use of leisure time (Kymissis, 1996). Smead (1995) developed a semi-structured interview protocol known as the TAP-In Selection Checklist. The goals of this interview are: (1) observing the potential group member's interpersonal behavior; (2) exploring if the potential member's motivation for seeking treatment and the group's treatment goals are aligned; and (3) informing the potential member of goals, processes, and rules of the group.

It is important to consider the developmental stage of potential group members, despite their chronological age. While discrepancy between developmental stage and chronological age may be obvious in a screening interview, careful assessment regarding the following three developmental levels provide a helpful guide for determining the appropriate group: (1) completion of early separation-individuation tasks; (2) resolution of preschool, interpersonal family relationships; and (3) adaptation to latency peer culture (Garland & West, 1984). If there is a clinician providing individual therapy to the young person, that therapist is one additional source for valuable information.

Some group therapists may opt to engage the prospective member in a more active process through which relational patterns can be observed. Reddy (2012) recommended a flexible, semi-structured screening interview with young children and parents that includes a 15-min play session. This process allows the group therapist an in-person observation of the child's interaction with his or her parents (both verbal and nonverbal), fosters a dialogue between the therapist and the child's parents, and allows the child to become more familiar with the therapist and the playroom. Even though the brief therapist-child play session can provide valuable information about how well the child or adolescent separates from the parents, interacts with other adults, and manages structure and redirection, it provides only limited information on how the child or adolescent will interact with peers, since the screening interview is conducted by an adult therapist.

Screening Instruments

In order to make decisions about the fit of a young person for group treatment, therapists often utilize multiple forms of data gathering. Psychological assessment instruments provide another level of screening for potential members, offering more thorough information about personality features and symptom patterns. These instruments may be more global in nature or targeted at specific problem areas that are to be addressed by group intervention.

Researchers have tried to explore which factors are most important in predicting potential group members' success and potential growth through group therapy. This research includes the Personality Assessment Inventory (PAI; Morey, 1999) and the NEO Five-Factor Inventory (McCrae & Costa, 2004). Both of these assessments provide information on adolescents' individual personality characteristics and suggest that this information may be used effectively in predicting group therapy behavior and outcome (Baker, 2010). Other assessments cover such problems as anxiety, depression, autism spectrum, hopelessness, and social responsiveness. The results of the use of psychological assessment measures have been mixed.

Johnson, Burlingame, Olsen, Davies, and Gleave (2005) suggested that determining positive and negative interpersonal factors helps to adequately capture the therapeutic relationship in a group. Positive interpersonal factors can be summarized as openness, extroversion, and agreeableness, while negative interpersonal factors describe defensive behavior, avoidance, rebellion, and conflict. Shechtman (2007) found that a potential group member's attachment style is a good predictor of treatment success.

More recent scales such as the Group Therapy Questionnaire (GTQ; MacNair-Semands, 2002), and the Group Selection Questionnaire (GSQ; Burlingame, Cox, Davies, Layne, & Gleave, 2011;

Kroegel, Beecher, Presnell, Burlingame, & Simonsen, 2009) target areas of dependency, angry hostility, social phobia/inhibition, low ego strength, and expectancies for success in group to indicate which clients will benefit most from the group therapy experience. Though these measures have not yet been normed for use with children and adolescents, they show great promise in predicting successful candidates for group membership.

Overall, psychological testing that focuses on interpersonal behavior appears to be a helpful screening tool for group selection and for formulating treatment goals for members. However, psychological testing is not currently a highly utilized method for screening new group members (Riva, Lippert, & Tackett, 2000). This may be due to a variety of reasons including lack of time or resources, financial considerations, or insufficient knowledge and training with the administration and interpretation of psychological tests.

Group Observation

As has been noted, while screening interviews, semi-structured play sessions, and the use of formal psychological assessment measures may provide a wealth of information about a potential group member, none of these methods serves to directly demonstrate how a prospective group member might engage with peers. The most effective means of ascertaining this information is through direct observation of potential members in a small group setting (see Hariton, Chapter 32, this volume). This process entails organizing a group of four or five members who are given enough structure that anxiety is kept at a moderate level but accorded sufficient leeway that typical interpersonal behaviors emerge.

