

Group Composition and Group Therapy for Complicated Grief

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

Anthony S. Joyce
University of Alberta

Rene Weideman
University of British Columbia

John S. Rosie
University of Alberta

This prospective study investigated the impact of group composition on the outcome of 2 forms of time-limited, short-term group therapy (interpretive, supportive) with 110 outpatients from 18 therapy groups, who presented with complicated grief. The composition variable was based on the patient's level of quality of object relations. The higher the percentage of patients in a therapy group who had a history of relatively mature relationships, the better the outcome for all patients in the group, regardless of the form of therapy or the individual patient's quality of object relations score. The findings have direct clinical implications for composing short-term therapy groups for outpatients with complicated grief and possibly for other types of group therapies and patient problems.

Keywords: group composition, quality of object relations, complicated grief, short-term group therapy, therapy outcome

Textbooks on the theory and practice of group therapy consistently emphasize the importance of group composition to therapy outcome (Brabender, 2002; Rutan & Stone, 2001; Yalom & Leszcz, 2005). Composition is a group-level variable that represents the combination of individual characteristics. For example, a group composed of depressed patients may be referred to as a depression group. Groups made up of individuals who share a primary characteristic are called homogeneous groups. Groups made up of individuals who differ on a primary characteristic are called heterogeneous groups. Textbooks advise therapists to consider the composition of a group before deciding whether an individual should become a member. If a new member differs on an important characteristic that the old members share, there is a danger that the new member may feel isolated or may be rejected by the other members.

Despite the fact that many therapists believe in the importance of group composition, there is a lack of research evidence to support its importance. Meta-analytic reviews of the literature (e.g., Ang & Hughes, 2002; Burlingame, Fuhrman, & Mosier, 2003) typically have compared the effect sizes of homogeneous

groups from one set of studies with the effect sizes of heterogeneous groups from a different set of studies. A serious problem with this methodology is that no single study includes both homogeneous and heterogeneous groups. Thus, there are many uncontrolled variables that may be responsible for differences in their effect sizes.

Conducting studies that involve the creation of both homogeneous and heterogeneous groups is challenging. Requirements include a large patient sample, efficient procedures for rapid assessment of patients, standard procedures for assigning patients to groups and conditions, a large number of groups, and a substantial number of trained therapists.

As a substitute for group therapy studies where composition is manipulated experimentally, Yalom and Leszcz (2005) reported findings from the human growth and social psychology literatures, where composition was manipulated experimentally in nontherapy groups. They extrapolated about possible clinical mechanisms. Whereas extrapolation can be suggestive of clinical processes, generalization of the findings to therapy groups is often tenuous. Similar concerns can be raised about studies that are based on the composition of support groups for persons with medical conditions (Lieberman, Wizlenberg, Golant, & Di Minno, 2005).

From a series of psychotherapy clinical trials conducted by our research team, the personality characteristic quality of object relations (QOR) has emerged as a potentially important group composition variable. QOR is defined as a person's enduring tendency to establish certain types of relationships that range along an overall dimension from primitive to mature (Azim, Piper, Segal, Nixon, & Duncan, 1991). We found that QOR was a significant predictor of working, remaining, and benefiting for a number of time-limited individual and group therapies (de Carufel, & Piper, 1988; Piper et al., 1991; Piper, Joyce, Azim, & Rosie, 1994.) These therapies followed an interpretive (expressive) orientation. By using techniques that were relatively probing and confrontive, the

William E. Piper, John S. Ogrodniczuk, and Rene Weideman, Department of Psychiatry, University of British Columbia; Anthony S. Joyce and John S. Rosie, Department of Psychiatry, University of Alberta.

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Correspondence concerning this article should be addressed to William E. Piper, Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver, British Columbia V6T 2A1, Canada. E-mail: piper@interchange.ubc.ca

therapist attempted to create a climate that was demanding, depriving, and anxiety arousing, yet conducive to interpretive work. Our primary explanation for the QOR findings has been that the more the patient's lifelong pattern of relationships is mature and mutually rewarding, the more that the patient is able to tolerate and work with the demanding features of interpretive therapy.

More recently, we found that QOR interacted with the form (interpretive vs. supportive) of short-term individual therapy (Piper, Joyce, McCallum, & Azim, 1998; Piper, McCallum, Joyce, Azim, & Ogrodniczuk, 1999). QOR was directly related to benefit in interpretive therapy and inversely related to benefit in supportive therapy. Supportive therapy provides emotional encouragement and repeated problem solving to improve the patients' immediate adaptation to their life situations. The therapist attempts to create a climate of gratification. We found even stronger evidence for this interaction effect in a study of time-limited group therapy (interpretive vs. supportive) for patients experiencing complicated grief (CG) (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). CG is common among psychiatric outpatients. Prevalence studies have reported that 20%–33% meet criteria for CG (Piper, Ogrodniczuk, Azim, & Weideman, 2001; Zisook & Lyons, 1990). In our previous study, the groups were heterogeneous in regard to QOR. High-QOR patients had better outcome in interpretive groups, and low-QOR patients had better outcome in supportive groups.

These findings suggest that the outcome of group therapy might be enhanced by referring high-QOR patients to interpretive therapy and low-QOR patients to supportive therapy. Each patient would be assigned to what appears from previous research to be the more compatible and effective form of group therapy. In addition to enhanced compatibility, the greater similarity among patients in homogeneous QOR groups could be expected to strengthen therapeutic factors such as universality and cohesion and facilitate collaborative work, which would be expected to result in greater benefit. Four conditions were created in the present study: homogeneous, high-QOR interpretive groups, homogeneous, low-QOR supportive groups, heterogeneous, mixed-QOR interpretive groups, and heterogeneous, mixed-QOR supportive groups. The primary hypothesis was that patients in the two homogeneous conditions would experience greater benefit than would patients in the two heterogeneous conditions.

