Designs and Discriminations for Clinical Group Supervision in Counselling Psychology: An Analysis

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ABSTRACT

Evidence suggests that group clinical supervision of counsellors and trainees is an effective mode of service delivery. However, clinical supervision is often understood to be concerned with teaching a generic set of skills. Without specifically labeling them as such, clinical supervision groups are implicitly identified as psycho-educational groups. This article argues that such groups are better understood as counselling groups. The critique of existing group supervision strategies highlights the common use of small-group fixed-outcome strategies when a small-group fixed-process strategy is more appropriate to the task.

RÉSUMÉ

Les données factuelles donnent à penser que la supervision clinique de groupes de conseillers et de stagiaires est un mode efficace de livraison de service. Toutefois, la supervision clinique est souvent comprise comme se préoccupant d'enseigner un ensemble générique de compétences. Sans qu'on les étiquette spécifiquement comme tels, les groupes de supervision clinique sont implicitement identifiés comme étant des groupes psycho-éducatifs. Le présent article avance que ces groupes sont mieux compris en tant que groupes de counseling. La critique des stratégies existantes de groupes de supervision souligne l'utilisation courante de stratégies pour petits groupes à résultats déterminés alors qu'une stratégie pour petit groupe à processus déterminé convient mieux à la tâche.

If clinical supervision of counsellors and psychotherapists is understood to be concerned primarily with teaching skills and refining clinical judgements (Evans, Hearn, Uhlemann, & Ivey, 1998), then psycho-educational groups appear to be an ideal vehicle for such an enterprise. Psycho-educational groups, concerned with a generic behavioural outcome such as the acquisition of a particular skill set, are a nearly ideal vehicle for such an undertaking because they provide efficient use of resources—one supervisor reaches many trainees with the same material—and the group provides feedback and validation for the refinement of the skills (Jacobs, Masson, & Harville, 2002). Individual supervision would then seem to be the logical complement of this process, with one-to-one supervision time providing the trainee with an opportunity to focus on case conceptualizations, very specific skills, and more person-centred issues such as transference (Bernard & Goodyear, 1998; Milne & Oliver, 2000). This is the usual way clinical supervision is understood and practiced.

If, however, a major component of effective clinical supervision is the development of the clinician as a person, in the capacity to make differential use of self as a vehicle of change, then the focus of clinical supervision in groups will be much different. This clinician-centred conceptualization of clinical supervision,

while not ignoring skills, puts the emphasis on adjustment and adaptation. This shift changes a crucial dimension of group work as well. Instead of seeking fixed outcomes, such as the acquisition of a particular skill, under this conceptualization, clinical supervision would seek variable outcomes—outcomes specific to the personal and developmental needs of each individual supervisee or trainee. This change also implies an important change in the focus of the group away from specific outcomes and on to process (S. Johnson & Johnson, 1995).

As implied in the analysis above, the conceptual framework of this article follows from the relationship of process and outcome to group design. S. Johnson and Johnson (1995) have shown that group designs applicable to clinical supervision can be classified into two basic types: psycho-educational groups, which have specific outcomes common to all group members, and counselling groups, in which outcomes are idiosyncratic to each group member (Carroll, Bates, & Johnson, 1997). For purposes of optimizing group supervision, the concern is to distinguish between psycho-educational groups and counselling groups. In order to achieve the fixed or standardized outcomes of a psycho-educational group, process is allowed to vary, as is the case when the leader of a psycho-educational group changes instructional strategies from demonstration to video presentations to discussion to participant modelling until each member has achieved the pre-determined outcome: a specific knowledge and skill set. In a psycho-educational group, process must be free to vary to take into account the individual learning style of each group member. By contrast, in a counselling group, it is the outcome that is idiosyncratic and variable, and the process, which is individual growth and adjustment, that is the common ground for all group members. The case of a basic counselling group interaction involving disclosure of immediate subjectivity provides an example. One can readily imagine that, in telling about immediate emotional awareness, one group member might talk about unprocessed family grief, while another might become aware of anger with a colleague. The process, self-disclosure of emotions, was the same for each group member, but the outcomes were quite different, and idiosyncratic to the needs of the particular group participant. In the sense that each member moves toward his or her own outcome based on the individuality of self and situation, the process of a counselling group can be said to be fixed, with variability in the outcome. Within the S. Johnson and Johnson (1995) framework, psycho-educational groups, with variable processes and fixed outcomes, are ideal for acquisition of objectively definable skills. Counselling groups, with relatively fixed processes and variable, or idiosyncratic, outcomes are the ideal for personal development.