Research shows that group behavior proves extremely useful in making selection decisions. For example, Connelly and Piper (1989) found that ratings of group members' on-task behavior and degree of participation in observational groups were positively correlated with these individuals' behavior in, and the benefit they derived from, psychotherapy groups. However, Riva et al. (2000) concluded that only a small proportion of therapists (about 10%) take advantage of group observation as a screening method.

Typology of Potential Group Members

When considering group dynamics and the importance of interpersonal influences on group members, therapists should carefully consider which individuals are most likely to benefit from the therapeutic opportunities offered by a group environment. This section will provide descriptions and some clinical illustrations of the kinds of young people who might benefit from group; those who the leader may have to think carefully about before placing in a group; and those who, in most cases, should be referred for other treatment modalities.

Suitable Group Candidates

Slavson and Schiffer (1975) offered a set of interactional patterns that provide helpful ways of thinking about group composition in terms of the role a member may potentially play when entering a group. They described a child as a *positive instigator* if his or her effect upon the group is psychologically and/or socially beneficial. This could happen by virtue of their mobilizing and reinforcing the inherent strengths of other members or, more importantly, their catalyzing beneficial interpersonal interactions in the group. *Negative instigators*, on the other hand, are children who promote disharmony, hyperactivity, rancor, and hostility. By working against the therapeutic purposes of the group, according to these authors, negative instigators threaten its effectiveness and, unless managed carefully, can potentially destroy the group.

Slavson and Schiffer (1975) referred to group members who can successfully counteract the effects of negative instigations and block destructive processes as *neutralizers*. The calming presence of these members benefits the group as a whole by serving as a healthy identification model, as well as by aborting destructive aggression and uncontrolled hilarity. In addition, their calm and resourcefulness models alternative avenues for expressing anxiety and frustration. Finally, these authors identified a type of group member with a floating or weak identity as a *neuter*. These young people tend to easily succumb to the influences of stronger personalities. As treatment progresses, however, and *neuters* are strengthened, they can become more active, assuming at various times the roles of both instigators and neutralizers.

Andrew, a 12-year-old boy, was the oldest child in his family. His mother had three children with three different men. Andrew's dad died of a drug overdose several years prior. His mother was remarried, and she and Andrew's stepfather, whom he viewed as a substitute dad, had a much younger child together. In the screening interview, Andrew presented as somewhat shy and kept his feelings to himself. He had few friends and was socially avoidant. Before starting group therapy, Andrew was quite oppositional yet also symbiotic with his mother. He was interested in smoking marijuana, which his mother resented. He did well academically but refused to participate in class. Through group therapy, Andrew learned to voice his discontent and anger; his acting out behavior, after initially increasing, decreased. He was able to return to school and establish goals for himself. Group therapy gave Andrew the feelings of belonging, acceptance, and having something to offer peers.

Andrew is an example of an isolated, inarticulate, acting-out adolescent who made a good group candidate. He was able to do well in group because he had high cognitive abilities, was looking for a place to be understood and accepted, and learned to express feelings rather than act on them. He needed a group because he was leery of adults and needed to experience that he was not alone with his feelings. Like Andrew, the members of the group were struggling with their home environments, tended to act out moderately, and had difficulty expressing feelings in words rather than actions. This group was based on verbal interaction alone with no play, which was important in Andrew's case since he wanted to be seen as more mature than his siblings.

Withdrawn children or adolescents like Andrew are often good candidates for group therapy, especially those who present as over-inhibited, submissive, fearful, shy, isolated, uncommunicative, inarticulate, constricted, or meek. Often these young people are unable to express feelings of affection or aggression, have few friends or playmates, and avoid social interaction. Withdrawn children tend to experience social isolation and have a fundamental need to gain access to uninhibited and safe interpersonal communication.

Children or adolescents who are developmentally younger than their actual age can also benefit from group therapy. These youth tend to be sheltered and are often unprepared for the realities of life outside their family. They crave social experience with peers, but frequently lack adequate appreciation for the needs and feelings of others. Their primary challenge is often an inability to empathize, while their greatest needs include opportunities to share objects, activities, and the attention of an adult. Therefore, they benefit from learning to both compete and cooperate, to fight and settle fights, and to bargain and compromise. Group therapy is especially helpful for these young people because their interpersonal issues can't be addressed completely in individual therapy.