Method

Settings and Referrals

The study took place within the outpatient psychiatry services of two university hospitals (University of Alberta Hospital, Edmonton, Alberta, and Vancouver General Hospital, Vancouver, British Columbia). Most patients were referred by health professionals in the community; a small number were self-referred. When an intake assessor suspected that the patient was experiencing CG, a subsequent assessment meeting was arranged with a research assistant, who administered three brief questionnaires to assess the presence of CG.

Inclusion criteria for CG were selected, after a review of previous studies, to include patients with at least moderate grief symptoms and social role dysfunction and to rule out immediate grief reactions. The patient had to have a score of 10 or higher on

a set of seven pathologic grief items developed by Prigerson et al. (1995), the Intrusion subscale of the Impact of Event Scale (IES; M. J. Horowitz, Wilner, & Alvarez, 1979), or the Avoidance subscale of the IES for at least one significant loss and a score of at least 2.0 or higher on one of the six subscales of the Social Adjustment Scale–Self Report (SAS-SR; Weissman & Bothwell, 1976). The loss had to have occurred at least 3 months prior to testing. In addition, the patient had to be an adult (aged 18 years or older), agree to no concurrent psychosocial therapy, appear capable of working in a group, and agree to the research conditions indicated on the consent form. Exclusion criteria included comorbid conditions that would interfere with group therapy (e.g., organic brain disorder), problems that required immediate management (e.g., suicidal or homicidal tendencies), and conditions that the patient decided to treat first (e.g., phobic disorder).

If CG was detected and the patient appeared suitable given the inclusion and exclusion criteria, an intake assessor provided further information about the forthcoming therapy group and research study. Participating patients provided informed consent to the procedures. The research coordinator contacted the patient to arrange for a set of pretherapy interview and questionnaire assessments that focused on predictor, demographic, diagnostic, and outcome variables. The assessors were unaware of the results of each other's assessments.

When approximately 16–20 patients were available, they were allocated to a group in one of two ways. If two heterogeneous, mixed-QOR groups were being formed, patients were matched as closely as possible in pairs on the basis of their QOR score, use of medication, and age and sex, when possible. One patient of each pair was assigned randomly to an interpretive therapy group and the other to a supportive therapy group. Then the pair of groups was assigned to a therapist, who led both groups during a 12-week period. If a homogeneous, high-QOR group and a homogeneous, low-QOR group were being formed, the patients were ranked from high to low on the basis of their QOR scores, with the upper half of the patients assigned to an interpretive group and the lower half of the patients assigned to a supportive group. The high-QOR group was then assigned to a therapist, who provided interpretive therapy, and the low-QOR group was assigned to the same therapist, who provided supportive therapy. A few exceptions occurred for two reasons. First, there was no control over the patients' QOR scores for each set of 16–20 patients that accumulated. Thus, it was not always possible to form two homogeneous groups or two heterogeneous groups. Second, there was no control over who dropped out of therapy and how that affected the composition. We required that a patient be a completer (attended 8 or more of the 12 sessions) and that the composition of the group be defined by completers. Thus, each completer in a group was exposed to a very similar interpersonal environment over a substantial number of sessions. The study was conducted in compliance with the Research Ethics Boards of the University of Alberta and the University of British Columbia. Required sample size was based on alpha (.05), power (.80), and estimated effect sizes.

During the referral period (May 2002–April 2005), 212 patients were assessed for eligibility. The pattern of patient flow is depicted in Figure 1. Thirteen patients (6.1%) did not meet criteria, and 199 patients (93.9%) did. Sixty-four of the 199 patients completed some or all of their pretherapy assessments but declined to participate. Forty-eight of the 64 had signed a consent form; 16 had not.

