1988

Supervision for Psychologists in Peer Groups: A Descriptive Study

David B. Hatch
Loyola University Chicago

SUPERVISION FOR PSYCHOLOGISTS IN PEER GROUPS: A DESCRIPTIVE STUDY

by

David B. Hatch

A Dissertation Submitted to the Faculty of the Graduate School

of Loyola University of Chicago in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

May

1988

ACKNOWLEDGEMENTS

I would like to thank the members of my committee, Dr. Gloria J. Lewis, Dr. Manuel S. Silverman, and Dr. Martha Wynne for their professional assistance, support and encouragement throughout this research project. Special thanks go to Dr. Gloria J. Lewis, the director of the committee for this dissertation, for her constant and outstanding modeling of what a true professional should be.

Those who touch my life most deeply have participated in ways which are difficult to convey in words. Special recognition and thanks go to my best friend and devoted wife, Judy, whose love, patience, support, understanding and motivation made completion of the Ph.D. possible. Also, I want to thank my children, Matthew, Julia, and Ethan, who have waited and waited for "Poppa" to complete his "big paper" and who constantly showed me things in life infinitely more important than Ph.D.s.

Finally, full acknowledgement and thanks must be given to my extended family and friends who have supported me and my family through this process. Buck and Mittie Hatch, Jack and Betty Matthews, Nat and Julie Hatch, Wally and Mary Schultz, Tom and Judy Marshall: you have provided the much needed anchors through the storm.

Vita

The author, David Bradley Hatch, is the son of James M. and Mittie Orr Hatch. He was born May 30, 1952 in Columbia, South Carolina.

His elementary education was obtained in several public schools in Columbia, South Carolina. His secondary education was obtained at Ben Lippen High School in Asheville, North Carolina were he graduated in 1970 as the validictorian of his class.

In May 1975 he received the Bachelor of Science degree, with honors, in Social Sciences from Wheaton College, Wheaton Illinois. He was awarded the Master of Arts in Marriage and Family Therapy from the University of Wisconsin-Stout in 1980. In September, 1982, he began his doctoral studies at Loyola University of Chicago.

The author has held positions in a social service agency and a college student development department working with all age clients in an outpatient setting. While completing requirements for the Ph.D. in Counseling Psychology from Loyola University he served as a psychology intern at the Veterans Administration Medical Center in Danville, Illinois.

The author has published one article in Professional Psychology: Research and Practice entitled: Peer Consultation Groups: A National Survey.

TABLE OF CONTENTS

LIST OF TABLES

CONTENTS OF APPENDIX

CHAPTER I

PROBLEM

Introduction

The dramatic increase in the number of psychologists in private practice as noted by Norcross, Nash, & Prochaska (1983) and Tryon (1983), has heightened the importance of research focusing on the special needs of private practitioners. Although independent practice appears to be a satisfying career for most of the psychologists who choose it (Nash, Norcross, & Prochaska, 1984), these psychologists can have special concerns since, without a formal structure and peer interaction, they are particularly vulnerable to stress, isolation and burnout, (Greenburg, Lewis, & Johnson, 1985).

Numerous suggestions appear in the literature for ways by which practitioners best can deal with the inevitable stresses of private practice. Burton (1969, 1972) recommends more non-vocational pursuits, such as traveling to foreign countries and experimentation with new therapies, such as multiple therapy and psychodrama. Burton also suggests that therapists have regular "satisfaction check-ups" conducted by senior therapists to help relieve frustrations. Freudenberger and Robbins (1979) advocate increased private time, nonprofessional pursuits, peer relations, continued training, sabbaticals, extended vacations, and return to personal psychotherapy. Professional

support groups are suggested by Farber & Heifetz (1982) and Nash, Norcross, & Prochaska (1984). Recently Greenburg et al. (1985) reported their positive experience in a Peer Consultation Group and call for further research into the existence, use and benefits of such peer groups among psychologists. From a national survey of psychologists in private practice, Lewis, Greenburg and Hatch (1988) found that peer consultation groups were in fact being used by a substantial number of private practitioners. "When you combine those who now belong to such a group with those who have belonged in the past, practically one of every two independent practitioners has used a group of peers to provide mutual help with private practice issues," (p 20). Lewis' study reported 111 peer consultation groups and the article describes the group members, the groups and the benefits derived from membership. In their conclusion the authors call for "more intensive studies of the content and process of existing groups with the goal of developing a model for peer consultation based on identified commonalties among successful enduring groups," (Lewis et al., 1988, p.24).

The groups studied by the Lewis team were quite diverse as to purpose, content and process therefore further study of these groups in a number of areas would be warranted. Nevertheless, within this diversity one theme surfaced which was common to a majority of the groups. The primary function of many of these groups was to provide direct clinical feedback to the private practitioners. Over 80% of the respondents indicated that they had received help with problematic cases in their groups and over half of them reported that they spent the greatest amount of time making case presentations. This supervisory-type function appeared to be central to the purpose and function of these 111 groups.

Some clarification of the concept of supervision will prove helpful before moving into the principle concern of the present study. Traditionally, supervision has been defined in terms similar to Wolberg (1954) who described supervision as "essentially a teaching procedure in which an experienced psychotherapist helps a less experienced individual acquire a body of knowledge aimed at a more dexterous handling of the therapeutic situation" (p. 642). More recently, Boyd (1981, p. 7) offered a three part definition stating that supervision:

> -is performed by experienced, successful counselors (supervisors) who have been prepared in the methodology of supervision.
>
> -facilitates the counselor's personal and professional development, promotes counselor competencies, and promotes accountable counseling and guidance services and programs.
>
> -in the purposeful function of overseeing the work of counselor trainees or practicing counselors (supervisees) through a set of supervisory activities which include consultation, counseling, training and instruction, and evaluation.

Embedded within these definitions (as well as in the functional use of the term "supervision") are several assumptions concerning supervision. First, it implies that the supervisory relationship is between a more experienced therapist and a less experienced therapist or trainee. Second, this relationship, by definition, is one of inequality with the powers of knowledge, skill, oversight, and evaluation residing with the supervisor. Third, the skill of becoming a psychotherapist (or counselor, therapist) is a time-limited process with a beginning and an end. There is a point in time when a novice therapist takes enough classes, learns enough theory, practices enough skills, receives enough feedback from her supervisor to become a therapist in her own right.

She then can, with or without further training, shift roles and supervise novice therapists. This leads to a fourth assumption: that there is a level of expertise in being a therapist where one no longer needs supervision or, at best, one can "self supervise" (Littrell, Lee-Borden, & Lorenz, 1979). At this point one becomes a "master psychologist" (Hogan, 1964).

This present study will be using the respondents from the Lewis et al. (1988) investgation and therefore some information about the subjects will be known prior to the beginning of the study. A dilemma which arises in the present investigation comes from the tension between some of the assumptions concerning supervision and the life situations of the subjects in this study. As discussed above, some traditional views of supervision imply a time limited, unequal relationship established for a therapist-in-training. The subjects of this study have chosen to be involved in a supervisory-type relationship and yet they condradict most of the assumptions concerning supervision. They are all practicing psychologists with an average of 13.3 post-licensed years experience as therapists and an average of 11.4 years experience in independent practice (Lewis, et al., 1988). By any definition, these are not novice psychologists. Their seeking clinical help in spite of their years of experience seems to indicate that they view becoming a therapist as "a life-long task," (Wagner & Smith, 1979, p. 288) without a definitive end. Furthermore, they have entered into a relationship not with senior and superior supervisors, but with peers where the relationship would tend to be one of equality rather than inequality. Finally, their involvement in a Peer Consultation Group suggests that they see the value of supervision throughout their career and not something to be terminated when they completed their structured, educational training.

On first thought, the conceptual tension described above could easily be resolved by not labeling the activities of discussing clinical material as "supervision". If this process of sharing therapy cases and receiving clinical feedback were called "consultation" then the present discussion would be muted. Consultation does usually imply a "freely solicited" relationship in contrast to supervision which "is generally imposed", (Friedlander, et al. 1984, p.190), however, by calling this process "consultation" the essence of what goes on in these groups is not described.

> Supervision...is a process that occurs over a period of time. It is distinguished from consultation which usually implies a task-oriented contact with an experienced advisor around a specific problem or issue. In contrast, supervision involves the development and use of a special relationship between supervisor and supervisee, (Phillips & Kanter, 1984, p. 178).

The groups to be studied have existed for an average of 6.5 years (Lewis et al, 1988) representing enduring relationships which have been developed to explore clinical issues on a broader level than case consultation implies. On the whole, these groups are not task-oriented contacts "around a specific problem or issue," (Phillips & Kanter, 1984, 178) but rather long-term group relationships where many levels of clinical experience can be shared, discussed, and influenced. Thus, for the purpose of this study it has been determined that the activities which these groups perform dealing directly with clinical issues will be called "supervision" and will conceptually fit into the developmental supervision literature as reviewed in Chapter II.

Principle Concern of Study

The principle concern of the present study is to describe the activities of Peer Consultation Groups which deal directly with the clinical aspects of the

members' professional life. Four major areas will be explored: the nature of the clinical presentations, the nature of the members' feedback to the presenter, the perceived benefits of such feedback, and the perceived comparison in value between these activities and other forms of supervision.

Obviously there are more aspects to these groups than will be covered by this present study. In Lewis et al. (1988) study it was discovered that groups differed in the amount of time spent on various activities. Each group participant rated a list of activities from one (least time) to seven (most time). In descending order of time allocated, the group activities were: case presentations; providing mutual support; sharing therapeutic techniques and tools; discussing ethical and professional issues; and sharing information. Although a majority of the groups (64%) reported spending more time (5-7 rating) on case presentations, there were still 29% which said that their group spent only minimal time on presenting cases. It would seem that these groups placed more emphasis on activities related to social support and sharing information in general rather than on activities directly related to their clinical practice. Nevertheless, it will be the activities that impinge directly on their clinical practice of psychology which will be the focus of this study. Questions of social support, information sharing, networking, etc. will need to be explored in other studies.

The study is exploratory in nature. A structured questionnaire mailed to group members, will provide the data leading to the formation of hypotheses concerning the nature of the peer supervision process and its benefits. The questions selected for the survey were based on relevant issues emphasized in the literature as well as discussions with a number of psychologists who participate in groups similar to those being studied.

Need and Significance of the Study

The sharp rise in the numbers of psychologists in independent practice as noted by Norcross, Nash, & Prochaska (1983) and Tryon (1983), has heightened the importance of research focusing on the professional experience of private practitioners. It has been suggested that psychologists in private practice may have unique needs related to their lack of institutional support and supervision, (Greenburg, Lewis, & Johnson, 1985) and therefore may need creative structures by which they can receive input in their clinical work. This study seeks information concerning one of those structures, the Peer Consultation Group. This study has the potential of not only offering a descriptive analysis of the supervision process in these groups, but also may offer a prescriptive alternative to those in independent practice who would benefit from peer supervision.

Another area of exploration that demonstrates the significance of this investigation is the area of the supervision of mature psychologists. The literature of supervision is built almost exclusively on the study of therapists or psychologists in training, with most of the research being done on beginning practicum students (Worthington, 1987). Although developmental models of supervision usually included a "master" therapist stage (Hogan, 1964; Ard, 1973; Gaoni & Neumann, 1974; Littrell, Lee-Borden, & Lorenz, 1979; Stoltenberg, 1981; Blount, 1982; Hess, 1986), numerous authors have concluded that this stage has been the least studied, (Worthington, 1987; Holloway & Hosford, 1983; Miars et al, 1983). Therefore, this study offers a unique opportunity to explore the supervision of one sub-group of mature psychologists: those in private practice.

Definition of Terms

Psychologist: Subjects in this study were drawn from the National Register of Health Service Providers in Psychology and therefore met the criteria for inclusion in that publication. Since membership within the Register does not reflect psychologists in general, the criteria for inclusion into the Register will be used as a definition for psychologist in this study. To be included one must be a "psychologist, certified/licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery, prevention, assessment, and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at high risk of impairment," (National Register, 1987). To be "duly trained" these individual need to be:

1. Currently licensed or certified by the State Board of Examiners of Psychology at the independent practice level of psychology.

2. A doctoral degree in psychology from a regionally accredited educational institution.

3. Two years of supervised experience in health service in psychology, of which at least one year is in an organized health service training program, and one year is post doctoral. (National Register, 1987, p. 23).

Peer Consultation Group: In the Lewis et al. (1988) study, Peer Consultation Groups were functionally defined as "three or more practitioners who meet for the purpose of providing mutual help with private practice issues." Since the present study is a follow-up to the Lewis study, all subjects involved in this research have labeled themselves as members of a "peer consultation group" as defined above. Within the literature there is no agreement on this label with some groups being called supervision groups, some peer groups, some consultation groups, and some therapy groups. Even within the initial

investigation of the groups used in the present study there were disagreements over what to call the groups, either "supervision" groups or "consultation" groups. However, for the present investigation "three or more practitioners who meet for the purpose of providing mutual help with private practice issues" will be used as the definition for peer consultation groups.

Supervision: Defining supervision is somewhat critical for the present study since the term is central to the entire focus of the research. We will use the definition of supervision as "a relationship in which one person's skills in conducting psychotherapy and his or her identity as a therapist are intentionally and potentially enhanced by the interaction with another person," (Hess, 1987, p.256) or persons. This definition is broad enough to included the supervision of a "paraprofessional learning basic skills to a master of the psychotherapy arts who needs consultation on a case," (Hess, 1987, p.251). Hopefully, some of the assumptions concerning supervision which would restrict the activity to therapists in training have been avoided here.

Summary

Chapter I has provided an introduction to the study, the study's primary concern, the need and significance of the study, definition of terms, and limitations. Chapter II will review the literature on theoretical and empirical foundations of peer groups with special attention paid to Developmental Supervision theory, peer groups for professional who are still in training, peer groups for mature professionals, and conclude with a review of the Lewis et al. (1988) study of Peer Consultation Groups. Chapter III will provide an outline of the design of the study and the research measures used. Chapter IV will

present the statistical analysis of the data. Chapter V will offer a summary of the study, conclusions taken from the data, recommendations for practitioners and potential future research.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

When post-doctoral psychologists meet together in a peer group to discuss clinical issues, what should the process be called? Is what they are doing continuing education? Consultation? Supervision? Consult-vision? This question involves more than just semantics since the nature of the literature review will be directed, to some extent, by its answer. For this study, supervision will provide the context out of which the literature review will develop. Supervision was chosen for two major reasons. First, the clinical presentations and resulting feedback within the groups to be studied most resembles the process of supervision as defined in the literature. Second, the extensive theoretical and empirical research on the supervisory process provide a much broader and deeper review than either professional development or consultation.

The first section of the literature review is concerned with the theoretical and, where available, the empirical foundations of this study. Developmental supervision provides the framework into which a study of mature therapists can be placed. Group supervision provides the modality of supervision which will

be explored. The second section is concerned with the literature which actually describes peer groups for both professionals-in-training and professionals. The purposes, activities, and benefits of these groups are reviewed. This section concludes with a review of the only major, data-based investigation of peer consultation groups for psychologists (Lewis, et al., 1988).

THEORETICAL LITERATURE ON DEVELOPMENTAL SUPERVISION

In an attempt to establish a conceptual or theoretical context into which the present research will be conducted, a brief survey will be made of the theory based literature on developmental and group supervision. Developmental supervision was chosen since it is first a current and heuristic theory of supervision and, second, it provides a meaningful explanation of the need for professional growth and development of the post-doctoral or mature therapist. Group supervision was chosen since it offers a theoretical foundation of the method used by these mature therapists to receive such professional growth and development.

DEVELOPMENTAL SUPERVISION

The construction of a theoretical model for clinical supervision has been of interest to mental health professionals for at least the last 30 years. For most of those years the basic approach to building theories has been to take an existing counseling theory and overlay it on the supervisory process, (Holloway, 1987). Examples of this include psychodynamic supervision, rational-emotive supervision, and behavioral supervision. This was done under the assumption that there was parallel dynamics and processes going in both in counseling and

in supervision. In recent years, several authors (Loganbill, Hardy, and Delworth, 1982; Stoltenberg, 1981) have suggested that the two processes are substantively different and thus, a new, fresh theory must be developed for supervision.

The last five years have seen a shift in the conceptualizations of supervision as theorists have begun to develop models of supervision which incorporate psycho-social developmental assumptions into their framework. The supervisory process must include a progressive teaching approach that accommodates the different training needs of more experienced versus less experienced supervisees and must take into account an emphasis on positive growth and age-related changes people make, (Goodyear & Bradley, 1983). "Eighteen different models of supervision that refer to developmental principles have been cited in the psychiatric, psychological, and social work disciplines (Holloway, 1987). Specifically within the counseling psychology literature there have been a number of substantive presentations of a developmental nature including Littrell et al. (1979), Stoltenberg (1981), Loganbill et al. (1982), and Blocker (1983). As early as 1964 Hogan's developmental model of supervision surfaced in the clinical literature and provides the foundation for several of the theoretical and empirical writings on developmental supervision. Numerous empirical studies (to be summarized later) have attempted to explore a developmental approach to supervision (Worthington, 1987). All in all, "developmental models have become the zeitgeist of supervision thinking and research," (Holloway,1987, p. 209).

Special attention will be paid to the developmental supervision literature for two reasons. First, this perspective is predominate and offers a promising

model for the entire supervision process. Second, a developmental approach should provide a conceptual nitche for therapists at all levels of experience and training including mature therapists who are the focus of the present study. This review will examine the five developmental models of supervision which have been predominate in the counseling literature in recent years: Hogan (1964), Stoltenberg (1981), Littrell et al. (1979), Loganbill et al. (1982), and Blocker (1983).

Hogan's Model

Hogan depicted counselors in training as working with different issues at each of four different levels of development. Since each level dealt with different issues, the training of therapists should change over time to reflect these differences. "Supervision needs to be appropriate to the level of development in the therapist," (Hogan, 1964, p. 139). Hogan described each of these four levels in terms of the needs of the therapist and appropriate methods of supervision to meet those needs.

In Level One therapists try to apply everything they have learned. They are dependent on the supervisor, neurosis bound, insecure, and un-insightful, (Hogan, 1964, p. 139). The methods used in supervision are built on the assumption that imitation in supervision is inevitable. Direct teaching by the supervisor is present at this level. Interpretation designed to encourage constructive self-awareness is also appropriate. The supervisor should also counter the student's anxiety with support and yet gently push the student to become more self-aware. Finally, the supervisor should be free to exemplify himself as a therapist in relation to a client so that the therapist-in-training can

observe.

As therapists-in-training begin to become free from their technique-bound tendencies and begin to invest more of their personality into the therapeutic relationship, they move into Level Two. This level is characterized by a dependency-autonomy conflict, "in which they reflect their character in the attempt to find themselves in their work while still struggling with their dependency needs," (Hogan, 1964, p. 140). They can be both overconfident in their new found skills and also overwhelmed by the responsibility of their profession. There is also a vast fluctuation in their level of motivation during this level at one time begin deeply committed to the profession and at another time having serious misgivings. Supervisory methods here are built on the assumption that the learning of the counseling profession will be a mixture of successes and failures and that they both should be respected. The supervisor should continue support by affirming the basic potentials of the trainee. Ambivalence-clarification is helpful to the therapists in making the elements of their struggle clearer. Both exemplification and direct teaching will continue but to a less extent than in Level One.

Level Three is when the therapists become masters of thier trade. Increased professional self-confidence has replaced the dependency-autonomy conflict and greater insight has emerged. The therapists have a clarity about neurotic and health motivations and their motivations in the profession have stabilized. This growth in the therapists should be reflected in a movement towards 'peership' by the supervisor. Mutual sharing increases and needed exemplification continues. Professional and personal confrontation becomes common and is central to this level of supervision.

The final stage in supervision is Level Four and is characterized by:

> "personal autonomy adequate to independent practice, insightfulness with awareness of the limitations of insight, personal security based on awareness of insecurity, existence with changing modalities of motivation, and awareness of the need for idiomatic confrontation with the struggles of living," (Hogan, 1964, p. 140).

Hogan writes that at this point the control supervision is "far inferior to the peer supervisor," (1964, p. 141) where sharing, confrontation, and mutual consultation are the techniques of choice.

Stoltenberg's Model

Stoltenberg's (1981) model of counselor development is based on Hogan's (1964) descriptions of the various levels through which trainees go. Stoltenberg argues that each of the levels for the counselor-in-training needs to be matched by a optimal learning environment before the tasks of each level can be accomplished. For each of the four levels he addresses the student's interpersonal perception, identity, motivational orientation, emotionality, and cognitive structural attributes. The supervision environment should match each of these areas at each level.

Each of the levels of the counselors' characteristics and corresponding environments follows rather closely Hogan's (1964) model. Since the basic elements are the same, only the fourth level will be reviewed here which applies to mature therapists. Awareness of their personal limitations, frees master counselors to be capable of independent practice. Their awareness of insecurity gives them personal security, their acknowledgment of the limits of insight provide the basis for valuable insightfulness; and their moderate

fluctuations in motivation do not hinder their overall productivity. These master counselors have progressed past the point of willful independence and feel comfortable with interdependence with others. "The counselor(s) have an increased understanding of their personal characteristics, values, and abilities as being different yet existing on the same dimension as those of colleagues," (Stoltenberg, 1981, p. 63).

The supervision environment most productive for master counselors would be substantively different from supervision at other levels. The individual would be fully capable of independent practice since sufficient self awareness and an integrated counselor identity would enable adequate functioning in most professional settings. "This level of personal development also gives the counselor enough insight to know when professional consultation is necessary. Such an individual would be best utilized as a supervisor for less advanced counselors or as a participant in collegial supervision with other advanced counselors," (Stoltenberg, 1981, p. 63).

Littrell, Lee-Borden, and Lorenz's Model

Littrell et al. (1979) also proposed a four stage developmental model of supervision. What is distinctive about this perspective is that it is constructed out of four previous models of supervision: counseling/therapeutic, teaching, consulting, and self supervising. Whereas the previous models were advocated as adequate descriptions of the complete process of supervision, Littrell et al. thought that since each one emphasized a unique task to be accomplished they must all be included in an overall model of supervision. The counseling/therapeutic approach emphasized understanding and overcoming

personal and emotional concerns; the teaching approach emphasized the conceptualization and implementation of effective treatment plans; the consulting approach emphasized meeting with supervisor as colleague about client issues; and the self-supervising emphasized the incorporation of the skills, attitudes,and knowledge of the other models as a self-supervisor (p. 129). In supervision, the counselor-in-training moves progressively through the four stages where "the trainee assumes a greater responsibility for his or her learning" (p. 130) at each stage.

In stage one the supervisory relationship, the setting of goals, and the establishing of a contract are the primary focus. The role of teacher and/or counselor begins to be played out by the supervisor in stage two. Here is where the interpersonal dynamics and the professional skills of the trainee become the content of supervision. The supervisor holds primary responsibility for the conceptualization, implementation, control, and management of supervision. In the third stage this responsibility begins to be equally shared with the trainee who now sets the goals for supervision and uses the supervisor as a consultant, a role defined by experience, and expertise. The relationship becomes cooperative as supervisor evaluation is de-emphasized and trainee self-evaluation is supported. It is here where the supervisee takes on increasing responsibility for her own training and changing. Littrell's et al. (1979) final stage stresses a counselor who is "sensitive to personal-emotional issues, is skilled in understanding clients and effective methods of helping, and is able to step outside of counseling situations and objectively assess his or her impact as a counselor," (p. 134). The self-supervising counselor takes full control of the direction and implementation of supervision as his or her

professional role.

Loganbill, Hardy, and Delworth's Model

The Loganbill et al. (1982) model is perhaps the most comprehensive developmental model of supervision (Holloway, 1987, p. 210). It takes its primary theoretical foundation from the developmental psychology of Margaret Mahler, Erik Erikson, and Arthur Chickering. They assume that there are distinct, sequential, hierarchical, and necessary stages in the development of a counselor. "Some of the stages and processes may be very painful, but it is developmentally important for the supervisee to experience them fully" (p. 4). This model does not just reflect development during a formal training program but is continuous throughout one's professional life since the model is actually one where the counselor "may cycle and recycle through these various stages at increasingly deeper levels" (p. 17).

The Loganbill et al. model proposes three stages: stagnation, confusion, and integration. Stagnation can be identified in a beginning counselor by a naive unawareness of any difficulty or deficiency in a specific area or in an experienced counselor by a "stuckness" or blind spot in some area of professional development. Stage two, confusion, can be characterized by instability, disorganization, erratic fluctuations, disruptions, and conflict. The supervisee is shaken free of old, stagnant attitudes and behaviors and desperately seeks some equilibrium. The transition from stage two to stage three, integration, is often a very welcome one for the trainee. This third stage can be described as reorganization, integration, a new cognitive understanding, flexibility, personal security based on awareness of insecurity and an ongoing

monitoring on the important issues of supervision (p. 19).

The counselor moves progressively through these stages in each of eight areas of professional life: competence, emotional awareness, autonomy, identity, respect for individual differences, purpose and direction, personal motivation, and professional ethics. As the supervisor builds a relationship with the trainee, the primary goal is to assess the trainee in each of these areas and determine at which stage they are. The supervisor then has five types of interventions to facilitate transition from stage to stage: facilitative, confrontive, conceptual, prescriptive, and catalytic interventions.