Clients with phobic reactions can also be appropriate for group therapy. Their anxiety is expressed in specific displaced fears, such as fear of dirt, darkness, or loud noises. Usually they handle their anxiety by withdrawing from activities that seem dangerous to them. The greatest challenge for these clients is that they avoid situations that may create anxiety; yet they need to be exposed to these very situations and face their fears in the here and now (see Friedberg et al., Chapter 27, this volume). For these individuals, group therapy allows the phobia to be addressed in the here and now, by both the therapist and the other group members.

Children and adolescents who are dealing with parental divorce or separation can benefit from the supportive environment that group therapy offers (Pedro-Carroll & Velderman, 2016). These young people are often coping with the stress of big changes and family conflicts that leave them feeling isolated and misunderstood by peers. They are at higher risk for developing anxiety and depression, as well as social and academic difficulties. Group therapy experiences can help them cope by strengthening factors that promote resilience, emotion regulation, and adjustment. The safety of the group allows them to voice their concerns and receive support while sharing their experiences with peers.

Finally, children on the autism spectrum often work well in group therapy (see Hull, Chapter 31, this volume). Though usually their social skills are limited, they can learn from the group and become better interactive partners. An example of a child on the spectrum who benefited greatly from the group therapy experience is 8-year-old Nate, who had a diagnosis of Asperger's syndrome. Nate loved to play with trucks and rarely expressed himself verbally. Nate's mother was a recovering alcoholic who was overwhelmed by Nate and his younger siblings, and his father was out of the home working many hours. Nate's mother reported that she caught Nate peeing in the corner of his room on several occasions.

When Nate joined the group he was withdrawn, but he cautiously started to play with one other child and, eventually, several other children in the group. Children on the autism spectrum demonstrate deficits in spontaneous and social play with others. They have difficulty engaging in imaginative play as well as communicating and coordinating with peers. Including children on the spectrum in groups with typically developing peers can address these challenges (Wolfberg, 2016). Group experiences promote the development of the communication and social skills necessary to maintain relationships and therefore experience less isolation.

While children and adolescents with autism spectrum disorders typically have the desire to be included by peers, they often face rejection due to lack of understanding of their diagnosis and needs. Their inclusion in groups with typically developing children provides an opportunity for education about the autism diagnosis and their unique needs in a safe environment. With guidance, these young people may learn to interact and relate to each other more fully, while becoming more empathic and accepting of others.

Questionable Group Candidates

While group therapy can be immensely beneficial for many children and adolescents, there are some for whom this form of treatment is contraindicated. My experience with establishing and running groups has helped me identify a few different types of young people who may not be appropriate for group therapy. Careful screening of potential group members is important in determining which candidates fall into these categories.

Children who during the course of the screening/interview process are found to have intense sibling rivalry issues are not ideal for group. They often treat other group members as substitute siblings and can be unduly hostile. It can also be difficult for these children to share the group therapist with the other members.

In addition, some adolescents who engage in self-injurious behaviors may not be appropriate for group membership. When blending group members with different presenting issues, it is important to consider that young people often imitate each other's behaviors. Since children and adolescents are easily influenced by those around them, the introduction of a group member who is or was self-injuring can introduce other members to this negative coping strategy, which can escalate, rather than resolve, presenting problems. Introduction of young people with these kinds of behaviors into group should be undertaken with caution.

Children and adolescents with conduct disorder also tend to fight, show cruelty, truancy, and general destructiveness, yet they often can be helped by group therapy (see Mitchell et al., Chapter 33,

this volume). These aggressive behaviors may occur at home, at school, in the neighborhood, or across settings. If the behavior only occurs in one setting, it may indicate unconscious retaliation against real or perceived mistreatment by parents, teachers, or neighbors. The prime issue for many of these children is an inability to establish or maintain a relationship of trust due to previous negative experiences with adults and caregivers. In these cases, their greatest need is to express this aggression in a safe way, and eventually develop self-control. Group can be insulating for them, diluting much of the tension that would otherwise exist if they had no means of escape from closer contact with the therapist (Slavson & Schiffer, 1975).