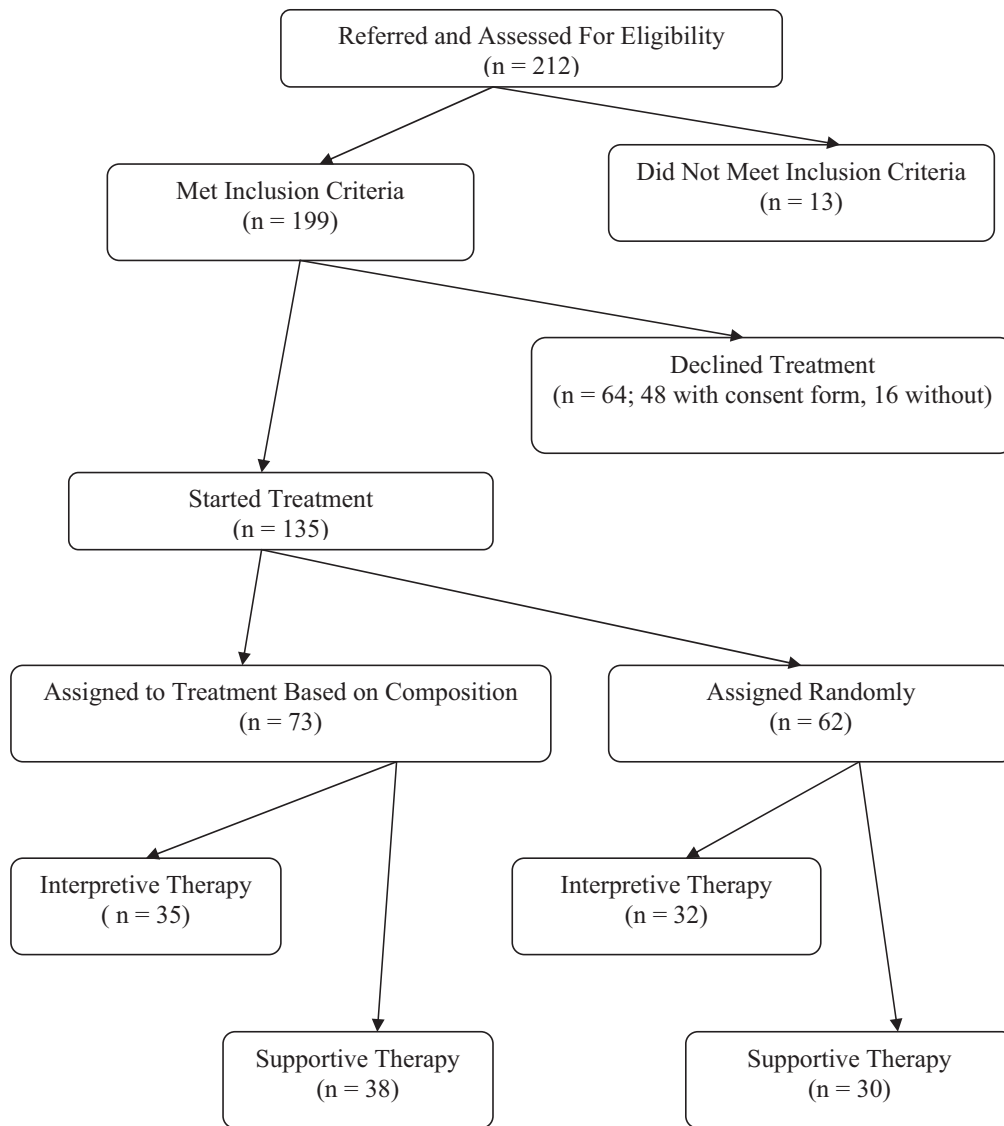


Figure 1. Patient flow.

A total of 135 patients started therapy in a group. Sixty-two patients were assigned randomly to interpretive therapy ($n = 32$) or supportive therapy ($n = 30$). Seventy-three patients were assigned to create a high-QOR or low-QOR group composition for interpretive ($n = 35$) or supportive ($n = 38$) therapy, respectively. Twenty-five patients (15 from interpretive therapy, 10 from supportive therapy) dropped out (attended seven or fewer sessions). The difference between the dropout percentages—22% for interpretive therapy and 15% for supportive therapy—was not significant. One hundred ten patients (52 from interpretive therapy, 58 from supportive therapy) completed therapy, that is, attended eight or more sessions.

Patients

The therapy completers received diagnoses according to the fourth edition of the *Diagnostic and Statistical Manual of Mental*

Disorders (DSM-IV-TR; American Psychiatric Association, 2000). Axis I diagnoses were identified by the computer-administered SCID Screen Patient Questionnaire Extended (First, Gibbon, Williams, Spitzer, & Multi-Health Systems Staff, 2001) and validated by an independent clinical diagnosis assigned jointly by an intake assessor and a psychiatrist. Forty percent of the patients received an Axis I diagnosis. The most frequent disorders were major depression (25%), posttraumatic stress disorder (9%), and panic disorder (6%). Axis II diagnoses were determined by the computer-administered SCID II Patient Questionnaire and the Computer-Assisted SCID II Expert System (First, Gibbon, Spitzer, Williams, Benjamin, & Multi-Health Systems Staff, 2000). Rater reliability for the Expert System Axis II diagnoses was calculated for nine randomly selected cases and three raters. Kappa (κ) was calculated for each disorder. The mean kappa was .95. Thirty-seven percent of the patients received an Axis II diagnosis. The

most frequent disorders were avoidant (19%), obsessive-compulsive (12%), and borderline (9%).

The average age of the patients was 45.2 years ($SD = 11.7$, range = 22–74). Seventy-nine percent were women. Thirty-six percent were living with a partner. Of those not living with a partner, 16% were separated or divorced, 12% were widowed, and 21% had never lived with a partner. Fifty-nine percent were educated beyond high school, and 45% were employed. Eighty-four percent of the patients were Caucasian. Many (62%) reported receiving previous psychiatric treatment, and 23% reported previous psychiatric hospitalization. The types of losses (and their prevalence) were parent (50%), sibling (12%), partner (11%), child (10%), grandparent (5%), friend (4%), and other (9%). The average time since the loss was 8.4 years ($SD = 10.8$, range = 0.25–62.5), which is typical for CG. It does not indicate continuous symptoms, just that the currently troublesome loss occurred quite a few years ago.

Therapists

The therapists were a 45-year-old male psychologist, a 50-year-old male psychologist, a 46-year-old female social worker, and a 62-year-old female nurse. They had substantial experience practicing group therapy (13, 18, 19, and 25 years, respectively). They conducted 5, 4, 6, and 3 groups, respectively. Because of scheduling difficulties, one pair of groups was assigned to two of the therapists rather than to one therapist.

Therapies

Each patient received a form of group therapy that emphasized interpretive or supportive features. Their structural features were similar. The patient was scheduled for weekly 90-min sessions for 12 weeks. The therapist was paid by a third party. However, the overall objectives, session objectives, and therapist technique for the two forms of therapy were quite different.

Interpretive Therapy

In interpretive therapy, the primary objective is to enhance patient insight about repetitive conflicts and trauma associated with the losses that are assumed to serve as impediments to a normal mourning process. A related objective is to help the patients develop tolerance for ambivalence toward the people whom they have lost. The therapist attempts to create a climate of tolerable tension and deprivation wherein conflicts can be examined using here-and-now experience. The therapist encourages the patients to explore uncomfortable emotions and withholds immediate praise. The therapist is active, interpretive, and transference focused.