Blocker's Cognitive Developmental Model

Blocker's (1983) model is similar to Stoltenberg's (1981) model in that they both were interested in forming a supervisory learning environment that would optimize the trainee's learning; however, Blocker's application of cognitive development to supervision is unique. Blocker used the knowledge in human cognitive development and applied it to the growth and development of cognition available to the learning therapist. Stages of development are not emphasized but rather the unique learning process determined by the student's particular learning style and developmental history (1983, p. 28). This model assumes that there is a demand for highly complex functioning in the counseling situation. "Thus the supervisor, when designing the learning environment, must focus on the ultimate goal of the trainee's acquisition of new, more complex, and more comprehensive schemata for understanding human interaction, (Holloway, 1987, p. 212). Blocker argued that there were seven basic dynamics involving the interaction of learner and environment: challenge,

involvement, support, structure, feedback, innovation, and integration. Systematic learning takes place when there is an optimal person-environment fit between the trainee needs and the supervisor's interventions in each of these areas.

GROUP SUPERVISION

Since group supervision usually has been thought of as an adjunct to individual supervision, little theoretical justification has been attempted in the literature. "Unfortunately, there are neither adequate models nor convincing empirical studies" (Holloway & Johnston, 1985, p. 338) of group supervision so that any advantages of this approach are merely listed rather than being embedded within some theoretical framework. Because of this, Holloway & Johnston conclude that group supervision remains "widely practiced and poorly justified," (1985, p. 339). Several authors have addressed why the group method of supervision would be advantageous and they will be reviewed within the descriptive section of Peer Groups.

EMPIRICAL LITERATURE ON DEVELOPMENTAL SUPERVISION

Worthington (1987) has extensively reviewed the empirical research on the changes in supervision as counselors and supervisors gain experience. Since Worthington's article is both current and thorough his conclusions will be reviewed here rather than the specific research articles on which his conclusions are based. What is known empirically about developmental

supervision can be summarized as follows:

1. There seems to be some support for general developmental models as proposed by Hogan (1964), Stoltenberg (1981), Loganbill et al. (1982), and others. Nevertheless this support has been questioned by Holloway (1987) who argues that the assumptions of developmental theory have not been met by these models.

2. Perceptions of supervisors and supervisees have been broadly consistent with developmental theories. Reising and Daniels (1983) explored some of Hogan's (1964) concepts and "showed that from anxiety, need for techniques, and an unwillingness to be confronted to low need for work validation, counselors develop high independence but some ambivalence as to their role as a counselor," (Worthington, 1987, p. 195).

Wiley (1982) investigated Stoltenberg's theory by describing his four levels of counselor development and the four environments for counselors at each level. Wiley tested three major hypotheses and found: (a) that the supervisors perceptions of counselor's development matched the actual amount of supervised experienced of the counselors, (b) that supervisor reported that they provided differing levels of supervisory environments with supervisees with differing levels of experience, and (c) that congruence between supervisory environment and counselor's level of experience was not related to either supervisee's or supervisor's satisfaction with supervision. Miars et al. (1983) also studied Stoltenberg's (1981) model and found that supervisors claimed that they conducted supervision differently depending on the level of counselor's experience. In three studies, Heppner and Roehlke (1984) explored supervisee's ideas of supervision prior to beginning

supervision, their perceptions of supervisor's behaviors during supervision, and their evaluation of supervision at termination. Since three progressively experienced groups of supervisees were used, the authors were able to compare any differences between groups on each of the areas of investigation. They discovered that supervisees at different levels of experience did not differ on their perceptions of supervision prior to the start of supervision, they differed in what they found to be satisfactory within supervision, and they differed in what they perceived to be critical incidents throughout supervision. "Heppner and Roehlke's (and Worthington's) studies provide limited but reasonably congruent support for developmental models of supervision," (Worthington, 1987, p. 201).

3. The behaviors of supervisors change as counselors gain experience.

> Supervisors of advanced trainees made higher proportions of statements that focused on (a) the client, (b) the client in therapy, and (c) the supervisor. Supervisors of beginning trainees made higher proportion of statements that focused on (a) the counselor's behavior in therapy, (b) the counselor's feelings and thoughts about therapy, and (c) the supervisory relationship, (Worthington, 1987, 201).

4. The supervisory relationship changes as counselors gain experience. Generally, supervisees perceived their relationship with their supervisors as improving over time while the supervisors noted no difference as the semester progressed. Less experienced students felt that they had more positive relationships with their superiors than did the more advanced students.

SUMMARY OF DEVELOPMENTAL SUPERVISION LITERATURE

Within the theoretical literature, there is strong support that the learning

and supervision of psychotherapy are developmental processes. As therapists learn the profession they move through various stages and at each stage they evidence different needs. These needs can be served best when unique supervision environments are offered at each stage of development. The professional development of the post-doctoral therapist remains a process similar in kind to the initial learning of the skills of therapy. They simply are at a different developmental stage and so they experience unique needs associated with that stage. As with earlier stages, the supervisory needs of the mature therapist can be best met within the context of unique learning environments. Certain attitudinal approaches to supervision, certain methods of case review, certain techniques of intervention, and certain supervision modalities may offer unique environments which are best suited to the needs of the mature therapist. A number of authors have suggested that the peer-group approach could possible provide one such environment. Nevertheless, to this point in time, there have been no published investigations which explored any optimal learning environments for the mature therapist.

DESCRIPTIVE LITERATURE ON PEER GROUPS

PEER GROUPS FOR PROFESSIONALS-IN-TRAINING

GROUP COUNSELING/THERAPY

From the literature, there are three general reasons why therapist training

programs suggest peer group work as a part of a therapist's education. First, self understanding is seen as a crucial part of becoming a therapist and can be enhanced by group involvement (Battegay, 1983; Tate, 1973; Grotjahn, 1969; Reddy, 1970; McKinnon, 1969). Although the goal of "self understanding" was mutually shared by these authors, the exact understanding and description of "self understanding" varied widely. Battegay (1983) and Gratjahn (1969) spoke in psychodynamic language as they argued for peer groups for psychotherapists in training. Both strongly supported individual analysis but saw the group work as an additional means by which transference issues could be worked through. The group offered new transference potential since the multiple relationships (to the leader, to the peers, and to the group as a unit) tie back to the early family problems of narcissism, power, and rivalry (Battegay, 1983). With these issues surfacing more readily, the members have greater opportunity to work through their "collective family transference neurosis" (Grotjahn, 1969, p. 329) and to gain deeper self understanding. Tate (1973), Reddy (1970), and McKinnon (1969) spoke of the therapist's increased accuracy in viewing themselves as a result of their emotional-personal sharing and the resulting feedback within a group of professional peers. It was clearly assumed by all authors that this enhancement of self understanding would lead to better results in therapy.

The second purpose served by having peer groups for student therapists was to increase the actual skills and techniques of therapy. The group is ideal in "giving the participants a self-experienced view of what is typical for group psychotherapy," (Battegay, 1983, p. 199). From this view, students can observe (and learn) group developmental stages (Battegay, 1983), group process

issues (Grotjahn, 1969), facilitative behaviors of leaders and members (Tate, 1973), and actual change in member's behavior (Tate, 1973). Using the group to "try out" new skills in a safe place and to receive accurate, professional feedback also provide a learning experience for the novice therapist.

The third purpose served by these groups was to provide support or encouragement to professionals in a common, stressful situation. Medical and psychological training has increased in competition and rigor so that many times the schools becomes a "stressful, unsupportive, and restricting environment," (Dashef, et al., 1974). The students join groups to "share with their peers their anger, frustration, doubt, and insecurity, as well as their wonder and excitement" (Goetzel, Shelov, & Croen, 1983, p. 337) about becoming a professional.

The actual descriptions of these groups were often general and lacked detailed information concerning group structure and dynamics. Tate (1973) stated that the group's activities needed to be in line with the overall goals of the training program but failed to specify exactly which activities would meet this suggestion. Voluntary participation was advised since compulsory attendance would be counterproductive to group counseling goals. All members were asked for a commitment to share personal concerns, to set specific goals for change, to give help when needed, to receive help when offered, and to attend all sessions. A very similar philosophy of group activities was expressed by Reddy, (1979) although the format was different. This group met over a four day period using eight to twelve hours a day for group interaction. It consisted of staff members and practicum students and shared similar goals to Tate (1973).

Dashef et al. (1974) described a short term, elective sensitivity group

whose "focus was on immediate interaction, not personal exploration," (p. 287). This group was clearly defined not as 'therapy' but as a group whose activities always emphasized looking at group process and the individual's style of interaction with the group. These groups had co-leaders and met from four to six sessions for two hours. In contrast, Battegay's (1974) and Grotjahn's (1969) groups were intentionally set up as psychodynamic group therapy sessions led by mature psychotherapists. The thrust of the activities centered in personal sharing and the resulting interpretation from the leader and the group. Group process issues were acknowledged but were always placed within an interpreted dynamic framework.

Goetzel, Shelov, & Croen's (1983) support groups were composed of volunteer medical students meeting with two faculty members, "all of whom functioned as equals," (p. 338). The groups consisted of young professionals (mean age of 24.6) who were mostly single (84.6%) and who were all enrolled in medical school. It would seem from the results of this study that members shared many of the leadership functions while the focus of group discussions were on "external problems rather than the here and now," (p. 350).

Some empirical investigations have been undertaken to determine the effect of peer groups on therapists in training. Gazda & Ohlsen (1961) "stands in many respects as a model among group studies, notable for its careful design and its longitudinal approach to outcome measurements," (McKinnon, 1969, p. 196). Gazda & Ohlsen attempted to assess the effects a seven-week group experience on prospective counselors. Although the findings were limited to non-significant gains, the study did show uniformly positive long-range trends in self concept, social conflict, adjustment, and manifest needs.

McKinnon (1969) attempted to "assess some effects of a supervised counseling practicum; and of experience in group counseling, separately and in combination, on the ways in which student counselors see themselves, others, and the counseling task," (p. 196). Four groups were studied: one was involved only in group counseling, one was involved only in individual supervision in a counseling practicum, one had both experiences, and one group received no treatment. The results indicated that the group which had both group counseling and counseling practicum showed a statistically significant improvement on a continuum of Sees Self as Adequate to Inadequate and Responses are Internally to Externally oriented. However, no other measures attained a significant level of between-group differences, (p. 198). The "dearth of significant results in the study" (p. 198) led the authors to reconsider the instruments used and the time allowed for the practicum.

Betz (1969) conducted a study which tried to address which type of group counseling-affectively oriented or cognitively oriented-would have the greater impact on the therapy behavior of counseling students. The results were summarized by Betz.

> From the results presented in the present study, it is possible to increase counselors' ability to respond to affect by involving them in a group counseling experience which is deliberately structured to focus on affect within the group setting....Both groups did not change in their ability to become less leading and more client oriented, or in their ability to move from predominantly one or two response-pattern orientations to a more natural and multipatterned stance, (p. 532).

Reddy (1970) studied one T-group which lasted four days to see if it had any effect on the member's exhibition of a helping relationship (positive regard, empathy, and congruence), on the congruence between the group members

self report and their clients report of the member's helping characteristics, and on the student-faculty relationships. At the end of the group, the members perceived each other "as having higher levels of the conditions of a helping relationship than before their experience" at statistically significant levels, (p. 112). No support was found for a correlation between member and client reports of these conditions. Staff saw the experience as worthwhile yet students said it was only slightly worthwhile. Reddy concludes that more research is needed.

GROUP SUPERVISION

There have been numerous advocates for the use of peer groups as a method of supervision with therapists-in-training, yet the literature is limited to very few articles (6). As early as 1966 Dreikurs & Sonstegard described a form of group supervision modeled after the approach used by Alfred Adler who interviewed children and their parents before a group of teachers (p. 18). Dreikurs & Sonstegard led a practicum where the students interviewed clients and were supervised before a group of peers. Individual interviews with parent and their child, feedback to parent, model interview by supervisor, and critique/feedback to the student were all conducted within the group context. "The students, acquiring knowledge and skill in counseling in a group setting of his peers, experiences inestimably valuable feedback from the observations and the questions of his colleagues during and after each counseling session," (p. 19). The students rated the opportunity to counsel before the group as the most valuable aspect of their practicum, (p. 24).

Fraleigh & Buchheimer (1969) described a practicum situation where a

peer group supplemented and enhanced the one-to-one supervision that all students were receiving. This group was led by a trained psychologist experienced in group work and had as its chief goal to "provide support for the individual members and to offer a sense of safety to them," (p. 284). The authors saw three areas of value in this group experience: 1. serve as an effective supplement the practicum supervisor in the procedural, didactic, and modeling aspects of supervision; 2. offer a variety of styles of therapy from which a student can learn, and 3. help the student in self-exploration, (p. 286-287).

The triadic method of supervision, as described by Spice & Spice (1976), provides a method of supervision which has elements of both traditional and group supervision. Within a practicum setting, three students work together as a team yet each one fulfills distinct, rotating roles. One clinician presents for discussion a video- or audiotape, a case report, or some other sample of his or her counseling practice. Prior to the session, a second student reviews this work sample and develops a commentary on it. The commentator communicates his or her observations about the supervisee's work and encourages dialogue about those elements that the supervisee and commentator see as important. While these latter two persons focus on the supervisee's work, the "facilitator" focuses on the present, here-and-now dialogue between supervisee and commentator. The facilitator's role is to deepen the impact of this dialogue wherever possible, (p. 253). At the early stages of supervision a faculty member may join the triad to assure that all roles are fulfilled properly but then he/she gradually drops out of the group. This allows the students to build confidence in their own skills in each of the three

roles.

The field of family therapy offers several contributions to the concept and practical application of peer groups for training therapists. The collaborative team (Sperling et al., 1986) or "peervision" (Brown, 1985) offer a unique training and intervention model. Each clinical case is assigned a primary therapist (or co-therapists) who meets directly with the family in therapy. The team, made up of several peers and one supervisor, watches all sessions from behind a one-way mirror and becomes "the third member of the therapeutic system (family and counselor being the first two), which by virtue of its position outside the room can comment on the family-counselor system interactions," (p. 183). The team can simply observe the session and collect feedback which is given later, or it can actively participate by calling in messages on a telephone, by sending in a member to join the therapist, or by pulling the therapist out of the session for consultation and planning. Reported benefits of this team approach were the immediate feedback available to the therapists, the protection from being inducted into the family's conceptualization of the problem, the help in planning interventions, the opportunity to supervise cases, and the general support provided. Therapeutically, the team allows the therapist to side with the family against the team, gives the novice therapist needed direction, and, if needed, can rescue the therapist, (p. 188).

Similar to family therapy training, the nature of group therapy training lends itself to the use of peer groups. In Smith's (1976) article it was assumed that the group format was the modality of choice in training group therapist since the roles and dynamics of group therapy could be simulated by the supervision group (p. 24) and because the group helps the therapists assume responsibility

for their supervision. Smith argued that beginning group therapists all express concerns about (a) establishing a trust relationship with both their supervisors and peers, (b) assuming a group leadership position, (c) establishing a satisfactory co-leadership relationship, (d) knowing when and how to disclose information about themselves to their counseling groups, and (e) integrating theory and practice,

(p. 13). Since all students wrestle with these issues, these issues should become the content and focus of the peer group which would meet for supervision.

PEER GROUPS FOR MATURE PROFESSIONALS

The literature dealing with peer groups for mature, professional mental health workers is limited in quantity and is almost exclusively focused on the descriptions of specific groups of which the author is a member. Of the seventeen articles in this literature, four attempt to present peer groups conceptually, using their own group to illustrate the potential benefits within a profession (Fizdale, 1958; Judd et al., 1962; Apaka et al., 1967; Hare & Frankena, 1972). The majority of the articles (eleven) simply describe the activities and process of a particular group (Kline, 1972, 1974; Todd & Pine, 1968; Hunt & Issacharoff, 1975; Austin, 1984; Freedman, 1984; Rabi et al., 1984; Nobler, 1980; Morgan, 1971; Brandes & Todd, 1972; Greenberg, Lewis, & Johnson, 1985). The remaining article (Lewis et al, 1988) stands as the only empirical investigation of peer groups and will thus be discussed separately at the end of this section.

GENERAL DESCRIPTION

Peer groups for practicing professionals were started through the structured initiation of an agency (Apaka et al., 1967; Hare & Frankena, 1972; Fizdale, 1958), through the informal discussions among clinicians (Greenberg, Lewis, & Johnson, 1985; Hunt & Issacharoff, 1975; Nobler, 1980; Rabi et al., 1984), through invitations (Austin, 1984; Brandes & Todd, 1972; Todd & Pine, 1968), through school contact (Freedman, 1984), or in response to an article on the subject of peer groups (Kline, 1972, 1974). Once begun, most groups were open to new members but placed various stipulations on who and how other therapists could become members. Austin's group (1984) required that all members be full-time, systemic therapists with access to clients where family therapy was possible. A number of groups required its members to have had analytic training (Todd & Pine, 1968; Nobler, 1980; Morgan, 1971). Greenberg, Lewis, & Johnson (1985) illustrates several groups in that new members had to be invited and approved by the present membership. The number of members in each group remained relatively stable over time with members who dropped out being replaced rather quickly. Membership size varied from three (Brandes & Todd, 1972) to twelve (Austin, 1984) with most groups having five to six regular attenders.

The make-up of the membership was both homogeneous and heterogeneous depending upon the group. Some were all female (Greenberg, Lewis, & Johnson, 1985), all male (Kline, 1972, 1974) or mixed (Hunt & Issacharoff, 1975; Judd et al., 1962; Nobler, 1980). Most groups had members from one profession or training background but two groups freely mixed psychologists and social workers (Greenberg, Lewis, & Johnson, 1985; Hare &

Frankena, 1972). It was argued that both similar (Rabi et al., 1984; Freedman, 1984) and divergent (Greenberg, Lewis, & Johnson, 1985) theoretical orientations among members was valuable. The one providing a common language and orientation for the group while the other offering differing perspectives from which to view the clinical material. Both the age of the members and their level of experience varied between and within groups.

Groups met twice weekly (Frizdale, 1984), weekly (Judd et al., 1962; Kline, 1972; Hare & Frankena, 1972; Hunt & Issacharoff, 1975; Austin, 1984), or monthly (Greenberg, Lewis, & Johnson, 1985; Brandes & Todd, 1972; Freedman, 1984) usually for two hours with some meeting as long as four hours (Greenberg, Lewis, & Johnson, 1985). On the average the groups had been meeting four to five years with some enduring as long as fifteen (Brandes & Todd, 1972).

Leadership was of two varieties. A majority of the groups described themselves as not having anyone who was designated as the leader or as rotating leadership among the members as needed. The leaderless groups tended to be the ones where all members where independent therapists with extensive experience. The other groups had designated leaders but varied as to the role they played. Austin's group (1984) began with co-leaders who offered "the expertise and direction for the group" (p. 73) but then evolved to having one leader who used a strongly democratic style of leadership. Several agency-initiated groups had leaders who provided only administrative and not clinical leadership (Apaka et al., 1967) or who became active supervisors within a group context (Judd et al., 1962).

PURPOSES

The intended purpose(s) for beginning these peer groups varied extensively both from group to group as well as within each group. These stated purposes seem to depend upon the setting of the group (agency vs private practitioners) or on the individual needs of the group members. As early as 1958, Fizdale articulated several purposes of a peer group which formed within a agency setting. Fizdale focused on the potential conflict which can come in the individual supervision of mature therapists. On the one hand, supervision of therapy provides the administrators of an agency with a medium whereby they can accurately know what is going on in the "field". This knowledge leads to the "development of standards and policies" as well as an "increased professional competence through the identification of those areas of practice that require study and experimentation," (Fizdale, 1958, p. 443). On the other hand, supervision of experienced practitioners was seen as "potentially detrimental to the professional maturation of the worker" (p. 443) since it may bread unproductive dependence by the therapist on the supervisor. This creative tension between the needs of the agency and of the therapist led to the formation of a group whose purpose was to "review and improve the agency's practice, while permitting the caseworker gradually to assume more responsibility for his own practice, " (p. 443).

Judd, Kohn, & Schulman (1962) describe a similar setting to Fizdale (a private social service agency) yet their stated purposes for a peer group differed slightly. The primary goal of this group centered in "helping the caseworker achieve greater independence and thereby accelerating his professional development," (p. 96). The information and evaluative needs of the agency

were met through other means, leaving the group to exclusively deal with the clinical development of the therapists. Similarly, the social work department in a large hospital shifted from individual to group peer supervision with the purpose to "enlarge the scope of learning from one's peers and increase the scope of the caseworkers independence and responsibility," (Apaka, Hirsch, & Kleidman, 1967). In this setting the motivation to move towards group peer supervision came as a reaction to the inefficiency and duplicity inherent in individual supervision within a large agency. This was accomplished primarily through the "deepening and strengthening of casework skills," (p. 57).

One final institutional setting was described by Hare & Frankena (1970) were the impetus for peer groups came from "staff members who felt that consultation with colleagues on an informal basis and the free sharing of experience was often the most valuable help they received in their work," (p. 527). This help was seen to contrast to the difficulty young professionals had when they wished to "learn something new form teachers who may not be familiar with current ideas," (p. 527). The purpose of the group attempted to bridge the gap between older therapists who had years of experience and younger therapists who had current and innovative ideas.

A number of peer groups in the literature did not develop within institutions but rather developed out of informal relationships between professionals who were usually in private practice. The goals and purposes of these groups varied quite extensively and yet common elements are noticeable. First, there were groups which sought to use peer interaction to deal with some of the stresses of the practice of psychotherapy in general and private practice in particular, (Todd & Pine, 1968; Brandes & Todd, 1972; Nobler, 1980;

Greenberg, Lewis, & Johnson, 1985). Todd and Pine (1968) describe their group of psychiatrists who met over a 13-year period for the purpose of discussing problems in their therapeutic work with patients. The emotional stress of dealing with hostile, defeating, seductive, and failing patients pushed these professionals to seek peer support. Although supportive in nature, the group's purpose was "not primarily a leaderless therapy group; rather, the primary function of the group was to provide help with members' patients and to provide an ongoing supervision of members' attempts to grow as therapists," (p. 784).

Both Nobler (1980) and Greenberg, Lewis, & Johnson (1985) describe their groups' purpose as dealing with the inherent stresses of private practice. Countering isolation from colleagues, receiving support with problem cases, exchanging therapeutic ideas, sharpening clinical skills, and dealing objectively with countertransference issues were stated goals of both these groups. The groups' purposes differed slightly in that Nobler narrowed the intent to include only "peer supervision for its members," (1980, p. 52) meaning that only direct clinical material was addressed in meetings. Greenberg, Lewis, & Johnson (1985) broadened that focus to include goals related only indirectly to clinical work such as discussions of professional meetings, political issues, and third party payment (p. 441).

Second, there were several articles where the peer groups were used to strengthen and develop a particular theoretical approach mutually accepted by the members. Austin (1984), Freedman (1984), and Rabi, Lehr, & Hayner (1984) were all groups of family, systemic therapists working either in agencies or private practice. A common element in these groups was the strong desire of

the members to find other professionals who shared their unique theoretical perspective and "spoke the same therapeutic language," (Freedman, 1984, p. 63). The focus of all the groups was to increase theoretical understanding and clinical skills related to family therapy.

Third, some groups defined their purpose as therapeutic in nature with emphasis on group therapy rather than group supervision. Kline's two articles (1972, 1974) describe therapists who had no "gross personal or professional reasons for engaging in a new therapeutic process" and yet all members had experienced isolation, loneliness, and dissatisfaction with their work and lives. Essentially, existential despair provided the foundation on which the group was built. Although clinical work surfaced in some meetings, the primary direction of the group was for each member to become both a patient and therapist of alternate times in the group's development.

Another group (Morgan, 1971) consisted of psychotherapists and their wives and was formed to deal with the "many transference and countertransference trends...(which) tend to become fixed interactions in the marriage and family," (p 244). Although differing in composition, Morgan's group paralleled Kline's group in purpose, since the thrust was chiefly therapeutic. Again, clinical work surfaced periodically yet remained secondary to the goal of dealing with the personal issues of the therapists, their wives, and the marriage relationship.

One final group warrants attention in the area of their goals. Hunt & Issacharoff (1975) formed a group with goals similar to the goals of groups in the first section above; ie. to deal with the stresses of professional practice. "The group saw its task as helping members with their professional work

outside the group," (p. 1165). What is noteworthy is that by the end of the second year the group attempted to shift its focus and become a therapy group. This shift met "several severe obstacles" (p. 1165) and proved a failure. In critiquing the group's demise, the authors claimed that the "group changed from having a definite and attainable task [to improve their skills in therapy] to having the sole function of satisfying the emotional needs of its members," (p. 1166). Unable to sustain this new purpose, the group disbanded.