Consequently, a pivotal question becomes: When it comes to clinical supervision, which tactic is the difference that makes the difference? Personal development? Skill acquisition? Or both? This distinction will be the turning point for the design of the supervision group, for the content of the informed consent of the participants, for the creation of goals and group norms, and for the guidance of leader behaviour (Vasquez, 1992).

In designing and carrying out supervision groups, the theory presented so far predicts that if therapist behaviour is best supported by skill development, then

those aspects of groups that are based on variable processes and fixed outcomes should be the best predictors of clinical outcomes achieved by supervisees. On the other hand, if clinical outcome is more closely tied to differential use of self, then those aspects of group supervision that are based on relatively fixed processes and individualized outcomes should be the better predictors of efficacy. Cross-cultural counselling, with its emphasis on the specifics of cross-cultural knowledge and social skills particular to culturally defined groups, provides an opportunity to compare these predictions.

THE CASE OF CROSS-CULTURAL COUNSELLING

Training for cross-cultural counselling and psychotherapy is typically understood as the acquisition of knowledge about cultural differences, and the skills that are indicated or contraindicated for a particular cultural setting. However, Hanna, Bemak, and Chung (1999) offer an alternative to the notion that it is knowledge of cultures that makes the difference in cross-cultural counselling and psychotherapy. although this knowledge helps, it will be unsuccessful in making the necessary therapeutic alliance and creating the other conditions for change unless this knowledge is mediated by what these authors call wisdom, which they define as knowledge of one's self and one's own cultural heritage, experience and embeddedness, and awareness that this is almost always a powerful mediating factor in encounters with clients. Hanna et al. conceptualize these factors as cognitive and affective traits, but, tellingly, they infer these traits from behaviours consistent with existential group leadership. This idea is, essentially, use of other terminology for ideas of group therapy leadership articulated in Carroll et al. (1997), particularly the need for honesty, congruency, authenticity, and genuineness on the part of effective group leaders and group psychotherapists. Also, just as importantly, Hannah et al. are conceptualizing clinical group supervision as a process of counselling and not, fundamentally, as a delivery of information and specific skills.

Torres-Rivera, Phan, Maddux, Wilbur, and Garrett (2001) systematically studied supervision groups that had a general goal of improving the effectiveness of cross-cultural counselling by the group members. Torres-Rivera et al. found that there was a "strong relationship between personal awareness and multicultural counselling skills during group supervision" (p. 29). This result is, for most readers, a validation of theory already taken as a useful clinical guide. Therapists who are better adjusted and have better self-awareness will, in theory, produce better results. Yet technically, this study has some very powerful points to make beyond this helpful but unsurprising validation. Torres-Rivera et al. trained master's degree students using group supervision, emphasized personal self-awareness, and measured effectiveness using the Group Dynamics Inventory (GDI; Phan & Torres-Rivera, 2000, cited in Torres-Rivera et al.) and Counsellor Skill and Personal Development Rating form (CSPD; Wilbur, 1991, cited in Torres-Rivera et al.). The authors used repeated-measures Analysis of Variance (ANOVAs) to track changes over the training period and in spite of a small sample size ($n = 17$), achieved statistical significance at the .05

level. This result leaves a good deal of variance unaccounted for, and here is where the methodology helps us to see what varies and what stays the same. Torres-Rivera et al. document extremely high internal consistency for both their instruments (all alphas over .92) and strong factorial validity, with over 66% of variance explained by three robust factors in each instrument. Given this strong evidence of reliability and validity, it is striking that the factors measuring effective cross-cultural work correlated with therapist self-awareness, with correlations ranging from .87 to .92 and all significant at the .001 level.

What does this mean? While the authors do not specifically draw out this point, the data clearly support the idea that, while there is a good deal of variation between counsellors and in their rates of change (as demonstrated by the small *F*-ratios in the repeated-measures statistical tests), increases in self-awareness predicted improvements in cross-cultural skills, accounting for over 80% of the variance in this change. While replication is, at present, lacking, this result empirically demonstrates that the operative ingredient in group supervision for counsellor trainees is the development of the self, which is to say those outcomes of idiosyncratic personal growth achieved in a counselling group, as opposed to skills acquisition—outcomes achieved in a psycho-educational group.