Supportive Therapy

In supportive therapy, the primary objective is to improve the patients' immediate adaptation to their life situations. It is assumed that improvements in symptoms and functioning can be achieved through support and problem solving. The therapist attempts to create a climate of gratification wherein patients can share common experiences and feelings and receive praise (reinforcement) for their efforts aimed at coping. In regard to technique, the

therapist is active, noninterpretive, and other focused (i.e., focused on the patients' current external relationships).

Session attendance for completers was high. For interpretive therapy, the mean was 10.7 ($SD = 1.2$). For supportive therapy, the mean was 10.5 ($SD = 1.3$). Session attendance for dropouts was low. For interpretive therapy, the mean was 3.2 ($SD = 2.1$). For supportive therapy, the mean was 3.6 ($SD = 2.2$). There were no significant differences in attendance between the two forms of therapy for completers or dropouts.

Treatment Integrity

The therapists participated in 6 months of training for the two forms of therapy that included attending a weekly seminar and conducting pilot groups prior to conducting groups in the study. The therapists followed technical manuals for interpretive group therapy (Piper, McCallum, & Joyce, 1995) and supportive group therapy (McCallum, Piper, & Joyce, 1995) for loss patients. Adherence to the technical manuals was rated through one-way mirrors by external observers (bachelor's-level research assistants) using the Group Technique Adherence Scale (McCallum, Piper, & Joyce, 1995). The scale consists of 14 items (7 interpretive and 7 supportive) rated on a 5-point Likert-type scale ranging from 0 (*no emphasis*) to 4 (*major emphasis*). The full-scale score, which is keyed in the interpretive direction, ranges from 0 to 56. The therapists were given feedback after each session in the form of a copy of the completed adherence scale. Deviations were called to the therapists' attention.

The rater reliability for the adherence scale was assessed with the intraclass correlation coefficient (ICC; Shrout & Fleiss, 1979). The assessment involved six raters and 16 sessions. The average ICC (2, 1) was .93. The scale's internal consistency was also assessed. It involved six raters and 16 sessions. Cronbach's alpha for the 14 items was .93. Adherence was monitored for all sessions. For the nine interpretive groups, the mean full-scale score was 35.7 ($SD = 1.9$). For the nine supportive groups, the mean full-scale score was 16.2 ($SD = 2.8$). A *t* test comparing these means was significant, $t(16) = 17.36$, $p < .000$. The evidence indicates that the two forms of therapy were well differentiated and conformed to the technical manuals.

Medication

Management of medication was conducted by one of five psychiatrists, who met with each patient before and after therapy. Eighty-seven (79.1%) of the 110 completers were prescribed a therapeutic dosage of a psychotropic medication prior to the start of therapy. In most cases (81.6%), the medication was an antidepressant (selective serotonin reuptake inhibitor, tricyclic, or other). For an antidepressant, a therapeutic dosage was defined as equivalent to 150 mg/day of imipramine for 6 weeks. In the remaining cases (18.4%), an anxiolytic, antipsychotic, hypnotic, or mood stabilizer was prescribed. There were no significant differences between the two forms of therapy in initial use or pattern of use during therapy.

QOR

QOR is defined as a person's enduring tendency to establish certain types of relationships that range along an overall dimension

from primitive to mature (Azim et al., 1991). During a 1-hr semistructured interview, the patient's lifelong pattern of relationships was explored in reference to criteria that characterize five levels of object relations: primitive, searching, controlling, triangular, and mature. In regard to the two extreme levels of the scale, mature object relations means that the person enjoys equitable relationships characterized by love, tenderness, and concern for objects of both sexes. There is a capacity to mourn and tolerate unobtainable relationships. A tendency toward primitive object relations means that the person reacts to perceived separation or loss of the object, or disapproval or rejection by the object, with intense anxiety and affect. There is inordinate dependence on the object, who provides a sense of identity for the person. The interviewer, who used a scoring manual (Piper, Joyce, & McCallum, 1993), assigned an overall score that ranged from 1 to 9.

Rater reliability for the scale was assessed three times. After training and after using the measure for a year, the reliability of the Vancouver raters was checked. There were six raters and eight cases. The ICC (2, 1) was .77. Also using the measure for a year, the reliability of the Edmonton raters was checked. There were four raters and eight cases. The ICC (2, 1) was .83. Finally, the reliability for the combined Vancouver and Edmonton raters was checked. There were 10 raters and 8 cases. The ICC (2, 1) was .71.

Each patient was designated as high-QOR or low-QOR. A high-QOR patient had a QOR score of 4.2 or higher, and a low-QOR patient had a score of 4.1 or lower. This criterion was the same as the one used in our previous study of short-term group therapy, which identified a significant interaction between QOR and form of therapy (Piper, McCallum, et al., 2001). It is between the scale levels of 4 and 5, which theoretically is the boundary between more primitive (searching) and more mature (controlling) aspects of relationships.

Outcome Variables

Assessment of outcome included 12 measures (questionnaire or interview) that covered 13 variables in the areas of grief symptoms, psychiatric symptoms, interpersonal distress, social functioning, self-esteem, quality of life, and disturbance for individual target objectives.