ACTIVITIES

Presenting clinical material was the predominate activity in most of these groups as well as what took most of the time of each session. The specific emphasis of the clinical presentation shifted depending on the purpose of the group and on the group's development over time. Although several articles mentioned that only successful cases were shared before the group established trust, the majority of groups presented cases that had become a "stuck point" for the professional and sought help in choosing an appropriate clinical understanding or intervention (Apaka et al., 1967; Austin, 1984; Brandes & Todd, 1972; Freedman, 1984; Greenberg, Lewis, & Johnson, 1985; Judd et al., 1962). At times a detailed history of the case was given with a summary of all the previous interventions which had been tried (Austin, 1984; Rabi et al., 1984) and in some groups even a written report (Austin, 1984; Hare & Frankena, 1972) or family genogram (Rabi et al., 1984) accompanied the presentation.

Which cases to present appeared to be the choice of the presenter who would decide on what aspect of the case he/she needed the most input (for example see Judd et al., 1962). However, Hare & Frankena (1972) reported

that their group did not always allow the clinician to choose his/her case for presentation. One member in the group kept records of all the cases that each professional carried and would periodically select a case at random for a member to present. This tended to prevent members from sharing a limited variety of cases and also gave the group a chance to observe the therapist's style on a 'typical' client. Two other groups limited the choice of cases to those which were long-term so that case progress could be followed and countertranference issues could be explored in-depth (Brandes & Todd, 1972; Fizdale, 1958).

A number of interesting techniques were employed to present cases. Audio or video tapes of sessions were played for the group so that the limits of self reporting would be minimized (Brandes & Todd, 1972; Freedman, 1984; Hare & Frankena, 1972). Apaka et al. (1976) had an outside consultant come to the group every other meeting to help with diagnostic and group process issues. Written follow-up reports summarizing the progress of cases that had been presented were a regular part of Austin's (1984) group. Both Freedman (1984) and Rabi et al. (1984) brought clients to the group for live group consultation.

The feedback given to the presenter tended to be a free-wheeling discussion where all members participated in asking questions or offering advice. Emphasis on the client-therapist relationship seemed to be the norm for the groups (for example: Nobler, 1980; Judd et al., 1962).

Once the presenter had received clinical input from the group, it was up to him/her to decide what to do with the advice. In all but two of the groups the clinical direction and responsibility for the case remained exclusively with the

primary therapist. Contrary to the norm, Brandes and Todd (1972) noticed that as their group developed over time, it became common for the individual therapists to seek some group consensus before taking a specific clinical direction. Rabi et al. (1984) structured this type of group decision by having the group act as a team on the cases presented. This shifted the clinical responsibility for the case from the shoulders of the individual therapist to the shoulders of the entire group. All clinical decisions came from the group. If the group decided on some intervention then the therapist carried it out and reported the results back to the group for further direction. At times, the group members became co-therapists or active observers behind one way mirrors.

The activities of these peer groups did not exclusively deal with direct clinical presentations. Almost all of the groups made some reference to activities which could be seen as professional development in a broader sense than case presentations and feedback. Articles and books were reviewed (Austin, 1984; Freedman, 1984), workshops were summarized (Hunt & Issacharoff, 1975; Nobler, 1980), areas of expertise were presented (Greenberg, Lewis, & Johnson, 1985; Freedman, 1984), techniques were demonstrated (Nobler, 1980), and new staff members were oriented to the agency (Apaka et al., 1967). Nobler's (1980) group rotated leadership and then used the last portion of the session to critique the leader on his/her leadership style and effectiveness. The content of discussions ranged from general professional topics (Hare & Frankena, 1972; Greenberg, Lewis, & Johnson, 1985), to the group's own process (Hunt & Issacharoff, 1975; Nobler, 1980), to personal dreams (Morgan, 1971), and to the administrative details of psychological testing (Judd et al., 1962).

BENEFITS

Benefits derived from these groups were plentiful and provided the motivation for the authors to write the articles. In almost all cases the articles strongly suggested that mature therapists should try peer groups since they had had such positive effects for the authors. The primary benefits reported in the literature relate directly to the increase in clinical skills of the members who attended such groups (for example: Austin, 1984; Freedman, 1984; Greenberg, Lewis, & Johnson, 1985; Nobler, 1980; Hare & Frankena, 1972). Kline (1972) was typical in saying that there was a "dramatic change in therapeutic style of group members," (p. 239) as a result of being in the group. Brandes & Todd (1972) argued that the group offered unique opportunities to explore countertransference issues. Other professional benefits were learning new modalities of therapy (Brandes & Todd, 1972), sharpening group diagnostic skills (Apaka et al., 1967; Nobler, 1980), learning to evaluate clinical material quickly (Judd et al.,1962), and developing presentation techniques (Freedman, 1984).

Several authors compared the benefits of peer groups to traditional individual supervision and concluded that the groups offered much more to experienced clinicians. Mere efficiency could justify the groups over one-to-one supervision, (Apaka et al., 1967) since each therapist could learn not only from their own cases but also from the cases presented by their peers. Also, in individual supervision two of the central elements are judging and evaluation by the supervisor. With these two elements removed in the peer group the therapist is more likely to share himself and be freer to learn, (Judd et al., 1962).

Additionally, Hare & Frankena (1972) believed that the group provides less personality clashes than individual supervision. Even if there are clashes, the results are not as devastating since the benefits are not dependent upon the one relationship with the supervisor.

There were also benefits that were more personal in nature. As group members began to share clinical work and to receive feedback from group members, attitudinal shifts could be noted in the therapists. A gradual growth in the respect of ones peers (Judd et al., 1962) and of one self (Judd et al., 1962; Hare & Frankena, 1972; Morgan, 1971) came as mutual learning took place. Kline (1972) felt that therapists exhibited an increased willingness to ask others for help as they discovered that interdependence could be achieved without substantial risk. In agency settings these changes led to workers who were more self aware, more self reliant, and more independent (Nobler, 1980; Fizdale, 1958; Judd et al., 1962) as they broke with their over dependence on individual supervision.

Regardless of the specifics of the group, all reported that the members experienced some sense of personal or professional support from group participation as seen in Judd et al. (1962) where the group was a "strong source of support in their outside work," (p. 1165). As the members shared troubled feelings (Brandes & Todd, l972) and realized that professional problems were shared by all (Fizdale, 1984) they began to view the group members as a valuable support system (Austin, 1984; Greenberg, Lewis, & Johnson, 1985; Freedman, 1984). Many expressed that the group had helped counter isolation (Freedman, 1984; Greenberg, Lewis, & Johnson, 1985; Kline, 1972; Rabi et al., 1984) or prevented burnout (Austin, 1984).

LEWIS, ET AL.'S STUDY OF PEER CONSULTATION GROUPS

Although the literature reviewed above included isolated reports of peer groups for therapists, until very recently there was no information about the extent of participation among private practitioners and no general overview of the characteristics of either existing groups or group participants. In 1986 Lewis et al. (1988) designed a national survey of 800 psychologists in private practice to determine if there were peer consultation groups for psychologists; if so, how might these groups and their members be described; and which needs were expected to be met and which were actually met by group membership. Since this was the only data-based study of peer groups for professional therapists, an extended summary of the article follows.

GENERAL DESCRIPTION OF MEMBERS AND GROUPS

Of the total private practitioner sample, 23% responded that they were currently involved in a peer group and 24% reported that they had been involved in the past. Of those not currently in groups, 61% expressed the desire to belong if one were available. The typical peer group member was a 46 years old male with a doctorate in clinical psychology, who had been in private practice for 11 years in a metropolitan area. This professional was a full-time sole practitioner, with an office in a professional building. Services which he provided include some combination of marital-family and consultation-diagnostic services with the primary concentration in individual therapy. He is theoretically eclectic.

The typical peer group was organized through personal contact and had existed for six and a half years. It was small, of mixed genders, theoretically heterogeneous, an open to new members via sponsorship and group consensus. There was a 13-year range of private practice experience within the group. Meetings were regularly scheduled and lasted close to two hours. Members rotated hosting the meetings in their homes or offices. There was no designated leader and presentations tended to be spontaneous rather than assigned. Considerable group time was spent on case presentations and providing mutual support; however, some time was allocated to sharing therapeutic techniques and tools, discussing ethical and professional issues and sharing information.

PURPOSE OF GROUPS

The psychologists were asked to check what they had hoped they would gain by joining a peer group. According to their responses the members had both high and diverse expectations of their groups as seen by the fact that over 60% listed at least seven different reasons. The top three reasons listed by these psychologists for joining these groups include a hope to gain suggestions on problematic cases (87% listed this option), discussions on ethical/professional issues (82%), and help in countering isolation (73%).

ACTIVITIES

Group participants were asked to rate how much time their group spent on various activities from one (least time) to seven (most time). In descending order of time allocated, the group activities were: case presentations (M=4.68),

providing mutual support (M=4.20), sharing therapeutic techniques and tools (M=3.68), discussing ethical and professional issues (M=3.14), and sharing information (M=2.94). A closer look at the distributions of the ratings of time spent on these activities revealed much variation among groups. Nearly two-thirds of the respondents (64.5%) reported spending considerable time on case presentations, with over one-fifth (20.6%) indicating they spent the most time on this activity. However 29% said that they spent relatively little time on this activity.

Participants also reported much variation on time spent on providing mutual support. Over two-fifths (44.4%) reported spending considerable time here, yet over a third (37.7%) said they spent relatively little time in this way. The large majority (61.2%) reported spending little time discussing ethical and professional issues; still, a sizable 24.3% spent much time on this activity.

Activities reported in the open-ended "other" category included the following: exploring countertransference and interface issues; doing peer psychotherapy; socialization, fun and professional gossip; providing help with office problems; prayer; promoting practice development and setting new directions; dealing with business issues; preparing workshops and presentations for professional meetings; keeping abreast of psychoanalytic literature; and practicing diagnostic techniques.

The groups seem to be rather evenly divided on the degree of structure of the agenda and the degree of spontaneity of the presentations. Again the variation among groups was marked. Regarding the ways cases were presented to the group, most members (66%) reported single-session presentations. Another 18% indicated that their cases extended over multiple

sessions; the remaining groups tended to use both formats.

BENEFITS OF GROUP MEMBERSHIP

In an attempt to determine what the benefits of group membership were, Lewis et al. (1988) asked what needs were actually met by group participation. Over 80% of the respondents claimed that their groups met needs related to receiving suggestions for problematic cases, discussing professional issues, sharing information, and countering isolation. Almost one-half (48%) of these psychologists reported that their group helped them to counter burnout.

Several results indicate indirectly that these groups were very significant to the psychologists. First, members committed a good deal of time to group participation. Most of the groups (57%) met at least twice a month for about two hours each session. Second, the value of the groups can be noted in the member's commitment to the group over time. The duration of the groups and length of individual membership were relatively long, both over five years. Third, there was a surprisingly large number of psychologists in peer groups who lived in smaller communities where there were less than 11 psychologists within a 20 mile radius of their offices. Under such circumstances, it would seem difficult to find enough interested, compatible practitioners to form a group. The result indicate however, that the number of small-town psychologists in peer groups was relatively as large as those in metropolitan areas where accessibility would be so much greater. The final result which attests to the value of these groups was the high percentage of psychologists who reported that the groups actually met more of their needs than they had anticipated.

SUMMARY OF DESCRIPTIVE LITERATURE ON PEER GROUPS

Within the descriptive literature of peer groups for professional therapists it is clear that many professional therapists belong to such groups and attend them regularly. Although varying in purpose, size, and format a majority of these groups have a predominate function of providing input on clinical cases. Therefore they can be thought of as supervision groups for mature therapists. The literature does not include any empirically based studies which explore the supervisory function of these groups.

CONCLUSIONS

The theoretical literature on developmental supervision covered five different models of supervision, all of which assumed that supervision was a process of stages which ideally matched the professional development of the therapist. Each stage in the development of the therapist has certain specific tasks which the therapist needs to accomplish before the next stage is entered. For each of the stages, effective supervision should shift and change to meet the unique needs of the supervisee at that particular stage. Several of the models call for the supervisor to design different environments for each stage so that the needs of the therapist are met most effectively.

Implied in some of these models and explicit in others is the assumption that therapists who have completed their structured training would still receive supervision. This final stage in the development of a master therapist involves

issues unique to that period in the therapist's life and the supervision for this stage should be designed to address those issues. Although Littrell, et al. (1979) state that this final stage should be primarily one of self-supervision, the other models suggest a stage focused on peer interaction and inter-dependency. These developmental stage theories of supervision seem to be supported by the limited empirical literature which is available.

The descriptive literature in this area was divided into peer groups for therapists in training and peer groups for therapists in clinical practice. The purpose, focus, and structure of the groups for therapists in training varied greatly and consisted of therapy groups, supervision groups and support groups. The majority of the authors reported positive effects for students involved in such groups yet the variability between groups and the lack of empirical research methods preclude definite conclusions. The limited empirical literature that does exist in this area shows moderately positive results from group involvement.

The literature on peer groups for professionals in practice was exclusively descriptive and most often simply described the author's experience with one group. These groups differed greatly in setting, purpose, leadership, format, membership, and activities. The one common theme throughout almost all of the groups was their spending time discussing clinical cases of the members. For some groups this supervisory function was primary to their purpose while in others it played only a minor role. The benefits reported by the authors were numerous but centered on increased professional skills and enhanced personal support. A number of the authors suggested that the peer group format was ideal for the practicing professional therapist.

Since Lewis et al. (1988) presented the only empirical report of peer groups for professional therapists, a more thorough review was presented on that investigation. The 111 groups described by Lewis et al. were all groups of professionals in private practice who met together for help with difficult cases and support for the stresses related to independent professional work. The groups were small, enduring, purposeful, and beneficial. They were begun to provide the therapists with supervision of their cases and countering isolation. They spent most of their time in case presentations and providing mutual support.

This study seeks to fill the "one hole in the investigation of developmental theories [which] is in understanding the master counselor stage," (Worthington, 1987, 201). Since Zucker and Worthington (1986) conclude that investigations of master counselors require sampling counselors who have more experience than recent graduates, the sample used for this study will be all drawn from psychologists who are in private practice and are listed in the National Directory of Mental Health Providers (1983).

It can be concluded from the literature that there is a need for further research on groups of therapists who are meeting for peer supervision. This study will extend and sharpen the focus of the Lewis, et al. (1988) research by using the same group members as subjects but changing the content of the investigation to explore the supervisory nature of the groups.

CHAPTER III

RESEARCH METHODOLOGY

Introduction

This study investigated the process of clinical supervision which takes place within groups of peer psychologists. The specific questions explored through the research were the nature of the clinical presentations, the group's feedback, the benefits experienced, and the relative value of this form of supervision to other forms of supervision. Chapter III presents the design of the study and includes a description of subjects, procedures, instrumentation, and analysis.

Design

Descriptive or normative research was the design chosen for this study. Descriptive research implies generally that the researcher observes the phenomena of the moment and gives an accurate description of what has been observed. The term normative means that the observations taken at a point in time are normal and given the same circumstances may possibly be observed again at some future time. This approach is founded on the assumption that specific phenomena generally follow common and somewhat predictable patterns or norms. The descriptive approach allows the investigator to draw

conclusions which are based on one collection of data. These conclusions can be projected into the future as to what will probably happen under similar circumstances. There are obvious risks embedded within this approach and its underlying assumptions yet it is necessary if generalizations are to be made from what is observed, (Leedy, 1980).

The survey method was chosen as the type of descriptive research for this investigation. The purpose was to gather opinions, attitudes, and behaviors surrounding a certain topic from a specific sample and thus the survey method was appropriate, (Kerlinger, 1973, p. 411; Gay, 1976, p. 124).

Subjects

The study collected data from the 111 individuals who responded to a previous national survey of psychologists (Lewis, et al., 1988). They had been originally selected from the 1983 National Register of Health Service Providers in Psychology. The National Register was chosen for the subject pool since the requirements for listing are well-standardized and the sample is both national in its scope and broader than any one APA divisional membership. To qualify for inclusion as a Health Service Provider, one must be a psychologist, certified/licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventive, assessment, and therapeutic intervention services. These psychologists stated that they presently belonged to peer consultation groups. Also included in this study are five individuals who agreed to participate after hearing a presentation at the APA convention on Peer Consultation Groups at Washington, D.C in 1985.

Procedure

Instrumentation: Data was collected by a mailed questionnaire. This questionnaire was developed by the author. Validity in this type of research refers to the degree to which research findings are interpreted correctly. Kirk and Miller (1986) divide the concept of validity into apparent (or face) validity, instrumental, and theoretical (or construct) validity. Face validity was established when the instrument was piloted on a group of psychologists who were in a Peer Consultation Group. Each member of that group completed the questionnaire and then agreed to an individual interview where they were asked to critique the instrument. Although the changes these psychologists suggested were minor in nature, as many of them were incorporated as possible. The information they shared was compiled and translated into changes in the instrument which sharpened the instrument in terms of face validity (Kerlinger, 1973). The revised questionnaire (Appendix A) consisted of twenty-eight closed-ended questions and one open-ended question seeking general comments concerning the research topic.

Both instrumental and theoretical validity do not readily apply to the present study. The prior research done in the area of peer group supervision of mature therapists is so limited that no other valid alternative procedure is available for comparison with this survey and thus instrumental validity cannot be established.

The questionnaire began by asking if the respondents were currently involved in the same group they had described for the previous study of these groups, (Lewis et al., 1988) or if they belonged to a different group or if they no longer belonged to such a group. The body of the questionnaire continues with several general questions concerning the groups including size, gender distribution, how time was spent, and relative value of group activities. These items were followed by questions pertaining to the research questions and were divided into four sections which correspond to the four areas of interest: clinical presentations, feedback, benefits, and the relative value of other forms of supervision. Under the section on feedback two questions explored several issues of professional impairment among group members and the ability of the groups to confront these issues. Questions pertaining to personal and professional information concluded the survey. They included questions concerning the respondents age, sex, and years in the practice of psychotherapy.

Mailing procedures: Dillman's (1978) Total Design Method was used as a model for the approach to the initial mailing and follow-up procedures. In November 1987, each subject was mailed a copy of the questionnaire (Appendix A), a personalized and hand signed cover letter (Appendix B), and an addressed and stamped return envelope. The subjects were assured of the confidential nature of the study although the questionnaires were coded so that non-respondents were known. One week later a postcard (Appendix C) was sent to all 116 subjects reminding them to participate and thanking them for

their involvement. Four weeks later a second letter (Appendix D), a copy of the questionnaire, and an addressed and stamped return envelope was sent to subjects who had not responded by that time. After two more weeks, a telephone call was placed to the remaining non-respondents. They were offered a third questionnaire if needed and asked to return it as soon as possible. No further follow-up was attempted.

Treatment of Data: The returns were tabulated by the day of arrival so that some indication of return rate due to follow-up could be assessed. Responses to the survey questions were tabulated in their appropriate categories. Descriptive statistics were used in the analysis of the data.

Fifteen of the items on the questionnaire were structured using a Likert-type scale for the response mechanism. This scale is a summated rating scale which is a set of attitude items. All of the item choices are seen as having equal attitude value (Kerlinger, 1973) with the scale width providing degrees of intensity. For the most part, the scales for the Likert-type questions are analyzed by converting individual raw scores for each scale option into a percentage indices. Percentages were then rank ordered and comparisons made between appropriate items. For several of these questions it will be appropriate to compute the mean for all the scores and then compare the means by use of a paired t-test so that statistically significant differences can be noted. In addition, there were three of these Likert-type questions which had multiple activities for the respondent to rank. Since a comparison between

the activities was desired, the data was analyzed by summing the individual responses to each item, finding the arithmetic mean for that item, and rank ordering the means for comparison between items. If the data allows, an attempt will be made to collapse the number of items in these three questions into several scales by combining items which are statistically and conceptually similar. This will allow more stable comparisons between the constructed scales using t-tests when appropriate. Percentages are used in the presentation of the five demographic questions of the study. There are four other questions which are structured to ask the respondents to divide the available options into different percentages so that the total of the options equals one hundred percent. For these questions, the mean and percentage for each option will be determined and reported for all respondents. When appropriate, paired t-tests will be run on these questions to determine if any of the differences in means are statistically significant. Frequency distributions as well as modes will be used to report the remaining questions which are primarily nominal data. Any written comments or suggestions made by the subjects will be summarized and reported in their appropriate sections of the results.

Summary

Chapter III reviewed the methodology of this study. This chapter included commentaries on the design, the subjects, and the procedure. Chapter IV employs the procedures presented in Chapter III in order to provide an analysis

of this investigation. Chapter V presents a discussion of the results found in Chapter IV.

CHAPTER IV

RESULTS

Introduction

Chapter IV presents questionnaire data collected from 96 psychologists of whom 54 were in peer consultation groups. Since the respondents who no longer belonged to a group did not complete the survey, only the 54 surveys of group participants are used in this presentation. This chapter will include the rate of response information, demographic information about the members and their groups, general group information and the four major areas studied in this investigation: presenting case material, feedback to the presenter, potential benefits of this process, and comparative value of this type of supervision to other forms which these psychologists have received. One final section covers the degree to which these groups confront unethical behavior in members. The results of each question will be grouped and presented in logical order which may or may not correspond to the actual order the questions appeared in the survey. On items where there were missing data, the results are presented based on those who responded. For the sake of clarity, the actual survey question numbers will be provided in the text so that the reader may refer to the survey itself (Appendix A).

Response Information

There were 116 total surveys mailed out to psychologists throughout the United States. The vast majority, 111, were psychologists who had responded to a prior study by Lewis, Greenberg, and Hatch (1988) and who had indicated that they belonged to a peer consultation group. The five additional subjects were psychologists who had attended a presentation on Peer Consultation Groups in Washington, D.C. and who had agreed to participate in a follow-up investigation.

The first mailing of surveys were sent in the last week of November, 1987 with follow-up postcards being sent one week later. The first week of January, 1988 a second mailing of a coverletter and a survey was sent to all subjects who had not responded by that time. A final attempt to contact the subjects was made by phone after they had received the second mailing. Ninety-six psychologists returned the surveys for a response rate of 83%.

Appendix E provides the number of surveys that were returned each day. Since the second mailing was coded differently than the first mailing, it is possible to determine some of the effects of each of the mailings. It appears that the initial mailing and postcard resulted in approximately 75% (N=72) of the total surveys returned while the second mailing and phone call produced about 25% (N=24) of the total.

Demographic Information

Of the 96 psychologists who returned the questionnaire, 44% (N=42) reported that they no longer belonged to a Peer Consultation Group (first

question, un-numbered). Since the questionnaire did not include items addressed to individuals who were no longer group participants, there was no data collected in this area. However, one respondent wrote "I have relocated and am semi-retired," and thus not in a group while another reported "I have moved but I plan to join one." Other reasons given for not presently belonging to a group were "it doesn't meet any more", "the group changed its focus", and the "group spent too much time on monetary issues; not enough time on clinical issues". One psychologist returned an incomplete survey with an explanation that her group "concentrated on theoretical issues" and so was "unable to respond to the use of a peer group for clinical purposes." Therefore, the data reported in the remainder of this chapter comes from the 54 questionnaires from group participants. Of these 54, two psychologists reported that they had joined a new peer consultation group since the Lewis et al (1988) study and they completed the survey in reference to those new groups.

The respondent's ages (question 25) ranged from 34 to 65 with an average age of 46.8 years. Table 1 provides a frequency distribution and percentage by age-group for these psychologists. Of the 54 group participants, 32.1% (N=17) were women and 67.9% (N=36) were men (question 26) with one respondent not completing this section. On the average, these psychologists had 14.5 years experience in the practice of therapy after they had received their license (question 24) with a range from 5 years to 33 years experience. Table 2 provides the frequency distribution of this experience.

Table 1

Age of Group Members

Age	Frequency	Per Cent
31-35	2	3.8%
36-40	10	18.8%
41-45	18	34.0%
46-50	8	15.1%
51-55	5	9.4%
56-60	6	11.4%
61-65	4	7.5%
Total:	53	100%

Table 2

Years of Experience as Therapists

Years	Frequency	Years	Frequency	Years	Frequency
5	3	15	5	25	2
6	1	16	1	26	1
7	2	17	3	27	0
8	1	18	0	28	0
9	4	19	1	29	1
10	4	20	2	30	0
11	3	21	1	31	0
12	6	22	3	32	0
13	2	23	1	33	1
14	5	24	0		

General Group Information

The psychologists reported that the 54 groups had been in existence for an average of 7.5 years (question 27a) with the range being from 1 year to 28 years. Table 3 gives the frequency distribution of years in existence for all of the groups. Slightly over one-half (56.6%) of these groups had been in existence for over five years.

Table 3

Years Groups have Existed

Years	Frequency	Years	Frequency
1	3	10	6
2	5	11	1
3	6	12	5
4	3	13	2
5	6	14	1
6	4	15	2
7	3	16	1
8	1	≈≈	≈≈
9	3	28	1

When asked how long they had participated in their group (question 27b), the psychologist's responses averaged 6.8 years with their range of membership being from 1 year to 28 years. When a comparison was made between how long each group had been in existence and how long the psychologist from that group had been a member, it appears that 81.5% (N=44) of these psychologists had been members from the start of the group with

another 7.4% (N=4) joining within one year after the group began. The remaining 11.1% (N=6) professionals joined the groups sometime after the first year of meeting.

The average size of these groups was 6.4 members (question 28) with a range from 3 members to 18 members. A vast majority of the groups (70.1%, N=38) had seven or fewer members. Table 4 displays the frequency distribution of the number of members for each the groups. Of the 54 total groups 77.4% (N=41) were mixed in gender (question 28) while 22.6 % (N=12) were single gender groups with only male or only female members (one psychologist did not answer this question.) Of the 12 single gender groups, 7 were all male and 5 were all female.