While Torres-Rivera et al. (2001) do not offer this interpretation of their data, casting their numbers against a theory of variability in results and processes provides a very tight fit. Factors expected to vary in a fixed-process group, most specifically the clinical outcomes, did exactly that: they varied. In particular, measures of specific skill development showed high levels of variability, and before and after comparisons showed modest results. Those factors expected to make a difference in a counselling or fixed-process group, most specifically individual growth, were the factors that accounted for the change and the interpersonal variability of the specific content of the change. Torres-Rivera et al. come close to specifying the relationship between variability of process and variability of outcome when they state that they "do not believe that behaviour change in group supervision (or counselling) is sequential, as suggested by G. Corey (1995), but is random at best, and depends on the ability of the supervisor to make the right intervention at the right time" (p. 30). Again, there is an echo of Carroll et al.'s (1997) emphasis on leader responsibility and the primacy of process in counselling groups. While not specifically intended, this data set clearly shows that fixed process produced variable results, and that the variability could be accounted for at an extremely high level of confidence by measures of idiosyncratic change. While the authors look to group leadership and uncontrolled variables to explain their results, from the point of view of discriminating group types, the data in this study are almost precisely what one would expect from a counselling group (a group with fixed process) being treated as a psycho-educational group (a group with fixed outcomes).

The Torres-Rivera et al. (2001) study has been reviewed at length because the design provides for relatively precise quantitative comparisons of group process and relates these to subsequent clinical outcomes. However, other studies (Myers, Mobley, & Booth, 2003), as well as comprehensive reviews of clinical competen-

cies (Collins, Kaslow, & Illfelder-Kaye, 2004) also support the crucial nature of distinguishing between processes that develop the person of the trainee and processes that impart skill and knowledge sets.

The data and analysis so far suggest that, optimally, group supervision should be understood as a process fundamentally analogous to group counselling. Consequently, a helpful next step is to examine how clinical group supervision is typically conceptualized.

THE VALIDATION OF CLINICAL SUPERVISION AS A COUNSELLING PROCESS

The most popular method of counsellor and therapist training is group supervision (Bernard & Goodyear, 1998). Yalom (1995) points out that groups allow trainees to experience therapeutic effects, while at the same time learning about the content of group work, and learning how to bring these effects about. Philosophically, a modernist approach to the psychology of supervision would argue that those features of humanity held in common are determinant of behaviour, affect, and cognition, and therefore an educated clinician will know the skills by which to operate on those factors. Therapies and their associated philosophies explicitly use the terms "operant" and "analytic" in their descriptions of their methods. As Gergen and McNamee (1999) have cogently pointed out, a postmodern view of individuality emphasizes difference, not sameness, as the focus of the change agent's attention. This changes the relationship of the therapist from one who "operates" to one who "co-operates" with the client (Gergen & McNamee; Gilligan, 1999), and linear cause and effect gives place to a dynamic interplay of self, others, and context. Strikingly, this notion of dynamic interaction of self, others, and context was articulated in another context by Satir (Andreas & Satir, 1991) as a model of stress coping and therapist congruence. This, then, suggests the interactions of a counselling group as a crucible for therapist development precisely because of its emphasis on self-knowledge and interaction with others. It is worth mentioning that this line of reasoning, which emphasizes the development of the person of the therapist, is consistent with recent meta-analyses of psychotherapy outcomes that demonstrate that the therapist-client relationship, and not therapist skill or conceptual framework, is the most powerful predictor of therapeutic outcomes (Duncan & Miller, 2001).

Framing supervision as a counselling group requires a careful examination of group leader roles and responsibilities, especially in light of practice standards that enjoin supervisors to ensure that "appropriate relational boundaries are clarified and maintained, and that dual relationships are avoided" (Canadian Counselling Association, 2003, p. 37). If a supervision group is also a counselling group, then the activity involves all the personal risks of self-disclosures and self-growth activities and the possibility of a dual "counsellor-supervisor" relationship with the group leader. As Tomm (2002) has pointed out, the ethical problem in these situations is exploitation, not its context, and there is a case to be made that group supervision actually protects supervisees from exploitation. Koocher and Keith-Spiegel

(1998) suggest group supervision as a protection against the exploitation of power differences between supervisees and trainees. While Koocher and Keith-Spiegel make this suggestion because the relatively public setting of the group makes for more supervisor accountability, they seem not to have considered that the group supervision context will not only make the power difference public, but is likely to actually reduce it. In a group focused on personal development, as opposed to pure skill acquisition, the demand is on both supervisees and the supervisor to respond with immediacy, openness, and genuineness (Tudor, 1999), a situation in which the relative advantage of the supervisor is prone to be levelled. As Haley (1996) so wryly puts it, much of the posturing of supervisors is consistent with projecting what the name implies: "super vision." The process of a counselling group, and especially its developmental process, provides pressure toward immediacy and reciprocity, giving the supervisor "super responsibility" associated with leadership in the "here and now," as opposed to "super vision" derived from external factors of credibility such as position and credentials.