Grief symptoms were measured with seven pathological grief items (Prigerson et al., 1995), the seven-item Intrusion subscale and the eight-item Avoidance subscale of the IES (M. J. Horowitz et al., 1979), and the 13-item Present Feelings subscale of the Texas Revised Inventory of Grief (TRIG; Faschingbauer, Zisook, & DeVaul, 1987). These three scales were completed for the one or two most significant death losses in the patient's life. For psychiatric symptomatology, depression was assessed with the 21-item Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), anxiety was assessed with the 20-item Trait Anxiety Scale (TAS; Spielberger, 1983), and general symptomatic distress was assessed with the Global Severity Index (GSI) of the 53-item Brief Symptom Inventory (BSI; Derogatis, 1993). The overall score from the 64-item Inventory of Interpersonal Problems (L. Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) was used to measure interpersonal distress. The overall score from the 54-item SAS-SR (Weissman & Bothwell, 1976) was used to measure social (role) functioning. Self-esteem was measured with Rosenberg's (1979) 10-item Self-Esteem Scale. Quality of life was

measured with the 32-item Quality of Life Inventory (Frisch, Cornell, & Villanueva, 1992). Individualized target objectives were formulated by the patient with the assistance of an independent assessor (bachelor's-level research assistant). The patient's average rating and the independent assessor's average rating of severity of disturbance for the objectives were used as outcome scores. A rater reliability determination for the assessor's rating, using six raters and 16 cases, yielded an ICC (2, 1) of .99, indicating very high reliability. A content analysis of the objectives revealed that 72% of the patients made explicit reference to loss in one or more of their objectives, for example, "To deal better with the death of those that I have lost (husband and father)."

Calculation of Residual Change Scores

Residual change scores (pretherapy to posttherapy) were calculated for each of the 13 outcome variables. The scores represent change with the influence of the prescore on the postscore removed. Because of moderate to high correlations among the scores, a principal-components analysis with orthogonal rotation was used to reduce the 13 variables to a smaller number of outcome factors. Three factors (eigenvalues > 1) emerged, which accounted for 69% of the variance. The three factors (General Symptoms, Grief Symptoms, and Target Objective Severity/Quality of Life) and their corresponding outcome variables and loadings are listed in Table 1. Factor 1 represents a cluster of six types of psychiatric symptoms common to outpatient populations. Factor 2 represents common grief symptoms. Factor 3 represents severity of disturbance associated with target objectives and quality of life.

Results

Prior to testing the primary hypothesis, each therapy group was designated as homogeneous or heterogeneous. In addition, checks for confounding variables were conducted, and a Bonferroni adjustment was planned for each of three sets of outcome factors or

Table 1
Outcome Factors, Variables, and Loadings

Outcome factor and variable	Loading
General symptoms (48% of variance)	
Interpersonal distress	.84
Anxiety	.73
Social (role) dysfunction	.68
Depression	.63
General symptomatic distress	.62
Self-esteem	.61
Grief symptoms (13% of variance)	
Intrusion	.86
Pathological grief	.82
Grief (TRIG)	.68
Avoidance	.62
Target objectives severity and life dissatisfaction (8% of variance)	
Target objectives severity (independent assessor)	.76
Life dissatisfaction	.72
Target objectives severity (patient)	.62

Note. TRIG = Texas Revised Inventory of Grief.

outcome variables. To test the primary hypothesis in terms of statistical significance, a *t* test was conducted between homogeneous and heterogeneous groups, with each of the three outcome factors as the dependent variable. Next, correlations between the composition score and each of the three outcome factors were conducted. Because the composition score was confounded by form of therapy, a regression analysis was conducted to control for form of therapy in the examination of the relationship between composition and outcome. In addition, outcome factor differences between the two forms of therapy were investigated, as well as the relationship between patient QOR and the outcome factors.

The primary hypothesis was also tested in terms of clinical significance and reliable change. Three general outcome variables and three grief variables were investigated by conducting a chi-square analysis for each. Similar to the above-mentioned outcome factors, a regression analysis was used with each of the six general and grief outcome variables to control for form of therapy. Finally, the relationship between patient QOR and both clinically significant change and reliable change for the six variables was investigated.

Designation of Homogeneous and Heterogeneous Groups

Each group was designated as homogeneous or heterogeneous on the basis of the percentage of high-QOR patients who completed the group, that is, patients who had attended 8 or more of the 12 sessions. We believed that completers represented the most relevant sample on which to conduct analyses because they had been a part of and experienced the same core composition of patients in the group for most of the 12 sessions. Most dropouts occurred early in the life of the group (65% by Session 4). Thus, unlike the completers, they did not fully experience the core composition of patients in the group. For these reasons, we did not believe that an intent-to-treat analysis was appropriate for a composition study of the type that we conducted. The percent of high-QOR patients in the 18 groups ranged from 0% to 100%. The mean was 55%, and the standard deviation was 34%. The 18 therapy groups were separated into three distinct sets. Six groups, with percentages ranging from 0% to 33%, were designated as homogeneous, low-QOR groups. Five groups, with percentages ranging from 43% to 67%, were designated as heterogeneous, mixed-QOR groups, and seven groups, with percentages ranging from 71% to 100%, were designated homogeneous, high-QOR groups. Nine of the groups were interpretive, and nine were supportive. Eleven were conducted at the Edmonton site and seven at the Vancouver site.

Check for Confounding Variables

Before conducting the statistical analyses related to the primary hypothesis, we conducted one-way analyses of variance to determine whether there were significant differences for any of the three outcome factors on the basis of site, therapist, use of medication, or group. There were none.

*Adjustment of *p* Values for Analyses*

To reduce the probability of Type I error and while maintaining sensitivity to potentially important findings, a Bonferroni adjust-

ment was made for each of three sets of dependent variables. These were the three outcome factors ($.05/3 = .017$), three general outcome variables expressed in terms of clinical significance and reliable change ($.05/6 = .008$), and three grief outcome variables expressed in terms of clinical significance and reliable change ($.05/6 = .008$).