Table 4

Frequency Distribution of Group Membership

Number of Members	Frequency	Percent
3	7	13.2%
4	8	15.1%
5	12	22.6%
6	5	9.4%
7	6	11.3%
8	5	9.4%
9	1	1.9%
10	5	9.4%
11	0	0.0%
12	3	5.7%
≈≈	≈≈	≈≈
18	1	1.9%
Total	53	100%

Group Activities

From the prior investigation of these groups (Lewis et al, 1988) it was determined that the members spent time on various activities including, but not limited to, supervisory-type activities. In order to place the focus of the present study in the context of all the functions and activities of the groups, a question (question 1) asked the respondents to estimate how much time they spent on the different activities. The activity options provided in the questionnaire were "socializing", "discussing clinical work directly", "discussing other professional activities", "providing personal support" and an "other" category where respondents were encouraged to specify the type of activity.

Table 5 summarizes, in rank order, the average percentage of time all the groups spent in each type of activity. From this general summary, it appears that the time in these groups was spent primarily on "discussing clinical work

Table 5

Average Percentage of Time Groups Spent in Each Major Activity

Activity	Average Percentage of Time Spent (mean)	SD
Discussing Clinical Work Directly	48.519	24.699
Discussing Other Professional Issues	19.852	15.371
Providing Personal Support	15.278	18.763
Socializing	13.722	10.435
Other	2.720	9.688

directly" since the groups averaged 48.5% of their time in this activity. The second item in priority of time spent was "discussing other professional issues" with an average of one-fifth (19.9%) of the time begin spent here. "Socializing" and "personal support" followed in time allocated and seem to share approximately equal time.

Paired Student's t-tests were run to determine which pairs differed significantly from each other. Table 6 summarizes the results of the t-tests. The obvious significant differences surfaced between the time spent in discussing clinical issues and all the other categories. Only one other pair showed a significant difference and that was that "discussing other professional issues" was allocated significantly greater time than "socializing".

The data from each group was also examined separately in terms of which activity was allocated the most time for individual groups. Again, "discussing clinical work directly" appears to be the primary activity for most of these groups with over 63.0 % (N=34) spending more time on that activity than any other. However, a number of groups had a different primary focus. There were two groups (3.7%) which spent the most time "socializing", three groups (5.5%) which spent the most time "discussing other professional issues", seven groups (13.0%) which spent the most time "providing personal support", and one group (1.9%) where the respondent wrote-in that the group spent the most time in the "diagnosis of neuropsychological cases". The remaining 7 groups (13.0%) spent equal time on two or more of the activities.

There were also groups which reportedly spent little or no time on certain activities. Socializing was allocated 5% or less of the group's time in 14 groups

Table 6

Paired t-tests for Time Spent in Each Group Activity

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
CLIN	54	48.5185	6.23	53	.001
SUP	54	15.2778			
CLIN	54	48.5185	6.19	53	.001
ISS	54	19.8519			
CLIN	54	48.5185	8.44	53	.001
SOC	54	13.7222			
ISS	54	19.8519	1.27	53	.210
SUP	54	18.763			
SOC	54	13.7222	0.52	53	.602
SUP	54	15.2778			
SOC	54	13.7222	-2.42	53	.019
ISS	54	19.8519			

CLIN= Discussing clinical work directly.
ISS= Discussing other professional issues.
SOC= Socializing.
SUP= Providing personal support.

(25.9%) with 3 groups described as not spending any time on socializing. Eleven groups (20.4%) spent less than 6% of their meeting time discussing professional issues not directly related to clinical work with five groups spending no time at this activity. Providing personal support by talking directly

about personal issues was given less than 6% of the time in 23 groups (42.6%) with 11 groups (20.4%) providing no time for direct personal support.

Within this question there was an "other" category where the psychologists could list other activities of the group. "Discussing neurological cases" was mentioned above since it was a primary focus of one group. The other activities which were listed took lesser priority in the groups and were "administrative loves" (10%) , "consultation over administrating programs" (3%), and "working with our own dreams in a Jungian framework" (40%).

Value of Group Activities

The respondents were next asked (question 2) about the value of each of the activities listed above by rating each one from 1 (no value) to 7 (very great value). Table 7 summarizes the average value rating for each of the general activities the group could perform. Overall, the respondents rated all these

Table 7

Mean Value for Each Group Activity

Activity	Mean	SD
Discussing Clinical Work Directly	6.204	0.919
Discussing Other Professional Issues	5.604	1.182
Providing Personal Support	5.300	1.389
Socializing	4.736	1.318

activities as being more than "moderately" valuable. From this summary it appears that "discussing clinical work directly" was of the greatest overall value to these psychologists with "discussing other professional issues" being next in level of importance.

Paired t-tests were used to determine if the perceived differences among the means of these activities were actually at a significant level and are summarized in Table 8.

The t-tests suggest that these psychologists rated the value of "discussing clinical issues directly" significantly higher than the other three activities. On the other hand, these psychologists valued "socializing" significantly less than the other three activities.

In an effort to further understand how the respondents valued these activities, the specific ratings (1 to 7) given by each psychologist for each activity was explored and compared to their ratings of the other activities. Table 9 summarizes how each individual activity was rated by the group members. The ratings of 1 and 2 were collapsed to describe "little value", 3-5 were collapsed to describe "moderate value", and 6 and 7 were collapsed to describe "great value."

Over three-fourths (N=41, 75.9%) of these psychologists believed that "discussing clinical work directly" was of "great value." Further, when the four items were compared, "discussing clinical work directly" was valued more highly than any other activity for 27.8% (N=15) of the respondents. For another 38.8% (N=21) of the respondents, "discussing clinical work directly" was rated as the most valuable along with another activity which was rated of equal value. "Discussing other professional issues" was another activity which was also highly valued by these psychologists with almost 60% rating this

Table 8

Paired t-tests for Value of Group Activities

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
VCLIN	50	6.2000	3.90	49	.001
VSUP	50	5.3000			
VCLIN	53	6.1887	3.87	52	.001
VISS	53	5.6038			
VCLIN	53	6.1887	7.23	52	.001
VSOC	53	4.7358			
VISS	49	5.5510	0.97	48	.337
VSUP	49	5.2653			
VSOC	50	4.7000	2.60	49	.012
VSUP	50	5.3000			
VSOC	52	4.6923	3.50	51	.001
VISS	52	5.5769			

VCLIN= Value of discussing clinical work directly.
VISS= Value of discussing other professional issues.
VSOC= Value of socializing.
VSUP= Value of providing personal support.

activity as of "great value." Another 11.1% (N=6) of these psychologists answered that "providing personal support" was the most valuable activity among the choices with 20.4% (N=11) of the total saying that this activity was of "very great value". "Discussing other professional issues" was rated as the most

valuable activity for 7.4% (N= 4) and "socializing" was the most valuable for 3.7% (N=2) of the psychologists.

There were also psychologists who answered that certain activities, although performed by their group, were of little or no value (1-2 on the scale) to them. "Socializing" was rated as having little or no value to 7.4% (N=4) of these professionals and "discussing general professional issues" was similarly rated by 3.7% (N=2) of them, personal support by 13.0% (N=7) of them. No psychologists rated "discussing clinical work" as being of little or no value.

Table 9

Value Ratings for Group Activities

Activity	Little Value (1-2)		Moderate Value (3-5)		Great Value (6-7)	
	N	%	N	%	N	%
Discussing Clinical Work Directly	0	0.00%	13	24.1%	41	75.9%
Discussing Other Profess. Issues	2	3.70%	20	37.0%	32	59.3%
Providing Personal Support	7	13.00%	23	42.6%	24	44.4%
Socializing	4	7.40%	33	61.1%	17	31.5%

Supervision/Consultation Activities

The primary focus of this study involves only one of the activities which are mentioned above and that is "discussing clinical work directly." This activity of discussing clinical work was functionally divided into four sub-categories of

activities: presenting case material by one member, questions about cases from other members, feedback given to the clinician who presented, and general discussion of clinical issues. The questionnaire also asked (question 3) the respondents to estimate how much time their group spent on these four activities within the supervision/consultation process. Table 10 summarizes the average percentage of time all the groups spent in each of the activities.

Table 10

Average Percentage of Time Groups Spent in Supervision Activities

Activity	Average Percentage of Time Spent (mean)	SD
Presenting case material	34.130	15.654
Feedback given to clinician who presented	24.039	12.325
General discussion of clinical issues	22.648	20.291
Questions about cases from other members	18.926	10.207

Presenting case material appears to be the primary activity of the supervision process, yet the other three activities constituted a sizable portion of the groups' time as well. In an effort to determine if the observed differences were in fact statistically significant, paired t-tests procedures were used to explore any significant differences between specific pairs of activities. The summary of these t-tests can be found in Table 11.

Table 11

Paired t-tests for Time Spent in Supervision Activities

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
FEED	54	24.0926	0.38	53	.702
DISC	54	22.6481			
QUES	54	18.9259	-1.03	53	.309
DISC	54	22.6481			
QUES	54	18.9259	-2.22	53	.031
FEED	54	24.0926			
CASE	54	34.1296	2.56	53	.013
DISC	54	22.6481			
CASE	54	34.1296	3.41	53	.001
FEED	54	24.0926			
CASE	54	34.1296	6.14	53	.001
QUES	54	18.9259			

FEED= Feedback given to clinician who presented.
DISC= General discussion of clinical issues.
CASE= Presenting case material.
QUES= Questions about cases from other members.

The t-tests suggest that these peer consultation groups spent significantly more time "presenting case material" than any of the other activities. The only other significant difference between the pairs was that the groups spent significantly more time in offering "feedback given the clinician who presented" than in having "questions about the cases from other members". One further observation of the data revealed that of the ratings of all the activities except "presenting case material" were distributed in a normal fashion centered around the mean of that activity. The ratings of "presenting case material, on the other hand, was clearly bi-modal with responses clustered around 25% (N=11) and 50% (N=10).

Individual groups differed from one another as to which of the supervisory activities was allocated the most time in the group. "Presenting case material" was reported as being the activity which 37.0% (N=20) of the groups spent more of their supervisory time on than any other activity. Other groups reportedly spent the most time on "general discussion of clinical issues" (14.8%, N = 8), "feedback given to the clinician who presented" (14.8%, N = 8), and "questions about cases from other members" (1.9%, N = 1). The remaining 17 groups (31.5%) has several priority activities which were allocated equal time during the groups' meetings. Conversely, some groups spent 5% or less of their supervision time on the various activities. Seven groups (13.0%) indicated that less than 5% of their time was devoted to having members ask questions about cases, 5 groups (9.3%) spent less than 5% of their time in general discussion of clinical issues, 3 groups (5.6%) spent 5% or less time presenting case material, and two groups (3.7%) provided less than 5% of their time offering feedback to presenters.

Presenting Case Material

This section will describe the portion of the activities in the group where one group member communicates or presents a case to the other members. Nine questions on the survey dealt with this area. The responses to these questions will be discussed in logical order that will not necessarily match the order in which they appeared in the survey. This section has been divided into several sub-sections: the choice of cases, the methods of presentation, the clients presented, and the purposes or goals of the presentations.

Choice of Cases to Present

Group members were asked how it was decided who will present case material (question 11) and were given three choices: the members present material spontaneously as the meeting progresses; the members volunteer to present prior to meetings; and the members present material according to some structured rotation. 63% (N=34) of the psychologists wrote that this decision was spontaneous, 16.7% (N=9) wrote that members volunteered, and the remaining 20.4% (N=11) wrote that their group used some structured rotation. On this final option, the respondents were asked to explain their group's rotation system and several explanations were offered. Not all professionals responded to this question but of those who did, two groups presented in alphabetical order by last name, two groups assigned either two or three consecutive group meetings to each presenter, and one group prioritized items at the start of each session and used the resulting list as an agenda. Three of these groups' members added comments to indicate that any structured rotation would be changed if a pressing problem surfaced among group members.

The type of cases presented to the group was explored in two questions on the survey. One question (question 7) asked what modalities of clinical work were presented in the group and what percentage of the presentations fit into each of the modalities. The types or modalities of clinical work were individual psychotherapy, marriage therapy, family therapy, group therapy, supervision, and an "other" category with space provided for specification.

Table 12 summarizes the descriptive statistics of presentations made for each of the modalities of therapy. It is obvious that individual psychotherapy cases predominated the presentations of these groups. On the average, 65% of the total presentations were of individual therapy cases. All 54 of the groups used at least 20% of their presentations for individual psychotherapy cases with six out of every ten of these groups (63.0%,N=34) devoting over one-half of their presentations to these types of cases. The other types of cases were presented much less than individual therapy cases. Marriage therapy cases were presented by 83.3% (N=45) of the groups with almost two-thirds (74.1%, N=40) of the groups using 10% or more of their presentations for marriage work. Case presentations of family therapy were made in 77.8% (N=42) of the groups with 64.8% (N=35) of the groups using 10% or more of their presentations for family work. In contrast, only 38.9% (N=21) of the supervision groups presented clinical material related to group therapy. Only 24.1% (N=13)of all the groups used the peer consultation group forum to present group therapy for 10% or more of the time. Also, 38.9% (N=21) of the total groups brought supervision cases to present in the group and 7.4% (N=4) groups spent 20% or more of their presentations on supervision content. Eight psychologists listed types of cases which were not included in the list and were added in the "other" category. Seven of these groups specified what type of cases they presented

Table 12

Presentations of Each Therapy Modality

Modality of Case Presented	Groups Presenting Each Modality		Mean Percent of Presentations		Percent of Persentations			
	N	%	Mean	SD	1-25%	26-50%	51-75%	76-100%
Individual Psychotherapy	54	100%	65.370	22.158	4	14	22	14
Marriage Therapy	45	83.3%	13.315	9.826	38	7	0	0
Family Therapy	42	77.8%	10.667	9.738	39	3	0	0
Group Therapy	21	38.9%	3.833	6.043	21	0	0	0
Supervision	21	38.9%	4.222	6.618	21	0	0	0
Other	8	14.8%	2.593	8.619	7	1	0	0

and they were "forensic testimony" (5% of cases), "hypnotherapy" (10% of cases), "consultation relationships" (5% of cases), "peer cases" (5% of cases), and psychological assessments and evaluations (25%, 50%, 30% of cases).

Respondents were asked (question 8) what type of clinical material was presented in their groups and what percentage of the total presentations each type represented. The options offered the group members were: (a) difficult cases, clients who are "stuck" for the therapist; (b) clients who have been a "success" for the therapist; (c) topical clinical issues using several cases (bulimia, suicide, etc.); and (d) clinical techniques presented or demonstrated.

Table 13 summarizes the descriptive statistics concerning the presentations made for the various types of clinical material. Overall, almost two-thirds (61.7%) of all the presentations were of difficult or "stuck" cases. All of the groups spent at least 20% of their presentation time on these problem cases and 59.3% (N=32) devoted over one-half of their time to such cases. Presentations of clients who had been a "success" for the therapist occupied a much less significant role in these groups. Almost one-fourth (24.1%, N=13) of the groups never presented successful cases and 61.1% (N=33) of the groups used 25% or less of their presentations to do deal with "successful" cases. Interestingly, the primary focus of one group (1.9%) appeared to be successful cases since it used 60% of its time presenting and receiving feedback on them. Although, cases which were topical in nature (bulimia, suicide, etc) were presented in 79.6% (N=43) of the groups, the overall average time spent on such cases was only 15.1% of the total presentation time. One group (1.9%) spent over half of their time on these cases. Well over one-half (59.3%,N=32) of the groups allocated some of their presentation time for psychologists to

Table 13

Presentations of each Type of Clinical Material

Types of Clinical Material *Presented*	Groups Presenting *Each Type*		Mean Percent *of Presentations*		Percent of Persentations			
	N	%	Mean	SD	1-25%	26-50%	51-75%	76-100%
Difficult Cases	54	100%	61.685	22.468	4	18	16	16
Topical Clinical Issues	43	79.6%	15.130	13.680	33	9	1	0
"Success" Cases	41	75.9%	12.926	11.826	33	7	1	0
Techniques Demonstrated	32	59.3%	10.185	13.562	27	4	1	0

demonstrate clinical techniques to the other members although most of these groups took less than 25% of their presentations for these demonstations.

When asked how the content of the presentations were determined (question 12), 74.1% (N=40) of the group members said that the psychologist who was presenting shares with the group what he/she feels is important. Another 16.7% (N=9) of the respondents said that their group solicits what is presented by asking questions. Only 5.6% (N=3) reported that their fellow group members follow some agree-upon outline for presentations and just 3.7% (N=2) offered some "other" method by which the content was determined. These two options were "whichever individual or cluster of care-givers is most motivated or concerned" and the "therapist gives basic material , colleagues ask many follow-up questions for details."

Methods Used in Presentations

It was assumed that the presentations made in these groups would be predominantly verbal in nature with the therapist sharing the details of the case with the other group members. In an effort to determine if these groups used other methods to present clinical material, one item (question 4) asked the members to indicate any of six methods their group utilized by rating how often they used those methods on a scale from 1 (never) to 6 (always). The six methods were: audio tapes of sessions, video tapes of sessions, written summaries of sessions, techniques demonstrated, outside consultant visit, and clients visit group for therapy. Table 14 summarizes the percentages and frequencies of groups using the various methods to present clinical material. Over one-half of the groups used written summaries of their case presentations, demonstrated techniques for members, and had consultants visit the group. In

spite of the large percentage of the groups which made use of the methods, it seems that very few of the groups used the methods with much regularity.

Table 14

Various Methods Used to Present Clinical Material

Methods Used	Percent of Groups Using Method	Frequency of Use				
		Very Seldom	Seldom	Regularly	Often	Always
Audio tapes	38.9% (N=21)	15	3	2	0	1
Video tapes	20.4% (N=11)	9	1	1	0	0
Written summary	59.3% (N=32)	9	9	6	3	5
Technique Demonstrated	72.2% (N=39)	8	13	17	1	0
Consultant visit	50.0% (N=27)	10	14	1	1	1
Client visit	9.3% (N=5)	3	0	0	1	0

Identifying and Informing Clients

The group members were asked several questions concerning how clients were identified to the group and how the clients were informed (or not informed) about their case material being shared with other professionals. The psychologists who were group members indicated (question 9) that in 46.3% (N=25) of their groups no names or other indentifying material were shared as cases were presented. Eleven percent (N=7) of the groups used pseudo or fake names to protect their client's identity while 29.6% (N=16) of the groups used only first names. The remaining 13% (N=7) of the groups used both the

first and last names of clients who were discussed in group meetings. Several professionals wrote in comments which included "we use tags like 'the CPA' or 'the kids stepfather'" and another described a more formal hospital setting where patients are reviewed monthly and "often lucid patients attend and participate fully...sometimes family members, advocates or guardians participate".

Two survey questions requested information about informing clients: the first question (question 10a) simply asked respondents to check one of five options concerning how often their clients were informed and the second question (question 10b) asked specifics about how the clients were informed. Thirty-seven percent (N=20) claimed that they never informed clients before the client's clinical material was shared in the group while another 35.2% (N=19) "hardly ever" informed them. This means that over 72% of these psychologists hardly ever or never told their clients that case material would be shared in a group format. Eleven percent (N=6) told their clients "about one half of the time"; 7.4% (N=4) told them "most of the time"; and 9.3% (N=5) "always" told them about the consultation within the group. One psychologist within a teaching hospital wrote in that "all patients in our hospital and clinics sign a form informing them their material will or will not be used in teaching."

Table 15 lists the various methods by which the psychologists could deal with the issue of informed consent and includes how each item was rated by the 53 groups (one psychologist did not respond to this item). It seems that most of the psychologists did not communicate directly with their clients about the group where their case would be presented. Over one-half (51.9%, N=28) did not even verbally discuss the groups with clients. Of the psychologists who

Table 15

How Often Groups Used Various Methods of Informed Consent with Clients

Method Used to Inform	Percent Never Using Method	Frequency of Use					
		Rarely	Seldom	Sometimes	Often	Usually	Always
Verbally describe group	52.8% (N=28)	3	0	7	1	7	8
Written description of group	88.7% (N=47)	2	2	0	0	0	2
Client's verbal consent	58.5% (N=31)	3	1	4	3	6	5
Client's written consent	77.4% (N=41)	2	0	4	1	1	4
Client invited to group	84.9% (N=45)	2	4	1	0	0	1

did communicate information about the group and seek consent, the vast majority communicated verbally with almost no written information offered or written consent received. Eight out of ten of the groups (88.7%, N=47) did not provide a written description of the group or the consultation process and three out of four of the groups (77.4%, N=41) did not obtain a written consent from the client to have his/her case material shared within the group. Very rarely, in only 8 groups (15.1%), were clients invited to attend the consultation group where their case would be presented. One psychologist added that he had a "standard statement on confidentially policy and the occasions when confidentiality can or must be shared."

Goals for Presenting Clinical Material

The survey included an item (question 5) which listed thirteen possible goals a therapist might have in presenting clinical material to the group. This item was included in an attempt to explore what the members hoped to gain when they shared cases with their peers. It should be kept in mind that these goals pertain not to the group functioning in its entirety, but only to the portion of the group which deals with sharing clinical material.

The respondents were asked to rate each of 13 possible goals they might have for presenting clinical material. The rating scale for each goal was from 1 (not important to me) to 5 (very important to me). Table 16 lists the thirteen possible goals ranked in order according to their mean ratings from the 53 psychologists who responded to this question. For the entire group of psychologists, "identifying and resolving my characteristic problems and blind spots in working as a therapist" was clearly held as the most important goal.

It was of interest to determine whether some of the 13 possible goals would be seen as significantly more important than other goals. Therefore some method of collapsing the 13 items into fewer groupings would allow a comparison between how each grouping was rated by the group members. The relatively small number of subjects suggested that a direct factor analysis would not be appropriate. The approach chosen involved several steps. First, an inter-item correlation was run on the 13 items producing a correlation matrix of the possible goals (see Appendix F). Second, the items were grouped into two scales based on the correlational coefficients between each item. Next, a Cronbach Alpha was run on each of the scales to determine if the reliability coefficients were high enough to justify the inclusion of each item on

Table 16

Mean Ratings of Goals for Presenting Clinical Material (Rank Ordered)

Goals for Presenting	Mean	SD
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	4.434	0.694
11. Developing self-awareness of my reactions to clients.	4.170	0.914
9. Examining the relationship between me and the client.	4.132	0.900
12. Learning to understand the problems, behaviors, and/or dynamics of clients.	4.000	1.019
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	3.774	1.012
7. Learning by observing the techniques/ideas of a peer.	3.717	0.968
10. Obtaining direct advice about working with clients.	3.660	0.939
13. Gaining emotional support for my present cases.	3.623	1.023
1. Learning specific therapeutic interventions that I can immediately use with my clients.	3.358	1.226
5. Learning general therapy skills useful with many clients.	3.321	1.123
6. Developing my own style of conducting therapy.	3.132	1.225
3. Teaching other members techniques which I have learned.	3.000	0.941
8. Examining the relationship between me and the group.	2.887	1.187

(Items are numbered as they were in questionnaire.)

its scale. Once this had been accomplished, a paired t-test was conducted on the scales to see if their differences were of statistical significance.

There were two scales which resulted from the inter-item correlational matrix. One of the scales was composed of four items (4, 9, 11, 13) and the second was composed of eight items (1, 2, 3, 5, 6, 7, 10, 12). There was one item that could not be placed on either scale (8). The contents of these two scales are listed in Table 17. It seems that within the first grouping all items focus on issues where the person of the therapist is central and affective issues are included. These goals speak of the therapist's desire to increase self-awareness of his interactions with his clients, both in general and specific terms, as well as his desire to receive emotional support for his clinical work. These goals turn inward on the therapist himself. This stands in contrast to the second grouping where acquisition of skills and accumulation of knowledge seem the primary intent. The second grouping focuses much more on the desire to learn the techniques and specific skills of therapy rather than on the person of the therapist.

When these items were combined into the two scales and the scales were compared using a paired t-test, significant differences surfaced. The responding psychologists seem to have a significantly higher desire to reach the goals specified by the first scale than they did the goals of the second scale ($t = 5.61$, $p = .001$). It seems that their primary desire in sharing case material is not learning about the cases, but learning about themselves.

Table 17

Scales of Goals for Presenting Clinical Material

First Scale: "Person of the Therapist"	Reliability Coefficient: Alpha=.7050

4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.
9. Examining the relationship between me and the client.
11. Developing self-awareness of my reactions to clients.
13. Gaining emotional support for my present cases.

Second Scale: "Skills and Knowledge"	Reliability Coefficient: Alpha= .7835

1. Learning specific therapeutic interventions that I can immediately use with my clients.
2. Learning to conceptualize my cases and my therapy approachwithin a theoretical framework.
3. Teaching other members techniques which I have learned.
5. Learning general therapy skills useful with many clients.
6. Developing my own style of conducting therapy.
7. Learning by observing the techniques/ideas of a peer.
10. Obtaining direct advice about working with clients.
12. Learning to understand the problems, behaviors,and/or dynamics of clients.

Item not included in either scale.