This way of conceptualizing produces a shift from the quantitative—how many skills at what level of accomplishment—to a more qualitative analysis. Christensen and Kline (2001) have attempted to articulate a theory of group supervision from a qualitative perspective. Using Straus and Corbin's (1998) methodology for producing theories from qualitative inquiry, Christensen and Kline explored the relationship between principles of clinical supervision and the dynamics of peer groups, using members of clinical supervision groups as informants and the groups themselves as arenas for observation. Not surprisingly, the theory emerging has, as its major elements, supervisee pre-existing personal development, group development, and leader behaviour. This study is rich in fascinating detail, but for purposes of this article the main point is that this approach clearly specifies clinical supervision groups as process groups, and not as psycho-educational groups.

GROUP SUPERVISION OR INDIVIDUAL SUPERVISION?

Evidence suggests that group clinical supervision is used less often than it might be because it is less understood than its complement (or rival), individual supervision. In 1985, Holloway and Johnson published a review describing group supervision as "widely practiced but poorly understood" (p. 332). A decade later Prieto (1996) updated this review, titling his article (in part) "still widely practiced but poorly understood" (p. 295). Still more recently, Ray and Altekruse (2000), citing Lanning (1971) and Averitt (1989), note that the obvious comparison of group and individual supervision has only been taken on twice in the psychological literature. In both the Lanning and Averitt studies the two methods of supervision were found to be equally effective. More recently, Gillam and Crutchfield (2001) intentionally compared task-group, guidance-psycho-educational, and counselling groups as ways of developing therapist skills, concluding that group formats are superior to individual supervision for both professional development (i.e., discrete skills) and personal development.

Ray and Altekruse (2000) investigated the even broader question of whether individual supervision alone, or group supervision alone, is superior; whether a combination of group and individual supervision has advantages; and whether smaller supervision groups (four therapists to each supervisor) were more effective than large groups (eight therapist trainees per supervisor). This study relied heavily on trainee ratings done by doctoral student volunteers, and the reliability of these ratings was .78: acceptable, but leaving much room for variability. While client ratings did not show changes in the counsellors' performance over time, supervisory rating changes were significant at the .001 level, while independent raters saw much more variability and much smaller gains. Taking these data overall, there were no differences between the conditions, indicating that group supervision is comparable in effectiveness to individual supervision, and that group size, up to the ceiling of eight in this study, does not make a demonstrable difference.

The Ray and Altekruse (2000) study, while not definitive, is suggestive of several issues about the effect of groups on counsellor education. If the classic defense of individual supervision is the capacity of this mode to provide focus on the individual trainee, the theoretical defense of the group is that, to paraphrase Westwood, Mak, Barker, and Ishiyama (2000), there are some things you can only know about yourself from being in groups. There is a credibility to the spontaneous feedback of more than one individual (as when a whole supervision group reacts with shock to the presentation of a treatment plan inadvertently predicated on a point of sexism not obvious to the planner) that is unavailable in one-on-one encounters. Seen from the point of view of a group participant, in a group situation there is enough evidence within the variability of the responses from a variety of group members to distinguish among the relationship one has to the feedback giver, the effect of context, and the face validity of the message. If self-awareness is a major goal of therapist training, then group work is a modality of choice. And if that awareness is highly idiosyncratic, then a counselling group with a fixed process is the style of choice. Interestingly, Ray and Altekruse do not comment on the issue of group size, although this would seem to be a critical variable. Jacobs et al. (2002) review literature indicating that the ideal size for counselling groups is four to eight members, just the range studied by Ray and Altekruse, and theory suggests that no differences could be expected. The difference should come when the group becomes larger, thus limiting "air time," the depth of knowledge about other participants, and increased hesitancy to speak up as group size increases interpersonal risk (Jacobs et al.). D. W. Johnson and Johnson (1985) also note the tendency of groups to break up into subgroups at a critical size, usually over eight members, often creating difficult dynamics. A safer conclusion to the Ray and Altekruse study would have been that group supervision is effective across the range of group sizes usually recommended for counselling groups.

FOLLOW THE MANUAL OR FOLLOW YOUR HEART?