Analyses Based on Statistical Significance

Primary Hypothesis

A *t* test was calculated between the homogeneous and heterogeneous conditions for each of the three outcome factors with the group as the unit of analysis ($N = 18$). None of the three *t* tests were significant at the required .017 level (two-tailed), which indicates a lack of support for the hypothesis.

Composition and Outcome

Next, we explored the relationship between the Composition score for each group and the outcome factors by using the group as the unit of analysis ($N = 18$). Pearson product-moment correlation coefficients were calculated. The composition score, which is the percentage of high-QOR patients (4.2 or higher) in a group, was directly and significantly related to favorable outcome for General Symptoms, $r(16) = -.65, p = .004$. The 95% confidence interval was $-.86$ to $-.26$, and the power was .93. The QOR composition score was not significantly related to outcome for Grief Symptoms or Target Objectives/Quality of Life.

Composition and Outcome, Controlling for Form of Therapy

Because of the way in which the groups were composed for the study, there was a high correlation between the form of therapy and the composition scores, $r(16) = .79, p < .000$. Interpretive therapy had higher scores. Thus, form of therapy was confounded with the composition score. To control for this variable, form of therapy was entered in the first step, and the composition score in the second step, in a multiple regression analysis with each outcome factor as the dependent variable ($N = 18$). There was a direct relationship between the composition score and improvement in General Symptoms, $F(1, 15) = 8.12, \beta = -.006, p = .012$. The *R* for the second step was .68, and the change in R^2 from the first to the second step was .30. Similarly, there was a direct relationship between the composition score and improvement in Grief Symptoms, $F(1, 15) = 11.18, \beta = -.007, p = .004$. The *R* was .66, and the change in R^2 was .42. The relationship was not significant for Target Objectives. Thus, regardless of the form of therapy, the higher the composition score, the better the outcome on General Symptoms and on Grief Symptoms. There was no significant relationship between the Composition Score and attendance or dropping out.

Differences Between Forms of Therapy

Using the group as the unit of analysis ($N = 18$), *t* tests were calculated between the interpretive and supportive therapy conditions for each of the three outcome factors ($N = 18$). None were significant at the required .017 level.

Patient QOR and Outcome Factors

Pearson correlation coefficients indicated that the individual patient's QOR score was not significantly related to the three outcome factors for the entire sample of patients, those treated with interpretive therapy, or those treated with supportive therapy ($N = 110$). There was no interaction effect like the one found in our previous study (Piper, McCallum, et al., 2001).

Analyses Based on Clinical Significance and Reliable Change

Determination of Criteria for General Dependent Variables

Clinical significance refers to clinically important change as determined by norms. Reliable change refers to change that exceeds measurement error. Both were calculated for three outcome variables (depression, anxiety, and general distress) from the General Symptoms outcome factor. They are often seen as the complications of CG (Rando, 1993). The two-part procedure of Jacobson and colleagues (Jacobson, Follette, & Revenstorf, 1984; Jacobson & Revenstorf, 1988; Jacobson & Truax, 1991) and refined by others (Christensen & Mendoza, 1986; Tingey, Lambert, Burlingame, & Hansen, 1996) was used. To achieve the first part, a patient must move from a dysfunctional range, past a cutoff value, to a functional range. To achieve the second part, a patient must change by a reliable amount.

The measures for the three outcome variables were the BDI-II (depression), the TAS (anxiety), and the BSI (distress). For the BDI-II, Beck et al. (1996) reported a mean of 29.4 for 103 patients with recurrent major depression. Nietzel, Russell, Hemmings, & Gretter (1987) reported a mean of 7.2 for a large sample from the general population. For the TAS, Spielberger (1983) reported a mean of 48.1 for 60 anxiety reaction patients and a mean of 34.8 for 451 female working adults. For the GSI of the BSI, Derogatis (1977) reported a mean of 1.26 for 1,002 psychiatric outpatients and a mean of .31 for 974 nonpatients. The pretherapy outcome

means of the present study exceeded the norms for all three variables (Table 2), which confirms the clinical nature of the sample.

Using Jacobson and Revenstorf's (1988) formula, the clinical cutoff criteria were 15.1 for the BDI-II, 41.0 for the TAS, and .61 for the GSI. The percentages of patients who traversed the criterion were 40.7% for the BDI-II, 24.2% for the TAS, and 20.0% for the GSI.

Reliable change was 11.6 for the BDI-II, 11.0 for the TAS, and .57 for the GSI. The percentages of patients who achieved reliable change were 37.4%, 29.2%, and 29.0%, respectively. The percentages of patients who both traversed the clinical cutoff criteria and achieved reliable change were 30.2% for the BDI-II, 20.0% for the TAS, and 13.3% for the GSI.

Determination of Criteria for Grief Dependent Variables

Three of the outcome variables from the Grief Symptoms factor have normative data that permit calculation of clinically significant change and reliable change. The measures were the IES (Intrusion and Avoidance scores) and the Present Feelings Scale of the TRIG. For the Intrusion score, M. J. Horowitz et al. (1984) reported a mean of 20.1 for 35 patients who sought therapy after the death of a parent and a mean of 13.5 for 37 normal field volunteers. For the Avoidance score, the investigators reported a mean score of 20.8 for the patients and a mean score of 9.3 for the volunteers.

For the TRIG score, Faschingbauer et al. (1987) reported a mean of 34.2 for two samples ($n = 260$ and $n = 328$) of nonpatients. Pasternak et al. (1996) reported a mean of 52.2 for 25 bereaved widows with major depression.

The clinical cutoff criteria were 17.1 for the Intrusion score, 14.8 for the Avoidance score, and 37.0 for the TRIG score. The reliable change indices were 8.8 for the Intrusion score, 11.6 for the Avoidance score, and 4.9 for the TRIG score.