8. Examining the relationship between me and the group.

The respondents were then asked (question 6) to select the one main goal for presenting clinical material. Table 18 summarizes the frequencies and corresponding percentages which each option was chosen as the one main goal for presentations. The most frequently chosen goal was "identifying and resolving my characteristic problems and blind spots in working as a therapist" which was selected by 28.3% (N=15) of the professionals. Another 13.2% (N=7) chose "learning to understand the problems, behavior, and/or dynamics of clients" as their primary goal. Three of the options were not chosen by any of these psychologists as their major goal: "teaching other members techniques which I have learned", "learning by observing the techniques/ideas of a peer", and "examining the relationship between me and the group".

Feedback to Psychologist Who Presented

This section will describe the portion of the activities in the group where the group members offer feedback to the psychologist who has presented clinical material. As with the preceding section, the results in this section will be presented logically rather than in the order in which they appeared on the survey.

Styles of Feedback on Clinical Cases

The psychologists were asked (question 14) to rate how often certain global descriptors matched the general behaviors of the group as they gave feedback to the psychologist who presented. The descriptors were: supportive, directive, instructional, confrontive, and interpretive. Each of these descriptors could be rated from 1 (never) to 5 (always) in terms of how often the specific descriptor matched the behavior of group members as they offered feedback.

Table 19 summarizes the mean and frequency ratings for each of the five descriptors.

Table 18

One Main Goal for Presenting Clinical Material

Main Goal for Presenting	Frequency	Percentage
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	15	28.3%
12. Learning to understand the problems, behaviors, and/or dynamics of clients.	7	13.2%
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	5	9.4%
5. Learning general therapy skills useful with many clients.	5	9.4%
9. Examining the relationship between me and the client.	5	9.4%
10. Obtaining direct advice about working with clients.	5	9.4%
1. Learning specific therapeutic interventions that I can immediately use with my clients.	3	5.7%
6. Developing my own style of conducting therapy.	3	5.7%
13. Gaining emotional support for my present cases.	3	5.7%
11. Developing self-awareness of my reactions to clients.	2	3.8%
3. Teaching other members techniques which I have learned.	0	0.0%
7. Learning by observing the techniques/ideas of a peer.	0	0.0%
8. Examining the relationship between me and the group.	0	0.0%

(Items are numbered as they were in questionnaire.)

Table 19

Mean and Frequency Ratings of Styles of Feedback

Styles of Feedback	Mean	SD	Frequencies				
			Never	Seldom	Sometimes	Often	Always
Supportive	4.111	0.691	0	0	10	28	16
Interpretive	3.444	0.839	0	8	18	24	4
Instructional	3.037	0.931	2	11	25	14	2
Directive	3.019	1.019	4	12	20	15	3
Confrontive	2.407	0.858	6	24	19	5	0

Paired t-tests were run on the ratings of the five descriptors to determine if there was a significant difference between any pair of terms. Table 20 summarizes the results of these t-tests.

In the overall ratings of the feedback, a "supportive" description was found to be significantly higher than all the other descriptions. Feedback which was "interpretive" in nature was rated the next highest in describing the groups and was found to be significantly higher than the remaining three terms.

Focus of Feedback

In an effort to assess the specific focus of the feedback, one question (question 13) asked the psychologists to rate 13 specific areas in terms of what

Table 20

Paired t-tests for Styles of Feedback Given to Presenter

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
CONF	54	2.5074	-6.45	53	.001
INTER	54	3.4444			
INST	54	3.0370	-2.31	53	.025
INTER	54	3.4444			
INST	54	3.0370	4.19	53	.001
CONF	54	2.5074			
DIRE	54	3.0185	-2.41	53	.019
INTER	54	3.4444			
DIRE	54	3.0185	3.47	53	.001
CONF	54	2.5074			
DIRE	54	3.0185	-0.11	53	.917
INST	54	3.0370			
SUPR	54	4.1111	5.04	53	.001
INTER	54	3.4444			
SUPR	54	4.1111	10.51	53	.001
CONF	54	2.5074			
SUPR	54	4.1111	6.98	53	.001
INST	54	3.0370			
SUPR	54	4.1111	6.51	53	.001
DIRE	54	3.0185			

CONF= Confrontive.
INST= Instructional.
INTER= Interpretive.
DIRE= Directive.
SUPR= Supportive.

degree the group targeted each area as they gave feedback. These items were similar to the "goals" which the psychologists hoped to reach by presenting clinical material which was discussed previously. The focus here was not on what the group members hoped would happen, but what actually happened as feedback was given to group members who presented cases. They were to rate each area of feedback from 1 (never) to 5 (always) and the mean results are presented in Table 21. The primary focus of this part of the groups' time seems to be on the relationship between the therapist and the client; on helping the therapist understand the problems, behaviors, and dynamics of the clients and on helping the therapist be aware of his/her reactions to clients.

In the same manner which was discussed under the goals of presentations, the data here was collapsed into the two scales. Again, the first scale dealt with issues related to the therapist as a person and the second scale dealt with the learning of skills. The same items were used in these scales as were used in the scales measuring goals. A Cronbach Alpha yielded reliability coefficients on the four item scale with an alpha=.6992 and on the eight item scale with an alpha=.6199. When the paired t-test was run on the two scales it was found that the activities of the first grouping were rated significantly higher in terms of time spent in feedback than the items of the second grouping ($t=5.59$, $p=.001$). It is not surprizing that what the psychologists had set as goals for clinical presentations was in fact what was occupying the group's time.

Use of Feedback

Once the group members offered some form of feedback to the therapist who had presented a case, it was of special interest to discover how the

Table 21

Mean Ratings of the Groups' Focus during Feedback

Areas of Focus of Feedback	Mean	SD
9. On the the relationship between therapist and client.	4.037	0.751
12. On understanding the problems, behaviors, and/or dynamics of clients.	3.981	0.812
11. On the therapist's awareness of his reactions to clients.	3.870	0.754
13. On offering emotional support to the therapist.	3.704	0.861
4. On identifying and resolving the characteristic problems and blind spots of the presenting therapist.	3.574	0.742
1. On specific therapeutic interventions that the therapist can immediately use with my clients.	3.537	0.770
10. On offering direct advice about working with clients.	3.500	0.906
2. On conceptualizing the case and the therapist's approach to therapy within a theoretical framework.	3.463	0.818
3. On learning from the therapist who presented.	3.222	0.839
5. On general therapy skills useful with many clients.	3.093	0.917
6. On the therapist's style of conducting therapy.	3.037	0.823
7. On demonstrating techniques and ideas to the therapist.	2.667	0.932
8. On the relationship between the therapist and the group.	2.333	0.801

(Items are numbered as they were in questionnaire.)

therapist decided to use the information which was shared. In question 15, the psychologists were asked to rate three statements (from 1 = never to 5 = always) as to how often each occurred to them as they decided what to do with the group's feedback. A vast majority (88.9%, N=48) of the respondents said that they always or often "totally decide how to use the feedback I receive. There are very few expectations from the group as to what I should do. I can take or leave the group's input." In spite of this clear tendency for the members to be totally free in how they used the group's input, there were a number of them who thought differently at times. Over one-half of these psychologists (57.4%, N=31) expressed that they decided what to do with the group's feedback, but that, at least some of the time, they felt "strong expectations from the group to actively use that feedback." These strong expectations from the group was felt by four (7.4%) psychologists either "often" or "always." The third option in this question stated "once a case is presented to the group, the entire group decides how the feedback is to be used. It is a group decision." This option was chosen by only four (7.4%) of the respondents and they mostly said that it was a "seldom" occurrence. One group (1.9%) appears to approach the consultation process in a unique way since they "always" make a group decision on the case and how feedback is to be used.

Follow-up of Cases

Follow-up of cases that are presented to the group is done informally according to the psychologists who responded to question 16. They were asked to check one of four statements which best described how follow-up was carried out on cases which were discussed in the group meetings. Informal follow-up which was initiated by the therapist who presented the case was

practiced by 72.2% (N=39) of these groups while informal follow-up initiated by the other group members happened in 22.2% (N=12) of the groups. Several groups (3.7%, N=2) reported having regular or scheduled follow-up where one of these was in a medical setting so that "entries in patient's medical record" was the follow-up and the other one reported that "each client was presented for three sessions consecutively" which provided the follow-up. Finally, one group (1.9%) reported that no follow-up on cases existed.

Benefits of the Supervision/Consultation Process

This section will describe two questions which asked the respondents about the benefits they received from presenting clinical material and receiving feedback from the group.

Question 18 listed 13 possible benefits which the professionals may have received from the consultation aspects of their group. The psychologists were to rate each item from 1 (no benefit to me) to 5 (great benefit to me). Table 22 summarizes the mean ratings for each item for all the respondents.

It was of interest to determine whether some of the 13 possible benefits would be seen as significantly more important than other benefits. Therefore the same method used previously was chosen to collapse the 13 items into fewer scales would allow a comparison between how each scale was rated by the group members.

When these items were combined into the two scales the resulting reliability coefficients were alpha=.7741 for scale one and alpha=.7050 for scale two. The scales were then compared using a paired t-test and significant differences were found. The psychologists reported that the items in the first

scale (dealing with the therapist) were significantly more beneficial (t=4.54, p=.001) than the items in the second scale (learning skills and techniques).

The respondents were then asked (question 18) to select the one item which was the most beneficial to them. Table 23 summarizes the frequencies and corresponding percentages which each option was chosen as the one main benefit to presenting clinical material and receiving feedback from the group. "Identifying and resolving my characteristic problems and blind spots in working as a therapist" was chosen as the one main benefit by one-fifth (20.8%, N=11) of the psychologists and "examining the relationship between me and the client" was chosen by almost another one-fifth (18.9%, N=10). The other psychologists selected one of the other benefits as being most important with the exception of "examining the relationship between me and the group" which was selected by none of the psychologists.

Other Forms of Supervision

One section of the survey asked the responding psychologists to indicate which of several types of supervision they had had during training or after they had begun their professional career. They were then asked to rate to what degree each type of supervision had affected their personal development, professional development, ongoing behavior with clients, and their client's progress. They were to rate each of these areas from 1 (very negative effect) to 7 (extremely positive effect).

Table 22

Mean Ratings of Benefits Received from Presenting Clinical Material

Benefits from Presenting	Mean	SD
9. Examining the relationship between me and the client.	4.132	0.810
12. Learning to understand the problems, behaviors, and/or dynamics of clients.	4.057	0.864
11. Developing self-awareness of my reactions to clients.	3.925	0.851
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	3.887	0.913
13. Gaining emotional support for my present cases.	3.585	1.027
7. Learning by observing the techniques/ideas of a peer.	3.528	0.890
10. Obtaining direct advice about working with clients.	3.509	0.912
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	3.453	0.972
1. Learning specific therapeutic interventions that I can immediately use with my clients.	3.415	1.117
6. Developing my own style of conducting therapy.	3.321	1.052
5. Learning general therapy skills useful with many clients.	3.226	1.050
3. Teaching other members techniques which I have learned.	2.868	0.962
8. Examining the relationship between me and the group.	2.660	0.999

(Items are numbered as they were in questionnaire.)

Table 23

One Main Benefit of Presenting Clinical Material

Main Benefit from Presenting	Frequency	Percentage
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	11	20.8%
9. Examining the relationship between me and the client.	10	18.9%
12. Learning to understand the problems, behaviors, and/or dynamics of clients.	6	11.3%
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	5	9.4%
1. Learning specific therapeutic interventions that I can immediately use with my clients.	3	5.7%
5. Learning general therapy skills useful with many clients.	3	5.7%
7. Learning by observing the techniques/ideas of a peer.	3	5.7%
10. Obtaining direct advice about working with clients.	3	5.7%
11. Developing self-awareness of my reactions to clients.	3	5.7%
13. Gaining emotional support for my present cases.	3	5.7%
6. Developing my own style of conducting therapy.	2	3.8%
3. Teaching other members techniques which I have learned.	1	1.9%
8. Examining the relationship between me and the group.	0	0.0%

(Items are numbered as they were in questionnaire.)

Individual Supervision During Training

Practically all these professionals had experienced individual supervision as a part of their training (98.1%, N=53) and almost all of them experienced this process as having a positive effect on them. Table 24 presents the mean ratings for each of the four areas effected by individual supervision during training.

Table 24

Effects of Individual Supervision During Training (Rank Ordered)

Type of Effect	Mean	SD
Effect on my behavior with clients	6.1698	0.849
Effect on professional development	6.1132	1.121
Effect on client's progress	5.8868	0.870
Effect on personal development	5.6415	1.287

(1=very negative effect, 7=extremely positive effect)

Paired t-tests were run on the four areas to determine if there were any significant differences between the items and Table 25 presents the results. Basically the effects on professional development and behavior with clients were the same and were higher than the the effects that individual supervision had on client's progress. Personal development was significantly less affected by individual supervision than the were the other areas.

Group Supervision During Training

A very large portion of these psychologists had experienced group supervision in training (87.9%,N = 47) and on the whole found it very profitable. Table 26 presents the mean ratings for the areas which group supervision effected.

Table 25

Paired t-tests for Effects of Individual Supervision During Training

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
INDG1	53	5.6415	-1.69	52	.096
INDG4	53	5.8868			
INDG1	53	5.6415	-3.60	52	.001
INDG3	53	6.1698			
INDG1	53	5.6415	-4.75	52	.001
INDG2	53	6.1132			
INDG3	53	6.1698	3.26	52	.002
INDG4	53	5.8868			
INDG2	53	6.1132	1.54	52	.129
INDG4	53	5.8868			
INDG2	53	6.1132	-0.42	52	.679
INDG3	53	6.1698			

INDG1= Effect on personal development.
INDG2= Effect on professional development.
INDG3= Effect on my behavior with clients.
INDG4= Effect on client's progress.

Table 26

Effects of Group Supervision During Training (Rank Ordered)

Type of Effect	Mean	SD
Effect on professional development	5.9792	0.785
Effect on my behavior with clients	5.8542	0.850
Effect on personal development	5.7708	0.994
Effect on client's progress	5.5417	0.849

(1=very negative effect, 7=extremely positive effect)

Paired t-tests were run on the four areas to determine if there were any significant differences between the items and Table 27 presents the results. It appears that these psychologists believe that, although group supervision in their training positively affected their client's behavior, it did so significantly less than in the other three areas. Otherwise, the effects on professional development, therapist's behavior with clients, and personal development were all essentially equal and very positive.

Individual Supervision Since Training

A large number of the respondents had also experienced individual supervision since they had completed their training (83.3%, N=45) and overall had rated this experience as having a positive effect on their lives. Table 28 presents the mean ratings of the effects of individual supervision during training.

Table 27

Paired t-tests for Effects of Group Supervision During Training

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
GRP1	48	5.7708	2.20	47	.033
GRP4	48	5.5417			
GRP1	48	5.7708	-0.70	47	.485
GRP3	48	5.8542			
GRP1	48	5.7708	-2.11	47	.040
GRP2	48	5.9792			
GRP3	48	5.8542	3.47	47	.001
GRP4	48	5.5417			
GRP2	48	5.9792	5.59	47	.001
GRP4	48	5.5417			
GRP2	48	5.9792	1.52	47	.135
GRP3	48	5.8542			

GRP1= Effect on personal development.
GRP2= Effect on professional development.
GRP3= Effect on my behavior with clients.
GRP4= Effect on client's progress.

Table 28

Effects of Individual Supervision Since Training (Rank Ordered)

Type of Effect	Mean	SD
Effect on professional development	6.1333	0.944
Effect on my behavior with clients	6.0222	0.839
Effect on client's progress	5.8889	0.859
Effect on personal development	5.7556	1.282

(1=very negative effect, 7=extremely positive effect)

Paired t-tests were run on the four areas to determine if there were any significant differences between the items and Table 29 presents the results. It seems that the individual supervision received since these psychologists were trained effected professional development and therapist's behavior with clients significantly more than it effected their personal development or their client's changed behavior. Regardless of these differences, all the areas were rated as having been positively affected.

Peer Group Supervision/Consultation

Obviously, all the respondents have received peer supervision or consultation since leaving graduate school. They report that experience as having a positive effect in their lives. Table 30 presents the mean ratings of the effects of this group experience.

Table 29

Paired t-tests for Effects of Individual Supervision Since Training

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
INDS1	45	5.7556	-1.00	44	0.323
INDS4	45	5.8889			
INDS1	45	5.7556	-2.07	44	0.044
INDS3	45	6.0222			
INDS1	45	5.7556	-2.86	44	0.006
INDS2	45	6.1333			
INDS3	45	6.0222	2.21	44	0.032
INDS4	45	5.8889			
INDS2	45	6.1333	2.41	44	0.020
INDS4	45	5.8889			
INDS2	45	6.1333	1.15	44	0.256
INDS3	45	6.0222			

INDS1= Effect on personal development.
INDS2= Effect on professional development.
INDS3= Effect on my behavior with clients.
INDS4= Effect on client's progress.

Paired t-tests were run on the four areas to determine if there were any significant differences between the items and Table 31 presents the results. It seems that the experience in a peer consultation group effected professional development and therapist's behavior with clients significantly more than it effected their personal development or their client's changed behavior. Regardless of these differences, all the areas were rated as having been positively affected.

Table 30

Effects of Peer Group Supervision (Rank Ordered)

Type of Effect	Mean	SD
Effect on professional development	6.2222	0.604
Effect on my behavior with clients	6.1296	0.702
Effect on client's progress	5.8889	0.769
Effect on personal development	5.6852	0.907

(1=very negative effect, 7=extremely positive effect)

Comparison Between Types of Supervision

It was of interest to determine if the overall ratings of the four types of supervision were significantly different. In order to collapse the four specific effects for each type of supervision, a Cronbach Alpha technique was run to determine if the items were inter-correlated to the point where combining them would be justified. The resulting alphas were 0.8563 for individual supervision in training, 0.9067 for group supervision in training, 0.9102 for individual supervision since training, and 0.8464 for peer supervision group. Since the alphas were high, the four effects were collapsed into one measure for each of the four types of supervision. Table 32 presents the combined mean ratings of these four types of supervision.

Table 31

Paired t-tests for Effects of Peer Supervision Group

Variable	Number of Cases	Mean	t Value	Degrees of Freedom	2-Tailed Prob.
PGS1	54	5.6852	-1.85	53	0.070
PGS4	54	5.8889			
PGS1	54	5.6852	-4.12	53	0.001
PGS3	54	6.1296			
PGS1	54	5.6852	-4.70	53	0.001
PGS2	54	6.2222			
PGS3	54	6.1296	3.74	53	0.001
PGS4	54	5.8889			
PGS2	54	6.2222	3.99	53	0.001
PGS4	54	5.8889			
PGS2	54	6.2222	1.30	53	0.200
PGS3	54	6.1296			

PGS1= Effect on personal development.
PGS2= Effect on professional development.
PGS3= Effect on my behavior with clients.
PGS4= Effect on client's progress.

Paired t-tests were run on these combined ratings and it was determined that there were no statistically significant differences between the types of supervision except that peer group supervision was rated significantly higher in effects than was group supervision in training (t=2.02, p=0.049).

One question (question 23) asked the psychologists to compare the overall value of their experience in a peer supervision group to the other forms of supervision they had received. They were asked to rate their present group from 1 (much less valuable) to 5 (much more valuable) to other forms of supervision. Table 33 summarizes those ratings.

Overall, a small majority of these psychologists (51.9%,N=28) rated their group experience as being more valuable than other forms of supervision. However, 18.5% (N=10) rated their group experience as less valuable than other forms they had experienced.

Table 32

Comparative Effects of the Four Types of Supervision (Rank Ordered)

Type of Supervision	Mean	SD
Peer Supervision Group	5.9953	0.621
Individual Supervision (since training)	5.9500	0.132
Individual Supervision (during training)	5.9528	0.876
Group Supervision (during training)	5.7865	0.772

(1=very negative effect, 7=extremely positive effect)

Member's Professional Impairment

There were two questions which explored the area of how the groups offered feedback to their members on issues involving professional impairment

Table 33

Relative Value of Peer Supervision Groups to Other Forms of Supervision

Value of Group	Frequency	Percentage
Much less valuable	1	1.9%
Somewhat less valuable	9	16.7%
Same value	16	29.6%
Somewhat more valuable	17	31.5%
Much more valuable	11	20.4%
Total	54	100%

or ethical problems. The responding psychologists were asked first, to check any of six items which they had known about or observed in fellow members and second, on those items that were checked, to rate (1 = 'never' to 5 = 'always') how often the issue was confronted by or in the group. Table 21 presents the results of these two questions. Over three-fourths of these psychologists had known about fellow members being over-involved emotionally with clients and well over one-half of them had known about other members showing signs of depression or burnout and working with clients who should have been referred. When signs of professional impairment were observed in other group members, the willingness and ability of the groups to confront the psychologist varied. If the member exhibited symptoms of depression or burnout or being over involved emotionally with a client, then virtually all of the groups dealt with the issue at some point.

Table 34

Frequency of Observed Professional Impairment and Level of Group Confrontation

Type of Impairment	Observed N	Observed %	Not Observed N	Not Observed %	Level of Group Confrontation: Never	Seldom	Sometimes	Often	Always
1. Due to alcohol or drugs.	5	9.3%	49	90.7%	3	1	1	0	0
2. Sexual overture towards client.	9	16.7%	45	83.3%	2	2	1	3	1
3. Depression or "burnout".	38	70.4%	16	29.6%	0	9	13	11	5
4. Keeping clients who should have been referred.	32	59.3%	22	40.7%	1	9	14	5	3
5. Incompetence in clinical practice.	12	22.2%	42	77.8%	2	4	6	0	0
6. Over-involvement emotionally with client.	41	75.9%	13	24.1%	1	9	13	12	6

However, if the problems surrounded alcohol or drugs, 60% (N=3) would never confront that issue in or by the group. If the therapist make sexual overtures towards a client, then 22.2% (N=2) of the groups would never deal with it and if the problem was incompetency, then 16.7% (N=2) of the groups would never confront the member.

Added Comments

There was one final question on the survey (question 29) which asked the psychologists to add comments on their groups or the general area of research. Twenty comments were offered and most of them focused on the benefits received from group participation. Generally the comments were extremely positive such as "this group is the single most important influence on my professional and personal growth that I have ever encountered" or "the group is what all therapists need, many don't know it but you can't be in this business and be competent if you are not growing and being supported." Five of the comments mentioned that the groups were instrumental in preventing burnout and relieving the stresses associated with private practice. Other benefits mentioned were helping "unhook from stuck cases", "nourishing and stimulating me as a therapist", "helping blow off steam", and "showing me blind spots in working with clients."

Another group of comments dealt more with describing their particular group. The groups were described in a variety of ways such as "very intense", "long term so that friendships grow out of them and spouses are included", "open for all issues of life to be discussed", "deals primarily with conceptualization of cases", and "it is more of an encounter group." From the descriptions it is clear that although these groups were similar in many ways they represent a broad spectrum of purposes and focuses.

Finally, several respondents offered comments on the areas of research or on further questions that could be explored. Two psychologists mentioned

that the questionnaire was lengthy and took a long time to complete. Several others suggested that this area of research was underdeveloped and should be continued. Two of these group members felt that the research could possible encourage psychologists in private practice to understand the need for groups involvement and possible join a group. It was also suggested that further research investigate how these groups were formed and how they build trust among members.

Summary

The results of this investigation are based on 54 psychologists who answered the questionnaire concerning their experience in a peer consultation group. The respondents were mature professionals with a great deal of experience. The groups they described were small, long standing, and mixed in gender. The groups focused almost one-half their time on discussing clinical work (supervisory activities) while the remaining time was spent discussing other professional issues, providing personal support, and socializing. Although all of these activities were reported as being valuable to the therapists, discussing clinical work was viewed as significantly more valuable than the other areas. The time spent in supervisory activities was divided into four major areas. In descending order of time spent they were: presenting cases, giving feedback, having general discussions, and questioning from group members.

In presenting case material, the group members selected "stuck" cases and spontaneously shared pertinent material with the group. All varieties of therapy were presented but individual psychotherapy took most of the time. The

presentations were usually made verbally with some groups providing written summaries of the case to group members. Clients were not often informed that their case material would be presented and were not likely to know about the peer supervision process. The psychologists reported that the goals they had for presenting clinical material usually dealt with personal issues of how the therapist as a person reacted in therapy as opposed to issues of how therapy skills were developed.

The feedback given to the presenting psychologists was highly supportive and interpretive. Most of the groups were also able to be confrontive on occasion. The highest rated focus of the content of the feedback dealt with the relationship between the therapist and the client. The therapist who received the feedback was rather free as to how the feedback was used and follow-up on cases was done informally as the therapist or group initiated.

The benefits received from this supervision process focused on the development of the person of the therapist with "identifying and resolving my characteristic problems and blind spots" rated as the greatest benefit. Peer group supervision had positive personal and professional effects similar to the effects from other forms of supervision which these psychologists had received. Overall, the groups members rated peer group supervision as more valuable than previously experienced supervision.

Finally, these therapists reported a moderate amount of professional impairment among their groups. When issues of impairment were noticed in group members, the groups were mixed in their ability to confront and deal with the issue. In the areas of depression or burnout, over-involvement with clients, sexual overtures towards clients, and clients who should have been referred,

the groups would usually confront the group member. In the areas of alcohol or drug abuse the groups hardly ever handled the issue in the group.