By contrast, sociopathic young people are questionable for group participation. These children tend to be shallow, selfish, impulsive, and capable of committing extreme cruelties without apparent guilt or anxiety. They tend to lack empathy and are not concerned about the welfare of others. While externally they may appear charming and solicitous, internally they are often cold and distant. Sociopathic children may enjoy coming to group, but they often make group miserable for the others. In my experience they engage in acting out behaviors such as trying to bully group members, attempting to manipulate the therapist, monopolizing the play material, stealing toys, and eliciting hatred from peers. Therapeutic limits are often ineffective with these group members since they resist introspection and are quick to change topics when their behavior is directly addressed.

For children and adolescents with issues of anger and aggression, thorough screening and interviewing is essential. If their aggression is unpredictable and not responsive to intervention, then group is likely not appropriate for them. The clinician must decide if the potential member wants to be accepted by others and if he or she has the capacity to establish appropriate relationships; thus the clinician has to rule out if the child is psychotic, sociopathic, or has neurological damage.

Betty was an 11-year-old girl who lived with her grandparents. She hated her mom and grandma, and tried to provoke arguments between her grandparents. She was often verbally provocative, pretending to know everything, and suggesting that no one could tell her what to do. She had severe temper tantrums at times.

During screening, Betty presented as feeling out of control and needing to assert herself, yet having applied all the wrong methods to do so. She was placed in a children's group where the members had started to assert themselves and set up their own rules. Betty was able to tolerate this group because each child would take the role of the group leader for one session every two or three months. Though she initially sought to be the center of attention, it was through the help of the other children that Betty learned to regulate her need for control. For Betty it was extremely helpful that the children had managed to have their rules accepted and implemented due to discussing and exploring their wishes with the other children and the group leaders.

While views regarding the appropriateness of children and adolescents with trauma histories entering group have evolved over the years in favor of inclusion, there are still some circumstances in which trauma experiences make a child an inappropriate candidate for group membership. For example, children with severe dysregulation (rocking, crying, uncontrollable shaking) or who are easily triggered into fear states or flashbacks are not yet ready for group membership. For these children, individual therapy presents a better opportunity to develop containment and the ability to self-regulate in the face of distress. Children and adolescents with sexual abuse histories who demonstrate over-sexualized behaviors and premature sexual interests and activities through inappropriate dress, highly sexualized play, and excessive masturbation are often not suitable for a general group setting because of their tendency to make the space unsafe for other group members. However, these young people may do well in a group specifically for children with over-sexualized behaviors or premature sexual interests (see Gil & Shaw, Chapter 38, this volume).

Conclusion

In conclusion, the most frequent process of selection or exclusion of group members is based on the clinical judgment of the therapist, who will most often utilize a screening interview to determine if the client is appropriate for group. Most therapists believe that potential group members should exhibit social hunger, the need for recognition, and approval of other people. Social hunger is what fuels a young person's desire to gain acceptance from peers; to act, dress, and talk as they do; and to attain and maintain status. In return for peer acceptance, a child or adolescent is often motivated to change his or her behavior. Many young people can benefit from the corrective relationships and curative environment that group therapy provides. Proper screening and selection of members, and careful composition of a group, can maximize this corrective experience.

Gans and Counselman (2010) cautioned clinicians to be aware of countertransference feelings that may negatively affect the group selection process. For example, therapists are likely to feel pressure to maintain referral sources and to keep current groups adequately filled. The resulting anxiety may lead to the inclusion of members who are not suitable for the group, or for whom group therapy is not indicated.

Important factors for consideration when selecting group members include the individual's age (both chronological and developmental), diagnosis, and the quality of interactions with peers. Group therapists may utilize a variety of screening tools, including a small group experience, teacher and parent interviews, semi-structured play sessions, and psychological assessment measures, in addition to a clinical interview. When proper attention and time is given to the selection process, group therapy is effective in providing therapeutic benefits and addressing the needs of countless children and adolescents.

Note

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