The percentages of patients who traversed the clinical cutoff criterion for clinical significance were 47.2% for the Intrusion score, 50.6% for the Avoidance score, and 37.4% for the TRIG

Table 2
Means, Standard Deviations, and Effect Sizes for Outcome Variables at Pre- and Posttherapy

Variable	Pretherapy		Posttherapy		<i>n</i>	Effect size
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Anxiety	55.6	10.3	49.5	12.5	108	0.59
Depression	26.9	12.3	20.0	14.6	108	0.56
Interpersonal distress	1.5	0.5	1.4	0.5	108	0.20
Self-esteem ^a	3.8	2.1	3.2	2.0	108	0.29
General symptomatic distress	1.47	0.72	1.18	0.76	105	0.40
Social (role) dysfunction	2.6	0.5	2.3	0.5	100	0.60
Intrusion	19.8	7.8	15.4	9.1	106	0.56
Pathological grief	10.8	5.4	6.1	5.1	108	0.87
Grief (TRIG)	47.2	10.2	39.1	10.9	104	0.79
Avoidance	20.3	9.2	12.5	9.4	106	0.85
Target severity (assessor)	3.9	0.8	2.6	1.3	109	1.63
Target severity (patient)	3.9	0.8	2.8	1.3	109	1.38
Quality of life ^b	-0.1	2.1	0.6	2.0	102	0.33

Note. For grief variables, the scores used are the means of the two most significant losses. TRIG = Texas Revised Inventory of Grief.

^a Low scores are favorable (Rosenberg Self-Esteem Scale [Guttman scoring]). ^b High scores are favorable.

score. The percentages of patients who achieved reliable change were 39.0% for the Intrusion score, 48.8% for the avoidance score, and 69.2% for the TRIG score. The percentages of patients who both traversed the cutoff score and achieved reliable change were 40.3% for the Intrusion score, 43.2% for the Avoidance score, and 37.4% for the TRIG score.

Primary hypothesis. To test the hypothesis that homogeneous groups would provide more benefit than would heterogeneous groups in terms of clinically significant change and reliable change for the general and grief dependent variables, we calculated a set of chi-square analyses ($N = 18$). None were significant. Thus, once again, no support for the hypothesis was found.

Composition and outcome. We next calculated Pearson correlation coefficients between the composition score and the percentages of patients who achieved clinically significant change and reliable change for the general and the grief dependent variables for each group ($N = 18$). For the TAS, there was a direct relationship between the composition score and clinically significant change, $r(16) = .67, p = .002$. The 95% confidence interval was .01 to .92, and the power was .57.

Composition and outcome, controlling for form of therapy. To control for the effects of form of therapy, we again conducted regression analyses where form of therapy was entered on the first step and the composition score on the second step with clinically significant change and reliable change for the general and grief dependent variables ($N = 18$). The composition score was directly related to clinically significant change for the TAS, $F(1, 15) = 11.04, \beta = .528, p = .005$.

Relationship between patient QOR and clinically significant change and between patient QOR and reliable change. Correlations were calculated for all treated patients, interpretive therapy patients, and supportive therapy patients ($N = 110$). None were significant.

In summary, there was a lack of evidence supporting the primary hypothesis concerning homogeneous and heterogeneous compositions. However, evidence supporting the relationship between the composition score and favorable outcome was found from both the perspectives of statistical significance and clinical significance.

Discussion

Previous studies conducted by our research team suggested that optimal group therapy composition for patients experiencing CG might consist of homogeneous, high-QOR groups of patients treated with interpretive group therapy and homogeneous, low-QOR groups of patients treated with supportive group therapy. We hypothesized that patients in homogeneous groups would achieve better outcome than would patients in heterogeneous, mixed-QOR groups treated with interpretive or supportive group therapy. However, support for this hypothesis was not found. This was the case with the three main outcome factors of the present study and the two sets of outcome variables (general and grief) that were expressed in terms of clinical significance and reliable change.

The findings suggest that there may be a limit to the degree of homogeneity that is desirable in group therapy for certain patient characteristics. For example, whereas patients with low levels of QOR may do well in supportive therapy groups where there is a mix of high- and low-QOR patients, as our previous study indi-

cated, they may not do well in the virtual absence of high-QOR patients. The high-QOR patients may beneficially provide peer support and serve as models in engaging in useful problem-solving behavior. In their absence, the more primitive behaviors of low-QOR patients may result in a group culture where the provision of support and engagement in problem solving is regarded as intrusive and is met with suspicion and resistance. These possibilities are consistent with the reports of some investigators. For example, in their research involving the provision of interpersonal group therapy to outpatients who were homogeneous in terms of having been diagnosed with borderline personality disorder, Marziali and Munroe-Blum (1994) experienced very high dropout rates. Apparently, many patients could not tolerate a culture permeated by the primitive interpersonal processes of their peers. In contrast, therapy groups that are homogeneous in terms of high-QOR patients should not present a problem. The predominance of mature interpersonal processes should facilitate even greater benefit than that experienced in mixed-QOR groups. The validity of these possibilities is, of course, in need of verification by means of a direct process analysis of therapy-session behavior.

A different possible explanation for the failure to find support for our primary hypothesis concerns the high percentage (79%) of patients who were taking psychotropic medication. A positive therapeutic response to the medication would have a leveling effect on the outcome variables, which would make it more difficult to detect significant differences between the homogeneous and heterogeneous conditions. Although possible, it is noteworthy that the effect of medication did not prevent certain significant relationships from emerging, as described in the following paragraphs.