CHAPTER V

SUMMARY

Introduction

The focus of this chapter will be to discuss and analyze the results reported in Chapter IV. For the convenience of the reader a summary of the study will be provided initially. Next, both theoretical and practical implications of the findings of this study will be discussed. Limitations of this research also will be covered. Finally, possible directions for future research will be presented.

Summary

Purpose of the Study

The purpose of this study was to investigate the nature of the supervision process within peer consultation groups for mature psychologists. The subjects of the study were 116 psychologists in independent practice who had previously reported that they belonged to a peer consultation group of three or more professionals meeting regularly to meet the various needs associated with

independent practice. The format for data gathering was mailed questionnaire designed by the author and sent to the potential respondents. The study investigated the nature of the supervision process which takes place within these groups and how the members valued that process.

Review of the Literature

This study reviewed both the theoretical and descriptive literature which was relevant to the investigation of the peer supervision process which takes place within groups of practicing psychologists. Although the literature was relevant, there were very little written directly about this exact process.

Theoretical Literature

In an effort to place the study within a theoretical context, the literature on developmental supervision was reviewed. This area of study was selected for three reasons. First, the activities of these peer groups most resembled supervision, as opposed to consultation or professional development. Second, within the supervision literature, developmental supervision provided a concept broad enough to include the activities of psychologists who had completed their formal training yet were still receiving specific input on their clinical work. Finally, this area appeared to be the current focus of much of the theoretical writing on supervision, (Holloway, 1987).

Although differing in specifics, all the models of developmental supervision which were reviewed assumed that becoming a therapist was a process in which the person moves progressively through a series of stages. These models suggest that each stage has specific tasks which need to be learned or accomplished by the developing therapist before moving to the next stage. For each stage and each set of tasks, there are optimal supervision

environments which enhance the successful accomplishment of those tasks. It follows that the supervision environment needed at one stage in a therapist's development would not necessarily be the environment needed for another stage. Therefore, what happens in effective supervision differs depending upon the developmental stage of the therapist.

Each of the developmental models also included the concept that mature therapists would receive some form of supervision, although they differed greatly as to what form this would, or should, take. The Littrell, et al. (1979) model proposes that the final stage in therapist development should be the self-supervising professional. This model implies that the self supervising professional would no longer need input from others since they had learned to know themselves and their limitations. Loganbill's et al. (1982) model argues that therapists continually go through a three stage cycle not merely in training but for all of their professional life. The models of Hogan (1964) and Stoltenberg (1981) both include a specific stage of the mature or master therapist. They suggest that the self knowledge achieved by the master therapist stage should allow the therapist to know when he needs input from other therapists. The environment most conducive to this type of input would be mutual sharing and confrontation within a peer relationship.

The empirical literature on developmental supervision is extremely limited. The literature which there is does seem to support the general developmental models. Several studies (Reising & Daniels, 1983; Wiley, 1982, Miars, et al., 1983) show that supervisors perceive a difference in supervisees depending upon the level of training and experience of the supervisee. Studies also show that the actual behaviors of supervisors are different at different levels of trainee experience. When dealing with inexperienced trainees, the

supervisors tend to focus upon the trainee's behavior in therapy and their feelings/thoughts about therapy. As the trainee gains experience, the supervisors tend to focus on the client, the client in therapy and the supervisee (Worthington, 1987). Finally, the supervisory relationship seems to change as the supervisee gains experience but the exact nature of this change is unclear from the literature.

Descriptive Literature

There were a number of descriptions in the literature of groups which were formed for counselors as part of their training experience. The purpose of these groups varied from self exploration and understanding (therapy groups) to skill building, to support during graduate school. Betz (1969) noted positive yet not significant changes in practicum students who experienced group therapy as a part of their training and so concluded that it was difficult to show definitive changes from group therapy. Only a few articles cover group supervision during training and often these groups are targeted towards the learning of group-related skills such as family or group therapy. Although no empirical literature was discovered for these groups, all authors report positive effects on therapists in training.

The literature offers limited reports of groups which were designed for professionals who were past their structured training and now involved in clinical work. A few of the descriptions are of groups within agencies where the function was either to indoctrinate new employees into the systems of the agency or to provide supervision for mature professionals who otherwise were beyond one-to-one supervision. The rest of this literature describes groups of professionals who joined together to deal with the stresses of being therapists in independent practice.

The activities of the groups mentioned above seemed to focus primarily on sharing clinical cases and receiving feedback from the group members. The cases were presented verbally with some groups reporting that written summaries or tapes of sessions were used. Some of the specific techniques used by these various groups include playing audio or video tapes, writing follow-up summaries of cases, inviting clients or consultants to visit the group, sharing of book reports, and demonstrating techniques. Many benefits of these groups were suggested by the literature and included relief from the pressure of private practice, increase in clinical skills, supervision without evaluation, shift in attitudes to see value in peers, and personal support.

There was one empirical investigation of peer groups for mature professional therapists (Lewis, Greenberg, & Hatch, 1988). The authors surveyed 800 psychologists in private practice and discovered that 23% of those who responded were presently in a peer consultation groups and that another 24% had been in one previously. On the average the groups were 6.5 years old, had 6-7 members, were mixed by gender, had no designated leader, and meet twice a month for about two hours. Their primary purpose was to make case presentations and to provide mutual support. Some of the most frequently listed benefits from these groups were obtaining help with problem cases, discussing professional issues, sharing information related to clinical practice, and receiving help with isolation and burnout. At a number of different levels these psychologists suggested that their groups were very important for them.

The conclusions of the literature review suggest that although there is ample theoretical basis for peer group supervision for mature psychologists and

although there is limited descriptive literature on the subject, there needed to be an investigation of actual peer groups to explore issues of supervision.

Methodology

In order to ascertain the nature of the supervision process within these groups, psychologists who were members of peer consultation groups were the subjects of the study. These subjects were primarily drawn from a previous study (Lewis, Greenberg, & Hatch, 1988) where they had indicated that they belonged to such a group. Five subjects surveyed attended a presentation by the authors and reported that they also belonged to a peer consultation group. Of the 116 psychologists surveyed, all who responded were listed in the National Register of Health Service Providers in Psychology and stated that they spent at least part of their professional time in private practice.

Since the purpose of the study was to gather information concerning opinions, attitudes and behaviors of subjects within the context of their natural lives, the survey method of research was chosen. The survey was constructed by the author in conjunction with several psychologists who were currently in peer consultation groups. The survey asked questions concerning the demographics of the group members, the general characteristics of the groups, the nature of the clinical presentations, the nature of the feedback given to the psychologist who presented, the benefits of the supervision process, the comparison between this process and other forms of supervision, and the level at which these groups confront unethical behavior by group members. The initial survey was piloted on the six members of a peer consultation group, none of whom were in the subject pool. Their suggestions and comments concerning minor changes were incorporated within the final survey.

The subjects were first mailed a cover letter, a survey, and a return envelope. A post card reminder followed in two weeks and then a second mailing of the survey was made to those who had not responded. Telephone calls were also attempted to those subjects who had not answered any of the mailings.

Since the investigation was exploratory and descriptive in nature, the data was analyzed using descriptive statistics. For most questions, the results presented were frequencies and percentages. Where appropriate, means and standard deviations were reported. For several questions paired T-tests were used to determine if the perceived differences between items were actually statistically significant. Comments written by subjects on the survey were reported in appropriate sections.

Results

The typical group member who responded was a 47 year old male psychologist with 14 years of licensed clinical experience. The average group was 7 years old, had 6 members, was mixed in gender, and spent the majority of its time discussing clinical work directly. The rest of the time in the group was rather evenly divided between discussing other professional issues, providing personal support, and socializing. All these activities were valued by the members but time spent directly on clinical cases was viewed as significantly more valuable than anything else. Of the portion of the group's time which was allocated to clinical cases, the largest amount of time was given in presenting clinical material. The remaining supervision time was spent evenly divided

between general discussion, questions about the cases, and feedback to the presenter.

In case presentations, most of the group members presented spontaneously as the meeting progressed and tended to focus on individual therapy cases which had become 'stuck' for the therapist. The member usually decided what information to share with the group. Although most presentations were given verbally, a variety of other methods were used to present in the groups including audio and video tapes, written case summaries, and demonstration of techniques. Some groups had consultants visit and a few groups had clients come to the group. The identity of most clients was held confidential but most clients were not informed that their case material was to be shared in the group. The primary goals for sharing clinical material in the group related to personal issues for the therapist such as "identifying and resolving my characteristic problems in working as a therapist."

Feedback given to the group member who presented was described as supportive and interpretive as opposed to instructional, directive, or confrontive. The focus of the feedback centered on the personal experience of the therapist. Once feedback was given, a vast majority of the respondents were free to take or leave the input from the group with no expectations as to how the input was to be used. Follow-up on cases was handled informally with the responsible clinician bringing up the case for discussion. The benefits of this supervision process centered around the development of the therapist as a person and not as much with the acquisition of skills. The item rated the highest in benefits was "examining the relationship between me and the client."

These psychologists had almost all experienced individual and group supervision both while in training and since their training had ended. They

rated all these experiences as highly valuable. The value of peer consultations groups was rated as high as any other form of supervision and was rated as more valuable to over one-half of the respondents.

The psychologists reported various levels of professional impairment within their group membership. They also varied in the degree to which they would confront each issue in the group with issues of depression and emotionally involvement with clients being almost always confronted at some level. However, if alcohol or drugs was causing professional impairment, then the groups hardly ever confronted the member.

Implications for Developmental Supervision Theory

The literature of developmental supervision provides the theoretical foundation for this investigation. Within this literature numerous statements or arguments have been put forth concerning the nature of supervision. Several of these have been addressed directly by the present study.

Master Therapists Seek Supervision

First, the theoretical models of Hogan (1964), Stoltenberg (1981), and Loganbill et al. (1982) all strongly suggest that the developmental process of becoming a therapist does not end when university training is completed but can continue in the lives of therapists throughout their career. These models make a clear place for professional development through supervision in the life of mature therapists. The results of this study indicate quite clearly that mature psychologists do indeed practice professional activities which enhance their professional development. On the average these psychologists were 47 years old with over 14 years of professional experience. If becoming a therapist

ended with the granting of a degree or license, then surely these mature professionals would have reached a level of competence where no further development would be needed. But this is not the case.

It could be argued that these mature psychologists were engaged in professional development but were not actually being supervised. The present study offers strong evidence that these group activities are best described as supervision and thus, these mature psychologists are seeking supervision throughout their career. Almost one-half of all the time in all the groups was spent discussing clinical work directly. These professionals could have spent the majority of their time reviewing professional journals, or discussing theoretical concepts, or planning business ventures but that is not the focus of their groups. The clear focus, both in time spent and value gained, is to share "stuck" cases and to receive clinical feedback from the other members.

Characteristic Needs of the Master Therapist

Second, the literature on developmental supervision suggests that the needs of therapists are not static throughout their career but rather, change as they move through the stages of becoming therapists. Therefore, the professional and supervisory needs of the beginning therapist would be significantly different from the needs of the mature therapist. The projected needs of the mature therapist have been sketched briefly in the literature by Stoltenberg (1981). The characteristics of the master therapist include the ability to function in independent practice "due to the development of an adequate awareness of his or her personal limitations," (Stoltenberg, 1981, p. 63). This awareness of personal limitations moves the therapist to a "willful interdependence with others," (p. 63). Also, the master therapist "has an

increased understanding of his or her personal characteristics, values, and abilities as being different yet existing on the same dimension as those of colleagues," (p. 63).

The present study sheds some light on the characteristic needs of the master therapist. Obviously, these psychologists are capable of independent practice since all are in private practice and all have met the requirements for inclusion in the National Register. Yet this capacity to function independently seems to be built on some assumption of personal limitation. This sample of psychologists are very highly trained and experienced. If any group of therapists would not need professional input on their clinical cases, this would be the group. Yet these master therapists, with no external compulsion or educational requirement, freely sought out, joined and invested a substantial amount of time in supervision. There seems to be a freedom in these master therapists to acknowledge that in spite of vast amounts of training they have needs in their professional lives which can be met by other professionals.

These professionals also seem to exhibit what Stoltenberg (1981) describes as that "understanding of their own skills and values as being different from, yet on the same dimension as, those of colleagues" (p. 61). It would appear that this understanding has led these professionals to seek out peers, not superiors, to provide interaction on supervision issues. The nature of the groups indicate that these psychologists are at a point in their professional growth where they need equal, interdependent, and reciprocal relationships in supervision and have found those relationships within a group of peers.

The needs of the mature therapist can be further understood by looking at what these psychologists set as their goals for sharing in the groups and what aspects of the supervision they found to be the most valuable. When the

responses to the list of 13 goals were collapsed into two scales, one scale dealt chiefly with the acquisition of therapy skills and the items were more cognitively oriented (learning interventions, skills, techniques) while the other scale seemed to involve the therapists' understanding of themselves within the therapy relationship and the items were more affectively oriented (self-awareness, emotional support, countertransference issues). It was clear that the introspective, affectively oriented scale of goals was significantly more important for these psychologists than the goals related to therapy skills. This finding is similar to the the findings of Miars et al. (1983) who report that with supervisees having greater experience "more emphasis was placed [by supervisors] on personal development, tackling client resistance and dealing with transference/ countertransference issues," (p. 407).

What seems to surface here is that certain needs continue to exist even when the basic skills of therapy have been mastered. These needs center around self-understanding and emotional support. There maybe a time when the therapist feels that the behavioral skills and interventions of therapy have been mastered, but other aspects of being a therapist continue to need exploration and development. The complex issue of "identifying and resolving my characteristic problems and blind spots in working as a therapist" (the highest rated goal) is not settled at one point in time but rather becomes a process to explore throughout one's professional career. Likewise, "developing self-awareness of my reactions to clients" (the second highest rated goal) is the type of activity which would be appropriate for all therapists no matter what their level of training or experience.

Further, if the needs emphasized by these professionals are met, then they are the type which benefit the therapist as they continue to progress

through their own life cycle of change. It is assumed that these professionals encounter developmental milestones in their lives such as the birth of their children or the death of their parents. These events, along with the continued process of personal development, inevitably bring about changes in the person of the psychologist which makes them a different practicing therapist. Therefore, the desire to deepen self-understanding and to strengthen emotional support are the very type of development which could help integrate the changes going on in the person's life with their behavior in therapy. These groups seem to provide a setting where the multiple and progressive changes in the therapist's life can be productively translated into the therapy experience.

An Effective Environment for Supervision of the Master Therapist

Third, the developmental supervision literature argues that the needs of developing therapists are best met when each stage in their professional growth is matched by a particular supervisory environment suited for that stage. It is suggested that the supervisory environment for each stage is unique, containing elements which will enhance the growth for that particular stage but needs to be changed as other stages are reached. Following from this argument, there would be a unique supervisory environment for the mature or master therapists which would best fit their needs and most encourage their professional growth. Hogan (1964) states that this environment would be a peer relationship where "sharing, confrontation, and mutual consultation are the techniques of choice," (p. 141).

Since the present study is descriptive in nature, no conclusions can be made about the "one" best supervisory environment for mature psychologists. However, the study does offer substantial information about an environment

which seems to be meeting the needs of a sizable portion of master psychologists in private practice. This environment has several aspects which appear to be uniquely suited for the master therapist.

Some of the critical aspects of this supervisory environment are very obvious and may thus be overlooked. The environment investigated here is a group. This differs dramatically from the one-to-one supervisory environment most reported in the literature and most thought of in connect with supervision. The literature suggests a number of advantages of the group format including a variety of therapeutic styles from which to learn (Fraleigh & Buchheimer, 1969), increased support for individual members (Sperling et al., 1986), greater self exploration (Fraleigh & Buchheimer, 1969), increased levels and amounts of feedback (Dreikers & Sonstegard, 1966), lessening the personal risks in sharing material (Smith, 1976), increased professional maturation (Fizdale, 1958), and lessening the stress of professional work (Greenberg et al., 1985).

The environment is peer by nature. These groups are composed of a number of professional therapists. The equal status and power of the members is evidenced in the lack of structure in these groups (to be discussed later); the voluntary nature of participation; the freedom for members to choose what, when, and how they present clinical material; and the freedom for them to decide how to use the feedback they received. This aspect of the environment matches what Stoltenberg argues as being critical for supervision of master therapists who recognize their own abilities and values "as being different yet existing on the same dimension as those of colleagues," (1981, p. 63).

These groups have a distinct and rather narrow purpose. The clear purpose of these groups is for practicing clinicians to present active clinical cases and receive professional input on the therapeutic process. Although

most of the groups spend some time discussing other professional issues and socializing, the vast majority of groups' time is set aside to present clinical cases which have become a problem for the therapist. These are not therapy groups. These are not personal support groups. These groups are formed and continue to exist for the purpose of supervision.

This focused approach tended to give these groups a highly serious and thoroughly professional flavor. The allocation of time in these groups gave evidence to their serious nature. Although there was some time allowed for socializing (13.7%), dealing directly with clinical cases or discussing professional issues occupied an average of 68.4% of the time these professionals spent together. The type of cases these professionals chose to bring to the groups also is indicative of the groups' seriousness. These therapists presented cases which had become problems for them, cases on which they were professionally 'stuck'. On the whole, these presentations were not "show off" sessions where psychologists demonstrated how much they knew, but rather sessions where they admitted their limitations and asked their peers for help. Finally, the seriousness of these groups is seen by some of the techniques they used in group supervision. In almost six out of ten of these groups, written summaries of cases were given to the group participants at least some of the time. Over one-half of the groups felt that their professional development could be enhanced by input from others outside the group and invited consultants to visit during group meetings. Almost three-fourths of the groups had a member demonstrate therapeutic techniques for the other members to learn.

Although focused and serious in nature, this supervisory context provides an environment which was also supportive to the psychologists who

participated. Over 15% of the groups' time was taken up with providing personal support to members and this time was highly valued by them. The nature of the feedback given to presenters also strongly suggests that these groups are supportive environments. The "supportive" descriptor was used by these therapists significantly more than any other to label the typical feedback of the groups. Also, "offering emotional support to the therapist" was the fourth highest rated item describing the groups' focus during feedback. Finally, when the respondents were asked what benefits they received from the supervision, emotional support for present cases was listed fifth out of 13 benefits. Therefore, in time spent and value received, support was important in these groups.

Informality and lack of structure also seemed to characterize this supervision environment. Most of these groups have clinical material presented spontaneously rather than following some structured rotation through the membership. Once a case in presented, there is a rather even distribution of time given to feedback, general discussion, and questions from members. It seems that members present cases and then the focus shifts between clarifying the information shared, discussing the implications of the case and offering some suggestions to the clinician. There does not seem to be any structure for this process or agreed upon plan for allocating this time. Over 94% of the groups have no outline or plan to follow when deciding what clinical material to share. The vast majority of the groups allow the presenter to share the information they feel is needed. This may imply that what is presented by one therapist may differ markedly from what is presented by another. Finally, follow-up on cases is informal in 9 out of 10 of these groups. Overall, these groups

seem to assume that the motivation and maturity of the members preclude the need for strict rules and structure during supervision.

The peer group environment does include moderate levels of confrontation between members. Almost 90% of these groups have feedback sessions which are described by their members as "confrontive". It seems that confrontational feedback does not occur frequently, yet, what is important, is that the environment does allow this dimension in supervision. In the area of members being professionally impaired, the groups again demonstrate the ability to confront members. Although this confrontive behavior does not seem to be consistent across groups or within groups, the potential to confront exists for most of the groups.

In summary, the supervisory environment which has been effective for this sample of master psychologists includes a group format of professional peers who meet with a clear clinical focus. The group environment is serious, professional, supportive, informal and potentially confrontive. The combination of intense clinical direction, strong personal support, peer respect, and interdependency offer these master therapists a supervisory environment which seems to match their professional developmental stage and enhance their professional development.

Implications for Professional Practice

There are a number of issues which are covered by this investigation which are more practical in nature but are important to the psychologist who is in the applied areas of the profession.

Membership Decline

The results of the survey indicate that 44% of the respondents were no longer in a peer consultation group. This proportion seems rather high when less that two years earlier all of these psychologists were active members of a group. This drop-out rate is more dramatic when these same psychologists had indicated to Lewis, et al. (1988) that their membership had averaged over 6 years. What would account for such a high rate of turnover since the previous survey? The simplest explanation would be that it was much easier for these busy professionals to indicate that they no longer belonged to such a group, and thus be done with the long survey, than to comply with the request to answer all the questions. Unfortunately, there is no practical way to determine that this did happen and thus the results need to be taken at face value. Reasons could be suggested for such a high drop-out such as mobility of the members, dissatisfaction with the group process, or no longer needing such input. The question remains unanswered since this present study did not expect and thus did not explore this area.

Value of Supervision in General

Almost all of these psychologists had had experience with individual and group supervision both during and after training. Overall, these supervision experiences were rated by these therapists as being very valuable. What was reported as being the most valuable throughout the various forms of supervision was help they received in developing professionally and help in changing their actual behavior in therapy. Several observations concerning the specific areas of value are worthy of note.

When all the forms of supervision are compared, individual supervision in training had the highest effect on the therapist's behavior with clients. Within a developmental framework of supervision this follows logically. It is at the earlier stages in supervision, where inexperienced therapists are just beginning to learn specific behaviors to use in therapy, that the effects of supervision in this area would have the greatest impact. Supervisors are possibly more directive in offering specific ideas on how the therapist-in-training should act in therapy.

Although group supervision in training was rated as having the lowest overall value of the four types of supervision, it was still considered very valuable. One aspect that was interesting about group supervision in training was the relatively high positive effects it had on the therapist's personal development. Out of all the types of supervision, group supervision in training had the highest effects on personal development. These effects were still lower than professional development and behavior in therapy, but high relative to the other forms of supervision. It seems that while in training, group supervision may offer aspects which touch on more personal issues in the therapists life than the other forms of supervision. This may speak to the needs of the therapist at that time in training and the ability of a group of peers to meet those needs.

Value of the Groups

On one question in survey, the data shows that individual supervision in training, individual supervision since training, and peer group supervision since training are essentially equal in value and that the value of all three are extremely high for these psychologists. Actually, the ratings of the peer groups

was higher than the other forms yet the difference was not statistically significant. On the other question comparing forms of supervision, over one-half of these psychologists reported that they viewed their group as being more valuable to them than any other form of supervision they had experienced.

It is striking that these mature psychologists with a great deal of independent clinical experience viewed their involvement in their groups as being at least as valuable as any other form of supervision. These are the therapists who are at a level of experience where they 'should be' self-supervising (Littrell et al., 1979) yet they claim great value from being supervised by their peers. These groups seem to hold a significant place in their professional lives when it is considered that their involvement is not required by the profession, takes considerable effort, and involves significant amounts of time.

Confidentiality and Informed Consent

From the data it is clear that a great deal of the groups' time is spent discussing details of cases from the members' clinical practices. Since information about the clients is shared with the other members, ethical issues surrounding confidentiality and informed consent will be discussed. The statement on confidentiality within the Ethical Principles of Psychologists (1981) reads:

> Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the persons or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality (p. 636).

Two major issues are involved here. The first issue deals with the degree to which information about clients are held in confidence and the second issue deals with the degree to which clients are informed that their case will be or will possibly be discussed in the group.

The results of the survey indicate that, for the most part, these psychologists maintain a high level of confidentiality when they share case material. Almost 6 out of 10 of them used no identifying information or pseudo names to protect the identity of their clients. For the 29.6% of the psychologists who used only first names, it could also be argued that they were keeping the indentity of the clients confidential. However, this would be an ethically ambiguous situation where the "primary obligation to respect confidentiality" would be in question. Finally, there were 13% of the psychologists who reported that when they shared clinical cases they used the clients first and last name. In these groups the confidentiality of the case was clearly broken. It may be understandable how therapists would not take the energy to conceal their client's identity in the context of a supportive, professional, purposeful group of peers. However, this type of behavior could be seen as highly unethical when judged by the profession's standards. Since these groups are so common (Lewis, Greenberg, & Hatch, 1988), it would be advisable for some ethical standards to be devised to cover such complicated situations as supervision of mature therapists.

The results of the survey also indicate that 72% of these psychologists never or hardly ever informed their clients that their case material would be shared in the group. What this means is that the vast majority of these psychologist's clients had no idea that what they would be sharing within a

therapeutic relationship would be discussed within a group of professionals. Again this choice by the psychologists to keep this information from the clients is understandable. It would be difficult to disclose this information to many clients without them experiencing some sense of anxiety and restricting the therapeutic relationship. Nevertheless, not to inform the clients seems to present a clear ethical violation since what they say will not, in fact, be held in confidence. No matter how strongly the particular therapist trusts the group to remain professional with the information shared, the client should be informed that what they say in therapy may be discussed in the group. A possible solution to this problem would be to have some general statement describing the purpose of the group for clients to read. This could present the group to the client as a resource for their benefit where a number of professional consultants would be used to help with their case. This statement could be included within a general office statement where issues of payment, insurance, confidentiality, etc. are also shared with the client prior to the beginning of therapy.