If counselling and psychotherapy are understood to be based primarily on the application of particular skills to particular problems, while using a detailed and extensive body of knowledge to make these discretionary judgements, then the best way to teach counselling and psychotherapy would be in psycho-educational groups. Why is this? Because, technically, each counsellor should do the same thing for the same client under similar circumstances, that is, there is a definable clinical "best choice" based on knowledge of the client and the client's problem. Applying this to group theory, the outcome sought is fixed; each therapist learns the same skills and the same rubric of judgement.

If, however, the person of the therapist is understood to be a vital part of the therapeutic process, then training takes on another connotation. Responses to this will range from the classic psychoanalytic training analysis (which, technically, should reduce inter-therapist variability by privileging standard rational ego functions over relatively volatile primary process responses) to the radical individualism of some schools of therapy, notably practitioners such as Kempler, Whittaker, or even Satir (Becvar & Becvar, 1996).

Iberg (1991) offers an intriguing technical answer to this conundrum. Iberg suggests that, in evaluating therapist trainees, statistical control theory can be used to reconcile the requirements of clinical research and clinical supervision. In Iberg's paradigm, therapists do not follow a fixed protocol, but their behaviour is observed and coded along several variables thought to be important to therapeutic effectiveness, and this data set is compared to client characteristics, client presenting problems, and client ratings of therapeutic effectiveness. As Davidson and Horvath (1997) have since demonstrated, it is the client's perception of the therapist, and not the objectively rated behaviour of the therapist, that is predictive of psychotherapy outcome. Iberg's method allows the discrimination of expectable statistical variation in counsellor behaviour from reliable differences in therapist behaviour, and these can be related directly to outcome variables such as client return rates, client ratings of the service, and reported outcomes. This would be an esoteric point of methodology were it not for two points. One is that this relates actual therapist behaviour to specific supervision needs, and, even more important to the theme of this article, it relates process to outcome at two levels. The variable process of the therapist (which is invited by this paradigm) is consistent with a fixed outcome for the therapy, which is the resolution of the referring difficulty. The fixed process of the supervision is intended to produce a variable result in supervision, which is the effective differential use of self in supervision. Again, without specific reference to the frame of reference, this line of research validates not only the distinctions between process and results, but also identifies supervision as a counselling, as well as an educational, activity.

The same dimensions show up in qualitative investigations. Berg and Hallberg (2000) used phenomenological methods to look at the supervisory experience of psychiatric nurses. While the authors expected to see an emphasis on planning

in supervision—a process that is highly cognitive and involves the abstraction of objective information—what emerged as dominant themes in supervision experience were "reflection on action" and "confirmation," variables that can be broadly classified as experiential. These authors also saw the group supervision context as valuable by examining relationship issues and "taking the whole group of nurses into account when providing clinical supervision" (Berg & Hallberg, p. 125). Consistent with group theory, supervisors found that the group modality was difficult because it meant "encountering oneself as well as confronting the nursing group" (Berg & Hallberg, p. 126). Again, the theme is that much more than an exchange of skill and information is happening when supervision is provided in groups. While it may be scattered through the literature, and the data sets may be conceptualized in different theoretical terms, there is a body of evidence that not only supports group supervision of therapists, but also points to the optimal group process as a counselling group, a group with fixed processes and variable, idiosyncratic, results.

misidentification and missed analysis

What happens if these crucial distinctions among process, outcome, and group size are unrecognized? In another experiential documentation, Neretin (2002) describes the difficulty she, as a facilitator of a supervision class for graduate clinicians, experienced in getting the events of September 11, 2001, on the discussion agenda within the class structure. The terrorist attacks had actually pre-empted the first day of class, and so the initial experience of the group was one of accommodating to this change. Still, attempts to talk about these events in class seemed to "fall dead." Neretin understands this lack of engagement from a point of view of postmodern analysis, regretting the political power structure that seems to prescribe a role of "cool detachment" to professional trainees, and recommends that more politics and other issues of social context be included in the "clinical classroom." However, Neretin's article also illustrates another process. Her classroom, as described in the article, is a psycho-educational group in which members of the group are to achieve a set outcome of clinical skills—the same for each member—and one possible outcome is a poor evaluation from the "supervisor/teacher" who has relatively much more power than the students. From an existential point of view, this immediate experience and social hierarchy is the "politics" at play in the classroom, a "politics" likely to be much more immediate and influential than abstract threats from far away. Had Neretin understood supervision in terms of the distinctions between psycho-educational groups and counselling groups, understanding that the class is a psycho-educational group, then the reluctance of the students to discuss their personal political beliefs would have been entirely in context. Failure to make this possibly subtle, but arguably basic, distinction between group types and expected behaviour within each context seems, first, to have led Neretin on an intellectual "wild goose chase", and seems, second, typical of what often happens in clinical group supervision.