Although we did not find the hypothesized composition effect, we found a composition effect of conceptual interest and clinical importance. The composition score was the percentage of high-QOR patients in each therapy group. We found that, after controlling for the form of therapy, the higher the percentage of high-QOR patients, the better the outcome for all patients in the group in the areas of general symptoms and grief symptoms. We also found that the higher the percentage of high-QOR patients in each therapy group, the greater the clinically significant change for general symptoms of anxiety. The findings of the present study indicate that the QOR composition of the entire group was more important to the improvement of the individual patient than was the individual patient's own level of QOR or the form of group treatment received (interpretive or supportive). For example, a patient with a low QOR score who is placed in a group composed of a relatively high percentage of high-QOR patients can be expected to do relatively well. Conversely, a patient with a high-QOR score who is placed in a group composed of a relatively low percentage of high-QOR patients cannot be expected to do well despite his or her high QOR score.

Many authors have expressed the view that the composition of therapy groups is important but unfortunately have been unable to cite convincing evidence. Finding a composition effect has been an infrequent occurrence in the group therapy literature. Our discovery of a composition effect may have been facilitated by the specific nature of the composition variable (QOR), the nature of the patients' common problem (CG), and the type of treatment (short-term, time-limited group therapy).

Patients with high QOR scores have a lifelong tendency to engage others with a sense of respect and consideration. They

demonstrate general interest in others, accompanied by altruistic concern. Although they make take risks to initiate or maintain relationships, in the end, the relationships tend to be rewarding to both parties. In short, they are accustomed to forming mutually productive, give-and-take relationships. This is in contrast to patients with low QOR scores, who have a tendency to engage others in patterns of intense, unstable, and destructive relationships. There is a marked interest in helping themselves rather than helping others. In the end, the relationships are often disappointing to both parties. In short, they are accustomed to forming nonproductive, competitive relationships.

Having lost significant others, patients who are experiencing CG are in need of forming and maintaining mature relationships. Opportunities usually exist, both inside and outside of their therapy groups. In their groups, high-QOR patients can altruistically assist other patients in the work of the group, whether it consists of gaining insight into past conflicts and trauma (interpretive work) or solving everyday problems (supportive work). In the process of attempting to help others, they demonstrate to others how to form and maintain mutually rewarding relationships. In addition, altruistic behavior is also often rewarding to the provider.

Thus, it is possible that the presence of high-QOR patients facilitates relationships characterized by mature features, facilitates greater focus on others as opposed to a narcissistic focus on oneself, and facilitates work in line with the primary task associated with the particular form of therapy. Also, greater tolerance of the time pressures associated with time-limited, short-term group therapy on the part of high-QOR patients may have a calming effect on the whole group. This effect may have contributed to the patients' diminished anxiety, as indicated by the TAS findings. In the future, we plan to conduct process analyses of the therapy sessions to corroborate or refute these different possible explanations.

Short-term, time-limited group therapy provides a unique opportunity to examine issues related to loss in a situation where new losses (therapist, other patients, the group) are reexperienced after a relatively short period of time. Such events as arriving late, missing sessions, and dropping out of therapy, which are viewed as problematic in most therapy groups, can usually be used productively in loss groups. In addition, the brief duration of the groups creates pressure to work without unnecessary delay.

The fact that the findings may be attributed to the particular composition variable, patient sample, and type of group therapies that were studied also represents a possible limitation in regard to generalizing the findings. Another limitation concerns the low percentages of patients who achieved clinically significant change or reliable change for some of the variables. This limitation was more pronounced for the general variables (depression, anxiety, and general distress) variables than for the grief variables (intrusion, avoidance, and present feelings), perhaps because the groups were more focused on grief symptoms than on general symptoms. In addition, the average effect size for the three general variables was .52, whereas the average effect size for the three grief variables was .73 (see Table 2). These effect sizes are considerably higher than are the average effect sizes for outcome variables associated with bereavement interventions as reported in recent meta-analytic reviews of the literature. In their reviews, Allumbaugh and Hoyt (1999), Jordan and Neimeyer (2003), and Kato and Mann (1999) reported overall average effect sizes of .43, .13,

and .11, respectively. The relatively small effect sizes were attributed by the reviewers to a number of factors, which we believe did not characterize the present study. They included the possibility that the interventions were ineffective, that the interventions were not provided in a powerful dosage, and that the studies were laden with methodological shortcomings such as small sample size, low power, unreliable measures, and failure to control confounding variables. An additional difference between the present study and many of the bereavement studies reviewed is the nature of the samples that were studied. The bereavement studies often provided the intervention to participants who had experienced a death but who were not seeking treatment. In contrast, the present study involved patients who came to an outpatient psychiatry clinic for assistance with multiple symptoms and who met criteria for CG. In short, it is likely that they were more disturbed. Finally, in regard to limitations, a considerable number of statistical tests were conducted relative to the number of significant findings. However, a fairly stringent adjustment (Bonferroni correction) was applied to the p values that were interpreted as significant, and the relationship between the composition of the group (percentage of high-QOR patients) and outcome was consistent across tests of statistical significance and clinically significant change.

At a general level, the clinical implications of the findings are clear, whereas at a specific level, they are in need of determination. In the case of short-term group therapy for CG, the findings suggest that if a therapist wishes to enhance the benefit of the group for all patients in the group, the therapist should create a group composition that is characterized by a relatively high percentage of high-QOR patients. The question that remains, however, is how high should the percentage be? If it is set too high, patients who could benefit from therapy would be excluded. Also, waiting for a majority of high-QOR patients to become available could result in undesirable delays in starting groups. If the percentage is set too low, the entire group of patients may suffer. Thus, the determination of an optimal percentage is an important empirical question for future study. Another is whether the findings would be similar for other types of groups (e.g., long-term group therapy) and other types of problems (e.g., trauma).

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