Impaired Psychologists

Prevalence of the problem: The limited literature on impaired psychologists suggests that the profession of psychology, unlike the professions of medicine, social work, and dentistry, has been slow to address the fact that some of its members' work is adversely affected by physical, emotional, legal, or job-related problems (Nathan, Thoreson, & Kilburg, 1983). The profession has also developed an attitude of invulnerability that fosters high expectations for personal efficacy, equates personal difficulties with incompetence, and leads to an unwillingness to seek help from peers (Skorina, 1982). Wood et al. conclude that "the overall result is little external control or monitoring of most

psychologists' daily work activities, especially that of private practitioners, (1985, p. 843).

In the light of the growing realization of the problem and in the hope that "cost-effective programs can be developed through APA" (Wood et al., 1985, p. 844) this area was explored briefly in the survey. In this discussion, a comparison will first be made between the present findings and the findings of the Wood, et al. (1985) study. Next, the discussion will cover the potential ability of peer consultation groups to deal creatively with these problems in the profession of psychology.

There were three questions that both surveys asked dealing with professional impairment: drugs and alcohol, sexual overtures towards clients, and depression or 'burnout'. Wood et al (1985) reported that 38.5% of their respondents were aware of colleagues whose work was affected by drugs or alcohol. In the present study, only 9.3% of the respondents answered that they knew of fellow group members who had problems with drugs or alcohol. Sexual overtures were known by 39.5% of the psychologists in the Wood et al. study and by 16.7% in the present study. Depression or 'burnout' was known by 63.0% in the Wood et al. study and 70.4% in the present study.

The differences in the findings could be explained in several ways. The Wood study asked the question in such a way that the respondents could include any psychologist of their acquaintance while the present study limited the focus of the question to the other members of the group. This would allow the respondents in the Wood study to consider many more professionals as they thought about impairment. Since the present study placed such a restriction on the scope of the responses, the lower rates are understandable. Furthermore, if this argument is accepted, the responses given in this study

could be seen as dramatically high. What the present respondents are saying is that almost 10% of them have a group member who is professionally impaired because of drugs or alcohol, almost 17% have a group member who has made sexual overtures to clients, and over 70% have members who are considered depressed or 'burnout'. Given the limited numbers of psychologists that each respondent is considering (average of 6), then these figures are indeed high.

Another explanation for the lower rates in the present study could be the issues of confidentiality. Since the Wood study asked the respondents to consider all their professional peers, there was virtually no risk when the respondent shared sensitive information since there was no possible way of determining the identity of the impaired psychologist. On the other hand, in this study, the respondents may have been reluctant to share sensitive information since any response they made about impairment communicated that a member in their group was impaired. This would immediately limit the impairment to a specific professional who attended the group. This concern may have been communicated when one respondent wrote in concerning this question, "though any of the above have been extremely rare, I am very reluctant to answer the above."

Finally, there needs to be some explanation for the fact that in the area of depression and 'burnout' the reported rate in this study was higher than that reported in the Wood study. It is possible that since the present study used only group members as subjects, then the results are misleading. The type of psychologists who belong to these groups could possibly be more depressed or burnout than their non-group colleagues. Depression could be the very reason they joined a group in the first place.

Another explanation of the high ratings in the present study is that the group provides the opportunity for professionals to know each other more extensively than most other professional relationships. The very intense nature of sharing difficult cases over extended periods of time would surely provide the opportunity for members to know significant amounts of information about each other's professional lives. The focus on discussing clinical cases and aspects which impede therapeutic progress when linked with the supportive nature of the groups would also encourage sharing of information related to impairment. This same level of sharing and knowledge may not be present between most professional peers and thus would tend to elevate the ratings of group members relative to the ratings of the other study.

In spite of the difficulty in comparing the two studies, the results of the present study support the broader literature in that there seems to be a significant problem of impairment in the profession of psychology. The results of the three questions discussed above provide sufficient data to raise concern over whether the profession is monitoring itself appropriately to insure the protection of the public and the health of the profession.

Three further questions were asked by this survey which dealt more directly with clinical practice. The questions asked if the respondents knew of group members who: were over-involved emotionally with clients, kept clients who should have been referred, and were incompetent in clinical practice. The results indicate that over three-fourths of the respondents knew of peers in their groups who had become overly-involved emotionally with clients. Almost six out of ten held the opinion that colleagues were working with clients who would have been better served by being referred. Finally, one out of five of these psychologists appraised at least one group member as acting incompetent in

clinical practice. Overall, these results indicate that the professionals within these groups do experience serious problems in their professional lives dealing directly with clients. This heightens the conclusion reached above that the profession does indeed have a problem which demands some attention and potential action. Nathan's (1982) call for data to convince psychologists (and APA) that there is an unmet need continues to be answered by the present results.

Dealing with the problem: Wood et al. (1985) conclude their study by saying "that our sample of practitioners would rather take no action to control impaired practitioners than to risk retaliation," (p. 849). They also suggested that "cost effective programs can be developed through APA" (p. 844) which could provide the help to the professionals and the protection to the public.

The results of the present study may offer one partial solution to this complex problem. First, these groups provide the opportunity for psychologists to become aware of impairment related issues in the lives of fellow professionals. Awareness surely is not sufficient to providing help but it is definitely necessary.

Second, these groups seem to be able to confront some of these delicate issues in their members. In the groups where members displayed depression or 'burnout', all the respondents reported that their groups were able to carry out some level of confrontation. When sexual overtures became evident, 7 out of 9 of the respondents said their groups would confront at least some of the time. Impairment due to alcohol or drugs appeared to be the most difficult area for these groups to confront with 3 out of the 5 reporting they would not confront the impaired member. In the issues dealing with direct contact with clients the group's ability to confront members seems to improve. Virtually all (all but one)

of the respondents who reported knowing of a member being over-involved emotionally with client or working with a client who should have been referred, said that they would confront that member at least some of the time. When incompetency was involved, two members said that their groups would never confront while all the rest (N=10) said the groups confronted some in that area.

Third, it seems likely that these groups have helped prevent some of the problems of professional impairment. The emotional and personal support which was found by these psychologists in their groups could definitely help with issues of depression or 'burnout'. Lewis et al. (1988) reported that over 80% of these groups helped the psychologists counter isolation and that 48% of the groups helped counter burnout. The supervision nature of the groups could help therapists spot unseen emotional (and potentially sexual) involvements with clients or help them see when cases needed to be referred.

Limitations

The study was limited to 111 psychologists who responded to an earlier national survey (Lewis, et al., 1988) where they indicated that they belonged to a peer consultation group. All of these individuals were psychologists, were involved in private practice, and were listed in the National Register of Health Service Providers in Psychology. In addition, five subjects were individuals who attended a presentation concerning peer consultation groups and agreed to involvement. They were all psychologists, in private practice and were currently in a peer consultation group.

This study has limitations which govern the application of its findings. First, the findings are limited to psychologists who are listed in the National Register of Health Service Providers in Psychology, who are in private practice and who belong to peer consultation groups. Since many psychologists do not belong to the National Register, any findings of this study should not be applied to these individuals. Those in the National Register have had to fulfil the criteria set for membership, initiate contact with the publication, and pay the money required for inclusion. This may distinguish them from other psychologists who are unable or have chosen not to be included in the National Register. The individual subjects in this study also have an active private practice on at least a part-time basis. Although Lewis et al., (1988) concluded that the psychologists in their study did not seem to differ from psychologists in general, it is presently unknown what differences actually exist between those psychologist who function in independent practice and those who do not. Finally, these subjects have elected to join a group of peers and discuss their clinical work on a regular and ongoing basis. The type of person who would see the need for and be willing to initiate this kind of interaction may differ significantly from those who would not.The findings come from individual psychologist who had previously answered a questionnaire concerning their group involvement. Although the return rate of the first random sample survey was 70%, the psychologists who answered that survey may be different than psychologists who did not answer. One possible difference is that those who did not answer had had some negative experience in peer consultation groups and this experience influenced their decision not to respond. If that was the case, then the target sample of this study is positively biased towards peer consultation groups and the results should be interpreted in that light.

Second, the findings also need to be limited since the data collected comes from a self report instrument. These psychologists are asked to report their perceptions and opinions of a group of which they are a member. These perceptions are by nature unique to the outlook and experience of that one psychologist. The activities, benefits, and dynamics of these groups could very easily be described quite differently by another member of the same group. Thus, the findings of this study need to be interpreted as an individual's perceptions and not actual group experience.

Recommendations for Future Research

A review of the findings of this study can lead to proposals for further investigations regarding peer consultation groups for the supervision of practicing psychologists.

1. Since this study used member's reports of their perceptions of group supervision, it would be helpful to design a study where actual group behavior is observed and described through video tapes or direct observation.

2. Further exploration needs to be done in the comparing the differences between psychologists who join such groups and those who never join or who join and quit. Motivation for joining, personality characteristics, professional competence are several issues which could be explored.

3. Although these psychologists report that the groups are valuable to their professional lives, it needs to be determined how participation in such a group actually effects service delivery to clients. Are members of such groups more effective therapists because of their involvement? Do clients of group members change differently than clients of non-group members?

4. Further study could investigate the actual effects these groups have on issues related to the impaired psychologist. How does participation effect psychologists who are depressed, drinking too much, or involved in unethical behavior? How effective are the groups in changing impaired behavior of their members? Do what degree can these groups 'police' the profession and protect the public.

5. It would be valuable to determine how participation in such groups could effect the liability of psychologists who are charged with malpractice. To what degree can these groups serve as protection against law suits? How does group consensus on a clinical issue effect legal proceedings?

REFERENCES

American Personnel and Guidance Association (1977). Standards for the preparation of counselors and other personnel services specialists. Personnel and Guidance Journal, 55, 596.

American Psychological Association, Division 17 (1977). Licensing and certification of psychologists-a position statement by the division of counseling psychology. Counseling Psychologist, 5, 135.

American Psychological Association (1981). Ethical principles of psychologists. American Psychologist, 36, 633-638.

Allen, J.D. (1976). Peer group supervsion in family therapy. Child Welfare, 60, 183-189.

Apaka, T.K., Hirsch, S., & Kleidman, S. (1967). Establishing group supervision in a hospital social work department. Social Work, 12, 54-60.

Ard, B.N. (1973). Providing clinical supervision in psychiatric training. Bulletin of the Menninger Clinic, 17, 91-97.

Austin, G. (1984). The London, Ontario strategic-systemic therapy study group: Five year report. Journal of Stratigic and Systemic Therapies, 3, 2, 72-74.

Barak, A. & LaCross, M.B. (1975). Multidimensional perceptions of counselors behaviors. Journal of Counseling Psychology, 22, 471-476.

Battegay, R. (1983). The value of analytic self-experience groups in the training of psychotherapists. Internation Journal of Group Psychotherapy, 33, 2, 199-213.

Betz, R.L. (1969). Effects of group counseling as an adjunctive practicum experience. Journal of Counseling Psychology, 16, 6, 528-533.

Birk, J.M. (1972). Effects of counseling supervision method and preference on empathic understanding. Journal of Counseling Psychology, 19, 6, 542-546.

Blocker, D. H. (1983). Towards a cognitive developmental approach to counseling supervision. The Counseling Psychologist, 11(1), 27-34.

Blount, C.M. (1982). A developmental model of supervision: implications for practice and research. Paper presented at the annual meeting of the American Psychological Association, Washington, D.C.

Boyd, J. (1981). Counselor supervision: approaches, preparation, practices. Muncie: Accelerated Development.

Brandes, N. S., & Todd, W. E. (1972). Dissolution of a peer supervision group of individual psychotherapists. International Journal of Group Psychotherapy, 22, 54-59.

Brown, M.D. (1985). "I'll pitch, you catch": substituting "peervision" for live supervision of family therapy. Family Therapy, 12, 3, 279-284.

Burton, A. (1969). To seek and encounter critical people. Voices, 5, 26-28.

Burton, A. (1972). Interpersonal Psychotherapy. Englewood Cliffs, NJ: Prentice-Hall.

Cherniss, C. & Egnatios, E. (1978). Clinical supervision in community mental health. Social Work, 23, 219-223.

Cross, D.G. & Brown, D. (1983). Counselor supervision as a function of trainee experience: analysis of specific behaviors. Counselor Education and Supervision, 22, 333-341.

Dasberg, H. & Winokur, M. (1984). Teaching and learning short-term dynamic psychotherapy: parallel processes. Psychotherapy, 21, 2, 184-188.

Dashef, S.S., Espey, W.M., & Lazarus, J.A. (1974). Time-limited sensitivity groups for medical students. American Journal of Psychiatry, 131,3, 287-292.

Delaney, D., & Moore, J. (1966). Student expectations of the role of practicum supervisor. Counselor Education and Supervision, 6, 11-17.

Dillman, Don A. (1978). Mail and Telephone Surveys: The Total Design Method. New York: Wiley.

Drapela, V.J. (1985). An integrative approach to teaching consultation and supervision. Counselor Education and Supervision, 24, 341-348.

Dreikurs, R. & Sonstegard, M. (1966). A specific approach to practicum supervision. Counselor Education and Supervision, 6, 18-25.

Fizdale, R. (1958). Peer-group supervision. Social Casework, 39, 443-450.

Fraleigh, P.W. & Buchheimer, A. (1969). The use of peer groups in practicum supervision. Counselor Education and Supervision, 8, 284- 288.

Friedlander, S.R.; Dye, N.W.; Costello, R.M.; & Kobos, J.C. (1984). A developmental model for teaching and learning in psychotherapy supervision. Psychotherapy, 21, 2, 189-196.

Freedman, C. (1984). Study group I: A tale of three therapists. Journal of Stratigic and Systemic Therapies, 3, 2, 63-65.

Friedlander, S.R. & Ward, L.G. (1984). Development and validation of the supervisory styles inventory. Journal of Counseling Psychology, 31, 4, 541-557.

Freudenberger, H.J., & Robbins, A. (1979). The hazards of being a psychoanalyst. The Psychiatric Review, 66, 275-296.

Gail, M.S. (1976). Resident perception of psychotherapy supervision. Comprehensive Psychiatry, 17, 1, 191-194.

Gaoni, B. & Neumann, M. (1974). Supervision from the point of view of the supervisee. American Journal of Psychotherapy, 28, 1, 108-114.

Gay, L.R. (1976). Educational Research: Competencies for Analysis and Application. Columbus, Ohio: Charles E. Merrill Publishing Company.

Gazda, G. & Ohlsen, M. (1961). The effects of short-term group counseling on prospective counselors. Personnel and Guidance Journal, 39, 634-638.

Glenwick, D.S. & Stevens, E. (1977). The hierarchial peer ladder: A model of psychotherapy supervision. Paper presented at the national convention of the American Psychological Association, San Francisco.

Goodyear, R.K. & Bradley, F.O. (1983). Theories of counselor supervision: Points of convergence and divergence. The Counseling Psychologist, 11(1), 59-76.

Graves, W.H. & Graves, L.H. (1973). Analysis of feedback among group practicum members. Counselor Education and Supervision, 13, 111-116.

Greenburg, S.L., Lewis, G.L., & Johnson, M. (1985). Peer consultation groups for private practitioners. Professional Psychology: Research and Practice, 16, 437-447.

Grotjahn, M. (1969). Analytic group therapy with psychotherapists. International Journal of Group Psychotherapy, 19, 326-333.

Gybers, M., & Johnston, J. (1965). Expectations of a practicum supervisor's role. Counselor Education and Supervision, 4, 68-74.

Hansen, J.C.; Pound, R. & Petro, C. (1976). Review of research on practicum supervision. Counselor Education and Supervision, 16, 2, 107-116.

Hare, R.T. & Frankena, S.T. (1972). Peer group supervision. American Journal of Orthospychiatry, 42, 3, 527-529.

Hart, G.M. (1982). The process of clinical supervision. Baltimore, Md.: University Park Press.

Heppner, P.P. & Handley, P. (1982). A study of the interpersonal influence process in supervision. Journal of Counseling Psychology, 28, 437-444.

Heppner, P.P. & Handley, P. (1982). The relationship between supervisory behaviors and perceived supervisor expertness, attractiveness, or trustworthiness. Counselor Education and Supervision, 22, 37-46.

Heppner, P.P. & Roehlke, H.J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. Journal of Counseling Psychology, 31, 1, 76-90.

Hess, A.K. (ed) (1980). Psychotherapy supervision: Theory, research, and practice. New York: Wiley.

Hess, A.K. (1987). Psychotherapy supervision: Stages, Buber, and a theory or relationship. Professional Psychology: Research and Practice, 18 (3), 251-259.

Hess, A.K. (1987). Advances in psychotherapy supervision: introduction. Professional Psychology: Reasearch and Practice, 18 (3), 187-188.

Hester, L.; Weitz, L.; Roback, H.; Anchor, K.; & McKee, E. (1976). The supervisor-supervisee relationship; in psychotherapy training from the perspective of interpersonal attraction. Comprehensive Psychiatry, 17, 5, 671-681.

Hill, C. E., Charles, D., & Reed, K.G. (1981). A longitudinal analysis of changes in counseling skills during doctoral training in counseling psychology. Journal of Counseling Psychology, 28, 428-436.

Hogan, R.A. (1964). Issues and approaches in supervision. Psychotherapy: Theory, Research, and Practice, 1, 139-141.

Holloway, E.L. (1987). Developmental models of supervision: is it development? Professional Psychology: Reseach and Practice, 18 (3), 209-216.

Holloway, E.L., & Hosford, R.E. (1981). Towards developing a prescriptive technology of counselor supervision. The Counseling Psychologist, 11,1, 73-77.

Holloway, E.L., & Johnson, R. (1985). Group supervision: widely practiced but poorly understood. Counselor Education and Supervision, 25, 332-340.

Hunt, W. & Issacharoff, A. (1975). History and analysis of a leaderless group of professional therapists. American Journal of Psychiatry, 132, 1164-1167.

Johnston, J.A. & Gysbers, N.C. (1966). Practicum supervisory relationships: a majority report. Counselor Education and Supervision, 6, 3-10.

Judd, J., Kohn, R.E. & Schulman, G.L. (1962). Group supervision: A vehicle for professional development. Social Work, 7, 96-102.

Kadushin, A. (1974). Supervisor-supervisee: a survey. Social Work, 19, 288-297.

Kadushin, A. (1977). Consultation in Social Work, New York: Columbia University Press.

Karasu, T.; Rohrlich, J.B.; & Stein, S. (1978). A model for individual supervision in a general hospital. Comprehensive Psychiatry, 19, 4, 323, 329.

Karr, J.T. & Geist, G.O. (1977). Facilitation in supervision as related to facilitation in therapy. Counselor Education and Supervision, 16, 263-268.

Kaslow, F. W. ed. (1972). Issues in Human Services. San Francisco: Jossey-Bass.

Kaslow, F. W. ed. (1977). Supervision, Consultation, and Staff Trainng in the Helping Professions. San Francisco: Jossey-Bass.

Kaslow, F.W. (1986). Seeking and providing supervision in private practice. Clinical Supervisor,4, 143-158.

Kazanjian, V. (1982). Peer Review: A private practice model. Professional Psychology, 13, 1, 74-78.

Kell, B.L. & Mueller, W.J. (1966). Impact and Change: A Study of Counseling Relationships. New York: Appleton-Century-Crofts.

Kerlinger, F.N. (1973). Foundations of Behavioral Research (2nd. ed). New York: Holt, Rinehart and Winston, Inc.

Kirk, J. & Miller, M. (1986). Reliability and validity in qualitative research. Beverly Hills: Sage Publications.

Kline, F. M. (1972). Dynamics of a leaderless group. International Journal of Group Psychotherapy, 22: 234-242.

Kline, F. M. (1974) Terminating a leaderless group. International Journal of Group Psychotherapy, 24, 452-459.

Lambert, M.J. (1974). Supervisory and counseling process: a comparitive study. Counselor Education and Supervision, 14, 1, 54-60.

Lanning, W.L. (1971). A study of the relation between group and individual counseling supervision and three relationship measures. Journal of Counselng Psychology, 18, 5, 401-406.

Lanning, W.L. (1986). Development of the supervisor emphasis rating form. Counselor Education and Supervision, 25, 191-196.

Leddick, G.R. & Bernard, J.M. (1980). The history of supervision: a critical review. Counselor Education and Supervision, 19, 186-196.

Leedy, P.D. (1980). Practical research (2nd ed.). New York, NY: Macmillan.

Lewis, G.L., Greenberg, S., & Hatch, D. (1988). Peer consultation groups for psychologists in private practice: a national survey. Professional Psychology: Research and Practice, 19 (1), 81-86.

Lewis, J.M., Moskowitz, S., Rand, S.M., Stearns, A.E., Wagner, J.P., Constantine, J., Logan, L.N., & Saunders, A.M. (1978). Issues in supervision. Symposium presented at the 86th Annual Convention of the American Psychological Association, Toronto.

Littrell, J.M., Lee-Borden, N. & Lorenz, J. (1979). A developmental framework for counseling supervision. Counselor Education and Supervision, 19, 129-136.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: a conceptual model. Counseling Psychologist, 10(1), 3-42.

McBride, M.C. & Martin, G.E. (1986). Dual-focus supervision: a nonapprenticeship approach. Counselor Education and Supervision, 25, 175-182.

McKinnon, D.W. (1969). Group counseling with student counselors. Counselor Education and Supervision, 8, 195-200.

Miars, R.D., Tracey, T.J., Ray, P.B., Cornfeld, J.L., O'Farrell, M.O., & Gelso, C.J. (1983). Variation in supervision process across trainee experience levels. Journal of Counseling Psychology, 30, 3, 403-412.

Miller, C.D. & Oetting, E.R. (1966). Students react to supervision. Counselor Education and Supervision, 16, 73-74.

Morgan, D. W. (1971). A note on analytic group psychotherapy for therapists and their wives. International Journal of Group Psychotherapy, 21, 244-247.

Moskowitz, S.A. (1981). A developmental model for the supervision of psychotherapy: The effect of level of experience on trainees' views of ideal supervision. Unpublished Dissertation, Loyola University, Chicago, Illinois.

Mueller, W.J. & Kell, B.L. (1972). Coping with Conflict: Supervising Counselors and Psychotherapists. New York: Appleton-Century-Crofts.

Nash, V.C. (1975). The clinical supervision of psychotherapy. Dissertation Abstracts International, 36 (5), 2480B-2481B. (University Microfilms No. 75-24, 581)

Nash, J, Norcross, J.C., & Prochaska, J.O. (1984). Satisfactions and stresses of independent practice. Psychotherapy in Private Practice, 2,4, 39-48.

Nathan, P., Thoreson, R., & Kilburg, R. (1983). Board of Professional Affairs Steering Committee on Distressed Psychologists. Draft Report. Washington, D.C.: American Psychological Association.

National Register of Health Service Providers in Psychology. (1983 and 1987). Washington: Council for the National Register of Health Service Providers in Psychology.

Nobler, H. (1980). A peer group for therapists: successful experience in sharing. International Journal of Group Psychotherapy, 30, 51-61.

Norcross, J.C., Nash, J.M., & Porchaska, J.D. (1985). Psychologists in part-time independent practice: Description and comparision. Professional Psychology: Research and Practice, 18, 565-575.

Norcross, J.C., & Porchaska, J.D. (1983). Psychotherapists in independent practice: Some findings and issues. Professional Psychology: Research and Practice, 14, 869-881.

Orstein, P.H.; Orstein, A.; & Lindy, J.D. (1976). On the process of becoming a psychotherapist: an outline of a core-curriculum for the teaching and learning of psychoanalytic psychotherapy. Comprehensive Psychiatry, 17, 1, 177-190.

Payne, P.A.; Winter, D.E. & Bell, G.E. (1972). Effect of supervisor style on the learning of empathy in a supervision analogue. Counselor Education and Supervision, 11, 4, 262-269.

Phillips, G.L. & Kantor, C.N. (1984). Mutuality in psychotherapy supervision. Psychotherapy, 21, 2, 178-183.

Ponterotto, J.G. & Zander, T.A. (1984). A multimodal approach to counselor supervision. Counselor Education and Supervision, 24, 40-50.

Prochaska, J.O., & Norcross, J.C. (1983). Contemporary psychotherapists: A national survey of characteristics, practices, orientations, and attitudes. Psychotherapy: Theory, Research, and Practice, 20, 161-173.

Rabi, J.S., Lehr, M.L., & Hayner, M.L. (1984). The peer consultation team: An alternative. Journal of Stratigic and Systemic Therapies, 3, 2, 66-71.

Rank, R.C., Thoresen, C.E., & Smith, R.M. (1972). Encouraging counselor trainee afective group behavior by social modeling. Counselor Education and Supervision, 11, 270-278.

Reddy, W.B. (1970). Sensitivity training as an integral phase of counselor education. Counselor Education and Supervision, 9, 110-115.

Reising, G.N. & Daniels, M.H. (1983). A study of Hogan's model of counselor development and supervision. Journal of Counseling Psychology, 30, 2, 235-244.

Richardson, B. K., & Quinn, B. J. (1983). Counseling psychologists' attitudes and practices in continuing professional education--a national study. The Counseling Psychologist, 11, 4, 97-99.

Rosenberg, P.P. (1984). Support groups: a special therapeutic entity. Small Group Behavior, 15, 2, 173-186.

Rosenblatt, A. & Mayer, J.E. (1975). Objectionable supervisory styles: a students' views. Social Work, 20, 184-189.