MEASURE THE CLINICIAN OR MEASURE THE SKILLS?

Agnew, Vaught, Getz, and Fortune (2000) document that, although research on the effects of clinical supervision for school counsellors is rare, the extant studies of peer group supervision show no effect on clinical effectiveness. These researchers expanded the scope of inquiry to look at variables that should expectably change if peer supervision is not a group oriented toward changing discrete points of professional competence, but is, in a formal sense, a psychological intervention that should produce changes in areas broadly labeled as relationship and adjustment. An assessment by Agnew et al. of a peer supervision program showed that while clinical gains were marginal, improvements in confidence when at work and in a sense of professionalism were reported by almost all participants.

Milne and Oliver (2000) have created a taxonomy of supervision types and modalities. Within their system, the most favoured modality is one-to-one supervision, with one-to-one supervision in a group of two being the next most favoured, and group supervision a distant third, endorsed by only 14% of the supervisors responding to their survey. Milne and Oliver's summary of techniques in group supervision is very instructive. The supervision styles are labelled by the kind of therapeutic orientation from which they derive: Gestalt, experiential, cognitive-behavioural, family therapy, psychodynamic, and integrative. The techniques listed are more or less modifications of the therapeutic techniques of the orientations listed, and the outcomes sought are cast in terms of a mixture of specific clinical and cognitive skills. Strikingly, what is being described across all the examples given is a group with a very specific and fixed process, and with a fixed outcome as well. While much clinical literature, including Milne and Oliver's review, attributes the difficulty of clinical supervision groups to the complexity of supervisory relationships, there is strong presumptive evidence that the choice of group and group design is also contributing to tensions in these groups.

Yet, if properly understood, designed, and led, clinical supervision groups have strong potential for filling a crucial gap in professional practice and standards. Fischetti and Crespi (1999) report on a national sample of 232 school psychologists, indicating that they are getting far less supervision than is considered minimal by the American Psychological Association or the National Association of School Psychologists. These professionals, whether supervised or not, overwhelmingly endorsed the need for more supervision.

Watkins (1997), introducing a handbook for clinical supervisors, describes the role as moving flexibly from mentor to lecturer to colleague. This continuum of activities has near-direct parallels in the demands of group leadership (Carroll et al., 1997; Yalom, 1995), with the management functions coming through the teaching about professional competence and boundaries, the mentoring dimension building on the unique outcomes and developments sought by the supervisee, and the collegial connection related to the authentic interaction required in effective group work.

SUMMARY AND CONCLUSIONS

I have been supervising master's level trainees in counselling psychology individually and in groups at a training clinic every Monday for the last three years. The interns seem to be doing well; all those who have been through the clinic are employed, and none has had a professional complaint against them. There is, then, at least presumptive evidence that something is working.

The rationale for group supervision was, initially, a pragmatic application of fixed-results thinking: All the trainees need the same skills and information, so it is just more efficient to educate them in a group. However, what has evolved in the groups is a process of mutual support, personal exploration, and the adjustment of self to role. This is a fixed process, or counselling, function for the group. Retrospectively, problems in the group can be attributed to a lack of clarity about the kind of group and how to lead it. Trainee concerns about "What am I supposed to learn from this?" coupled with worries about "I just can't seem to get that behaviour to come out of who I am!" illustrate the frustration (not to mention potential harms) that can come out of clearly identifying group type.

This article has been, in effect, a reconceptualization of this group supervision work. It seems clear that group clinical supervision receives strong validation in both empirical and qualitative research. It seems equally clear that I am not alone in not having understood that while supervision groups almost always have some psycho-educational and task functions, supervision groups are, much more fundamentally, counselling groups. It is clearly a professional responsibility to have and to communicate clarity about roles and responsibilities in counsellor education (Sheppard, Schulz, & McMahon, 1999, p. 15). Understanding the groups this way makes for much more clarity about the needs of group members (including the need for informed consent), role structures, group norms, leader behaviour, and expectations for outcome and experience. Each of these dimensions is a topic in itself, and so this article can be considered as an introduction to a more detailed discussion of group clinical supervision.

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