Seligman, M. & Desmond, R. (1975). The leaderless group phenomenon: a historical perspective. International Journal of Group Psychotherapy, 25, 277-290.

Skorina, J.K. (1982). Alcoholic psychologists: The need for humane and effective regulation. Professional Practice of Psychology, 3, 33-41.

Smith, E.J. (1976). Issues and problems in the group supervision of beginning group problems. Counselor Education and Supervision, 16, 13-24.

Sperling, M.B.; Handen, B.L.; Miller, D.; Schumm, P.; Pirrotta, S.; Simons, L.A.; Lysiak, G.; & Terry, L. (1986). The collaborative team as a training and therapeutic tool. Counselor Education and Supervision, 25, 183-190.

Spice, C.G. Jr.; & Spice, W.H. (1976). A triadic method of supervision in the training of counselors and counseling supervisors. Counselor Education and Supervision, 15, 4, 251-258.

Stenack, R.J. & Dye, H.A. (1982). Behavior descriptions of counseling supervision roles. Counselor Education and Supervision, 21, 295-304.

Stenack, R.J. & Dye, H.A. (1983). Practicum supervision roles: effects on supervisee statements. Counselor Education and Supervision, 23, 157-168.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: the counselor complexity model. Journal of Counseling Psychology, 28, 1, 59-65.

Suran, B.G. & Sheridan, E.P. (1985). Management of burnout: Training psychologists in professional life span perspectives. Professional Psychology: Research and Practice, 16, 6, 741-752.

Tate, F.E. (1973). Counseling groups for counselor trainees: a process model. Counselor Education and Supervision, 13, 68-72.

Taylor, R.E. (1978). Demythologizing private practice. Professional Psychology, 9, 68-70.

Todd, W.E., & Pine, I. (1968). Peer supervision of individual psychotherapy. American Journal of Psychiatry, 125, 92-96.

Tryon, G.S. (1983). Full-time private practice in the United States: results of a national survey. Professional Psychology: Research and Practice, 14, 5, 685-696.

Tryon, G.S. (1983b). The pleasures and displeasures of full-time private practice. The Clinical Psychologist, 36, 45-48.

Tousley, M.M. & Kobberger, K. (1984). Supervision in psychotherapy: a systems approach. International Journal of Psychiatry in Medicine, 14, 2, 133-152.

Upchurch, D.W. (1985). Ethical standards and the supervisory process. Counselor Education and Supervision, 25, 90-98.

Wagner, C.A., & Smith, J.P. (1979). Peer supervision: towards more effective training. Counselor Education and Supervision, 18, 288-293.

Watson, K.W. (1973). Differential supervision. Social Work, 18, 80-88.

Wedeking, D.F. & Scott, T.B. (1976). A study of the relationship between supervisors and trainee behaviors in counseling practicum. Counselor Education and Supervision, 15, 4, 259-266.

Wiley, M.O'L. (1982). Developmental counseling supervision: Person-environment congruency, satisfaction, and learning. Paper presented at the annual meeting of the American Psychological Association, Washington, D.C.

Winstead, D.K., Bonowitz, J.S., Gale, M.S., & Evans, J.W. (1974). Resident peer supervision in psychotherapy. American Journal of Psychiatry, 131, 318-321.

Wolberg, L.P. (1954). The technique of psychotherapy. New York: Grune & Stratton

Wood, B.J., Klein, S., Cross, H.J., Lammers, C.J. & Elliott, J.K. (1985). Impaired Practitioners: psychologist's opinions about prevalence, and proposals for intervention. Professional Psychology: Research and Practice, 16, 6, 843-850.

Worthington, E.L. Jr. (1984). An emperical investigation of supervision of counselors as they gain experience. Journal of Counseling Psychology, 31, 63-75.

Worthington, E.L. Jr. (1987). Changes in supervision as counselors and supervisors gain experience: a review. Professional Psychology: Research and Practice, 18 (3), 189-208.

Worthington, E.L. & Roehlke, H.J. (1979). Effective supervision as perceived by beginning counselors-in-training. Journal of Counseling Psychology, 26, 1, 64-73.

Yogev, S. & Pion, G.M. (1984). Do supervisors modify psychotherapy supervision according to supervisees' levels of experience? Psychotherapy, 21, 2, 206-208.

Zuker, P.J. & Worthington, E.L. Jr. (1986). Supervision of interns and postdoctoral applicants for licensure in university counseling centers. Journal of Counseling Psychology, 33 (1), 876-89.

APPENDIX A

PEER CONSULTATION GROUPS: the SUPERVISION PROCESS

Are you still involved with a group of professional peers which meets regularly to provide mutual help with clinical issues? 1. _____ NO 2. _____ YES
3._____YES,BUT DIFFERENT GROUP

If you **no longer** belong to such a group, you have finished the questionnaire. We thank you for participating and ask that you send it back to us in the stamped self-addressed envelope. This will avoid your receiving follow-up requests.

GENERAL GROUP INFORMATION

1) What percent of time would you estimate your group spends on the following activities. Please rate each activity with a percentage so that the total equals 100%.

____% SOCIALIZING (food, casual talking, jokes etc)
____% DISCUSSING CLINICAL WORK DIRECTLY (case presentations, feedback, sharing clinical techniques, discusing clinical issues, etc.)
____% DISCUSSING OTHER PROFESSIONAL ISSUES(private practice issues, business, investments, insurance, referrals, etc.)
____% PROVIDING PERSONAL SUPPORT(talking directly about personal issues)
____%OTHER (please specify)_____
100% Total time spent in group.

2) How valuable do you find each activity? Rate each activity from 1 (no value) to 7 (very valuable, indispensable) by circling the appropriate number.

	No value			Moderate value			Very much value
Socializing	1	2	3	4	5	6	7
Discussing clinical work directly	1	2	3	4	5	6	7
Discussing other professional issues	1	2	3	4	5	6	7
Providing personal support	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7

3) Now consider only the time spent discussing clinical work directly. Of that time, what percent of time would you estimate the group spends on the following activities. Please rate each activity with a percentage so that the total equals 100%.

_____% PRESENTING CASE MATERIAL
_____% QUESTIONS ABOUT CASES FROM OTHER MEMBERS
_____% FEEDBACK GIVEN TO CLINICIAN WHO PRESENTED
_____% GENERAL DISCUSSION OF CLINICAL ISSUES
100% Total time spent discussing clinical work directly.

CLINICAL PRESENTATIONS: In this section we are seeking information about how members in your group **present** clinical material. Answer the following questions in regard to how clinical material is usually presented in your group.

4) Please check how often your group has used the following **methods** for presenting clinical material:

	Never	Very Seldom	Seldom	Regularly	Often	Always
Audio tapes of sessions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Video tapes of sessions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Written summary of sessions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Verbal summary of sessions	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Techniques demonstrated	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Outside consultant visit	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Client visit group for therapy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

5) The following list consists of possible **goals for presenting** clinical material in the group, or descriptions of what you hope to gain through your sharing clinical material. Using the scale below, indicate **how important** each goal is for you by circling one number for each goal.

	Not Important to Me				Very Important to Me
1. Learning specific therapeutic interventions that I can immediately use with my clients.	1	2	3	4	5
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	1	2	3	4	5
3. Teaching members techniques which I have learned.	1	2	3	4	5
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	1	2	3	4	5
5. Learning general therapy skills useful with many clients.	1	2	3	4	5
6. Developing my own style of conducting therapy.	1	2	3	4	5
7. Learning by observing the techniques/ideas of a peer.	1	2	3	4	5
8. Examining the relationship between me and the group.	1	2	3	4	5
9. Examining the relationship between me and the client.	1	2	3	4	5
10. Obtaining direct advice about working with clients.	1	2	3	4	5
11. Developing self-awareness of my reactions to clients.	1	2	3	4	5
12. Learning to understand the problems, behavior and/or dynamics of clients.	1	2	3	4	5
13. Gaining emotional support for my present cases.	1	2	3	4	5

6) Now, if you had to choose **ONE** goal which corresponds most closely to your main goal in sharing clinical material, what would that **ONE** goal be? Go back and circle the item number of that goal above.

7) What **modalities** of clinical work are presented in group? Specify the percentage of presentations each modality receives. (total should equal 100%).

____% INDIVIDUAL PSYCHOTHERAPY
____% MARRIAGE THERAPY
____% FAMILY THERAPY
____% GROUP THERAPY
____%CONSULTATION
____%OTHER.Please specify _____
100% Total of modalities presented.

8) What types of **clinical material** are presented? Specify what percentage of each type of clinical material is presented (total should equal 100%).

____%CLIENTS WHO ARE "STUCK" FOR THE THERAPIST, DIFFICULT CASES.
____% CLIENTS WHO HAVE BEEN A "SUCCESS" FOR THE THERAPIST.
____% TOPICAL CLINICAL ISSUES USING SEVERAL CASES(ie.bulimia, suicide)
____% CLINICAL TECHNIQUES PRESENTED OR DEMONSTRATED.
100% Total of types of clinical material.

9) As cases are presented how are clients <u>most often</u> identified? (check only one)

_____ FIRST NAME ONLY
_____ FIRST AND LAST NAME
_____ NO NAMES OR IDENTIFYING MATERIALS ARE USED
_____ PSEUDO- OR FAKE NAMES ARE USED

10) (**A**) Do you inform clients before their case material is shared in group?

_____ NEVER
_____ HARDLY EVER
_____ ABOUT HALF THE TIME
_____ MOST OF THE TIME
_____ ALWAYS

(**B**) If clients are informed, check how often you use the following procedures:

	Never	Hardly Ever	Seldom	Sometimes	Often	Usually	Always
Describe the group verbally to client.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Describe the group in writing to client.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Have client <u>verbally</u> consent to be presented in group.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Have client sign <u>written</u> consent form.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Invite client to visit group.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

11) Which one phrase comes closest to describing how it is decided **who** will present case material? (check only one)

_____ Members present material spontaneously as the meeting progresses.
_____ Prior to meetings, members volunteer to present.
_____ Members present material according to some structured rotation.
If so, explain _____

12) Which one phrase comes closest to describing how the **content** of presentations are determined? (check only one)

_____ We follow an agreed-upon outline for presentations.
_____ We present what the therapist feels is important.
_____ The group solicits what is presented by asking questions.
_____ Other, please explain _____

FEEDBACK When a presentation of clinical material is made, the group reacts in some way. We would like to focus on the nature of that reaction or feedback in this section. We are interested in what actually happens, not what you wish would happen.

13) To what degree does your group focus on each of the following in giving **feedback** to the therapist who presented. Please rate each item using the scale below.

The focus of the group's **feedback** is:	Never	Seldom	Sometimes	Often	Always
1. On specific therapeutic interventions that the therapist can immediately use with clients.	1	2	3	4	5
2. On conceptualizing the case and the therapist's approach to therapy within a theoretical framework.	1	2	3	4	5
3. On learning from the therapist who presented.	1	2	3	4	5
4. On identifying and resolving the characteristic problems and blind spots of the presenting therapist.	1	2	3	4	5
5. On general therapy skills useful with many clients.	1	2	3	4	5
6. On the therapist's style of conducting therapy.	1	2	3	4	5
7. On demonstrating techniques and ideas to the therapist.	1	2	3	4	5
8. On the relationship between the therapist and the group.	1	2	3	4	5
9. On the relationship between the therapist and the client.	1	2	3	4	5
10. On offering direct advice about working with clients.	1	2	3	4	5
11. On therapist's awareness of his/her reactions to clients.	1	2	3	4	5

12. On understanding the problems, behavior and/or dynamics of clients.	1	2	3	4	5
13. On offering emotional support for the therapist.	1	2	3	4	5

14) Using the scale below, please respond as to the degree to which the following items are indicative of your group's behavior in **feedback** to the therapist who presented.

Behaviors of groups members (in relation to the therapist who presented) are:

	Never	Seldom	Sometimes	Often	Always
1. SUPPORTIVE	1	2	3	4	5
2. DIRECTIVE	1	2	3	4	5
3. INSTRUCTIONAL	1	2	3	4	5
4. CONFRONTIVE	1	2	3	4	5
5. INTERPRETIVE	1	2	3	4	5

15) Once the group gives you feedback about clinical material you present, how do you decide what to do with that feedback. Please rate **each** statement as to how often this is true for you when you have received feedback from the group.

1	2	3	4	5
Never	Seldom	Sometime	Often	Always

_____ 1. I totally decide how to use the feedback I receive. There are very few expectations from the group as to what I should do. I can take or leave the group's input.

_____ 2. I decide how to use the feedback but I feel there are strong expectations from the group to actively use that feedback.

_____ 3. Once a case is presented to the group, the entire group decides how the feedback is to be used. It is a group decision.

16) After you have presented clinical material, is there follow-up with or by the group? Check which statement below best describes how your group usually follows cases that have been presented. (check only one)

_____ There is no follow-up on cases.
_____ Informal follow-up as needed, initiated by the therapist who presented.
_____ Informal follow-up, initiated by groups members as they are interested.
_____ Regular or scheduled follow-up by group.
Please explain _____
_____

POSSIBLE BENEFITS

17) The following list consists of possible **benefits** you have **actually** received from presenting clinical material and receiving feedback in the group. Using the scale below, indicate to what extent each item was beneficial to you (circle the appropriate number for each item).

	No Benefit to Me				Great Benefit to Me
1. Learning specific therapeutic interventions that I can immediately use with my clients.	1	2	3	4	5
2. Learning to conceptualize my cases and my approach to therapy within a theoretical framework.	1	2	3	4	5
3. Teaching members techniques which I have learned.	1	2	3	4	5
4. Identifying and resolving my characteristic problems and blind spots in working as a therapist.	1	2	3	4	5
5. Learning general therapy skills useful with many clients.	1	2	3	4	5
6. Developing my own style of conducting therapy.	1	2	3	4	5
7. Learning by observing the techniques/ideas of a peer.	1	2	3	4	5
8. Examining the relationship between me and the group.	1	2	3	4	5
9. Examining the relationship between me and the client.	1	2	3	4	5
10. Obtaining direct advice about working with clients.	1	2	3	4	5

11. Developing self-awareness of my reactions to clients.	1	2	3	4	5
12. Learning to understand the problems, behavior and/or dynamics of clients.	1	2	3	4	5
13. Gaining emotional support for my present cases.	1	2	3	4	5

18) Now, if you had to choose **ONE** item from the list above which was the **MOST** beneficial, what would that **ONE** item be? Go back and circle the item number of the most beneficial item.

19) There are a number of problems related to professional impairment (ie. impairment due to alcohol or drugs; sexual overtures towards clients; symptoms of depression or "burnout"; etc.). With regard to problems such as these:

Please read the list below and check any that you have known about or observed in other group members since you have belonged to the group (check all that apply in left column).

	Question 19 Known/observed in other members, (check all that apply)	Question 20 Degree confronted in/by group. (circle number)				
		Never	Seldom	Sometimes	Often	Always
a) Impairment due to alcohol or drugs.	(a) [ ]	(a) 1	2	3	4	5
b) Sexual overtures towards clients.	(b) [ ]	(b) 1	2	3	4	5
c) Symptoms of depression / "burnout".	(c) [ ]	(c) 1	2	3	4	5
d) Working with clients who should have been referred.	(d) [ ]	(d) 1	2	3	4	5
e) Incompetence in clinical practice.	(e) [ ]	(e) 1	2	3	4	5
f) Over-involvement emotionally with a client.	(f) [ ]	(f) 1	2	3	4	5

20) Now, for the problems you checked in the left column, please go back and circle the number which indicates how often these problems are confronted in/by your group (use right column).

OTHER FORMS OF SUPERVISION: Throughout your professional career your have undoubtedly received various forms of supervision. For each of the types of supervision you have had, specify the level of effect it has had in each of the four areas listed. Rate each area using this scale:

21) SUPERVISION **DURING** TRAINING (graduate school and internship):

(a) INDIVIDUAL SUPERVISION during graduate school and internship: (please rate all four areas)

_____ check if you had no individual supervision during graduate school or internship.

	Very negative effect			No effect			Extremely positive effect
1. Effect on my personal development.	-3	-2	-1	0	1	2	3
2. Effect on my profess. development.	-3	-2	-1	0	1	2	3
3. Effect on my behavior with clients.	-3	-2	-1	0	1	2	3
4. Effect on client's progress.	-3	-2	-1	0	1	2	3

(b) GROUP SUPERVISION during graduate school and internship: (please rate all four areas)

_____ check if you had no group supervision during graduate school or internship.

	Very negative effect			No effect			Extremely positive effect
1. Effect on my personal development.	-3	-2	-1	0	1	2	3
2. Effect on my profess. development.	-3	-2	-1	0	1	2	3
3. Effect on my behavior with clients.	-3	-2	-1	0	1	2	3
4. Effect on client's progress.	-3	-2	-1	0	1	2	3

22) SUPERVISION **SINCE** GRADUATE SCHOOL AND INTERNSHIP:

(a) INDIVIDUAL SUPERVISION since graduate school and internship: (please rate all four areas)

_____ check if you had no individual supervision since graduate school and internship.

	Very negative effect			No effect			Extremely positive effect
1. Effect on my personal development.	-3	-2	-1	0	1	2	3
2. Effect on my profess. development.	-3	-2	-1	0	1	2	3
3. Effect on my behavior with clients.	-3	-2	-1	0	1	2	3
4. Effect on client's progress.	-3	-2	-1	0	1	2	3

(b) PEER GROUP SUPERVISION, your present group: (please rate all four areas)

	Very negative effect			No effect		Extremely positive effect	
1. Effect on my personal development.	3	2	1	0	1	2	3
2. Effect on my profess. development.	3	2	1	0	1	2	3
3. Effect on my behavior with clients.	3	2	1	0	1	2	3
4. Effect on client's progress.	3	2	1	0	1	2	3

23) How would you compare the overall value of this group to the value of other forms of supervision you have received? (check only one)

_____ 1. THE GROUP HAS BEEN MUCH LESS VALUABLE THAN OTHER FORMS
_____ 2. GROUP HAS BEEN SOMEWHAT LESS VALUABLE THAN OTHER FORMS
_____ 3. THE GROUP HAS BEEN ABOUT THE SAME VALUE AS OTHER FORMS
_____ 4. GROUP HAS BEEN SOMEWHAT MORE VALUABLE THAN OTHER FORMS.
_____ 5. THE GROUP HAS BEEN MUCH MORE VALUABLE THAN OTHER FORMS

PERSONAL AND PROFESSIONAL INFORMATION

24) How many years have you practiced psychotherapy since receiving your license?
_____ years

25) Your present age _____ YEARS.

26) Your sex? 1. _____ FEMALE 2. _____ MALE

27) a) How many years has the group existed? _____ YEARS
b) How many years have you participated in it? _____ YEARS

28) How many women/men are in your group?
1. NUMBER OF WOMEN _____ 2. NUMBER OF MEN _____

29) We would deeply appreciate any comments you may have about your group or about this area of research:

_____
_____
_____
_____

We sincerely thank you for your participating in this study. Please check the space below if you wish a report of the results. [ ]

APPENDIX B

Dr. < >
address
address

Dear Dr. < >

A number of months ago you graciously responded to a questionnaire concerning your participation in a peer consultation group. Because of your help we were able to discover 111 such groups that are meeting throughout the United States. Our sample indicates that over 24% of private practitioners like yourself belong to such groups. From this initial study we discovered that most of the groups were being used, among other things, to provide the members with input on their clinical cases. In other words, these groups were functioning as some form of clinical peer supervision.

Since there is very little known about how mature practitioners receive input on their clinical work, it is very important to further explore the nature of this peer-group supervision process and the resulting benefits. Because of your unique role as a psychologist who is a member of one of these groups, we are asking you to answer the enclosed questionnaire related to this supervision process.

We fully realize how busy you are and how valuable your time is. We ask your participation because we are convinced that this topic is of sufficient importance to the private practice of psychotherapy to warrant your taking approximately 15 minutes to complete the enclosed questionnaire. We believe that the information gathered in this survey will be useful to all of us who are working as therapists.

Your name has been selected from our original mailing list which indicates that you had previously belonged to a peer consultation group. All other information about you has been held in confidence as will the information you share in the present survey. The numerical coding system on the questionnaire allows us to avoid unnecessary follow-up letters.

Should you have any questions on this project, please write or call us at (217) 446-1749.

We thank you for your highly valued contributions to this project and for your prompt response.

Sincerely,

Gloria J. Lewis, Ph.D.
Chairperson
Counseling and Educational Psychology
Loyola University of Chicago

David B. Hatch
Psychology Intern
VA Medical Center
Danville, Illinois

APPENDIX C

Last week we sent you a questionnaire on the supervision process in peer groups. If you have already returned it to us, thank you. If it is still on your desk awaiting the 15 minutes needed, we urge you to fill it out now. Your participation will help insure our achieving a representative sample from our subject pool.

If you have misplaced the materials, please call 217-446-1749 or write us for a replacement. We do need, and appreciate, your cooperation in this research important to our profession.

Gloria J. Lewis, Ph.D.
David B. Hatch, MA
Project Directors

APPENDIX D

January 1, 1988

Dr. < >
address
address

About five weeks ago we wrote to you seeking information concerning your involvement in a peer consultation group. As of today we have not yet received your completed questionnarie.

We have undertaken this research project because of the belief that our profession knows relatively little about how mature private practitioners, like yourself, receive input on their clinical work. Thus, we believe that it is very important to further explore the nature of this peer-group consultation/supervision process.

We are writing to you again because of the significance that each questionnaire has to the usefullness of this study. Your unique role as a member (or ex-member) of a peer consultation group offers a perspective on our profession which we cannot obtain elsewhere. Since our total potential sample is only 116, every psychologist's response is critical inorder to achieve a reasonable representation.

If you no longer belong to such a group, please indicate this on the first question and return the survey in the stamped return envelope.

We realize that you may have received our first mailing in the midst of the pressures of the holiday season and so we have waited until the new year before contacting you again. We also fully realize how buzy you are and how valuable your time is. We are again asking you to take the approximately 15 minutes needed to complete the questionnaire since this topic is of sufficient importance to all of us who work as therapists in psychology.

In the event that your questionnaire has been misplaced, a replacement is enclosed. Should you have any questions on this project, please write or call us at (217) 446-1749.

We thank you for your valued contributions to this project and for your prompt reply.

Sincerely,

Gloria J. Lewis, Ph.D.
Chairperson
Counseling and Educational Psychology
Loyola University of Chicago

David B. Hatch
Psychology Intern
VA Medical Center
Danville, Illinois

APPENDIX E

RETURN RATE INFORMATION

DATE	ACTIVITY	NUMBER OF RETURNS	RUNNING PER CENT
11/26	First mailing		
11/30		2	2.1%
12/1		1	3.1%
12/2		3	6.3%
12/3	Postcard mailing	11	17.7%
12/4		12	30.2%
12/7		11	41.7%
12/8		2	42.7%
12/9		5	49.0%
12/11		4	53.1%
12/14		12	65.6%
12/16		2	67.7%
12/18		1	68.8%
12/21		3	71.9%
12/28		3	75.0%
12/30	Second Mailing		
1/5		1	76.0%
1/6		1	77.1%
1/7		5	82.3%
1/8		4	86.5%
1/11	Start Calling	4	90.6%
1/19		3	93.8%
1/20		1	94.8%
1/22		1	95.8%
1/25		3	99.0%
1/26		1	100.0%
Total		96	

APPENDIX F

Correlation Matrix of Goals for Clinical Presentation

Correlation Matrix

	G1	G2	G3	G4	G5	G6	G7	G8	G9	G10	G11	G12	G13
G1	1.000												
G2	.2061	1.000											
G3	.5336	.1414	1.000										
G4	.0171	.0057	-.1474	1.000									
G5	.5155	.2174	.2914	.1142	1.000								
G6	.1471	.3347	.2169	.1123	.4020	1.000							
G7	.3786	.2277	.2323	.0719	.3681	.4211	1.000						
G8	-.0112	.0103	.2927	.1308	.0999	.2880	-.0284	1.000					
G9	.0434	.0968	-.1591	.3379	.2048	.3677	.3528	.0863	1.000				
G10	.3081	.0591	.3047	.1125	.3241	.0564	.2517	-.1386	.1451	1.000			
G11	.2019	.0216	-.0224	.4274	.1895	.2542	.0988	.3369	.6970	.1804	1.000		
G12	.2001	.2796	.2608	.1360	.5211	.5852	.4288	.0636	.4615	.5223	.3302	1.000	
G13	.1712	-.0655	.1399	.2351	.1576	.2246	.1813	.2332	.3059	.2242	.2959	.2029	1.000

Each item above corresponds to the items on the questionnaire of the same number.

APPROVAL SHEET

The dissertation submitted by David B. Hatch has been read and approved by the following committee:

Dr. Gloria J. Lewis, Director
Department Chairperson, Counseling and Educational Psychology
Loyola University of Chicago

Dr. Manuel S. Silverman
Professor, Counseling and Educational Psychology
Loyola University of Chicago

Dr. Martha Wynne
Professor, Counseling and Educational Psychology
Loyola University of Chicago

The final copies have been examined by the director of the dissertation and the signature which appears blow verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation if therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

June 6, 1991
Date

Gloria J. Lewis
Director's Signature