

Supervision 2.0:

E-Supervision A Decade Later

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We, as family therapists, do not need to read a research report to notice the increased reliance on mobile devices in not only our own personal and professional lives, but the lives of our clients, supervisees, trainees, and professional peers. When the AAMFT published Supervision Bulletins on *Cybersupervision: Some Ethical Issues* (Greenwalt, 2001) and *Face to Face on the Line: An Invitation to Learn from Online Supervision* (Fialkov, Haddad, & Gagliardi, 2001), it was still optional to have an e-mail address or a cell phone. Fast Internet connections were not widely available and wireless connectivity was just in its infancy. In 2001, social networking did not exist, and video-conferencing required very expensive equipment. At that time, the Internet was a collection of static information (Web1.0) rather than a virtual, collaborative and fluid set of materials (Web 2.0). In just a decade, the Internet was transformed, from being an efficient storage, retrieval, and delivery medium, into a true networking platform. A decade earlier, there were no online family therapy courses, no hybrid programs, nor entire university programs offered online, like we have now. There was no accreditation process for distance education. But today, we have policies that intend to regulate and accredit online learning. E-supervision will most likely become much more common and an acceptable part of a routine rather than novel approach.

Why e-supervision?

One of the consequences of using the Internet for health-related activities is generalized among the adult population. Secondary data analysis, surveys, and qualitative studies unequivocally report an increased reliance on the Web as a source of information, peer-to-peer support and the demand for professional-patient interactions via the Web. This is analogous to a second order change, not a cumulative one but in itself a revolutionary transformation of our way of interactively thinking, and being in the world. For relational therapists, me included, who intend to develop collaborative and transparent forms of supervision, these digital and technological developments should be welcome since they offer new tools, conceptual and technological, to strengthen participation, collaboration, openness, and reduce the barriers

to the inclusion of many stakeholders. In the case of “Medicine 2.0” (Eysenbach, 2009), these second generation practices emphasize apomediation and social networking. In the case of the former, it is “explicit modeling of connections between people,” and apomediation involves, among other things, patients having much more access to relevant information (i.e., medical records) with professionals and peers helping them to navigate through this information.

In adopting emerging and seemingly complex technologies, we first need to accept that this can be scary and can make us feel inadequate. My initial general advice is to think less about what we do not know and think more about how to process and potentially incorporate these evolving tools. Our choices and preferences for particular technology (hardware, software, etc.) are probably temporary. Like other decisions in our personal and professional lives, the tools we choose or have to live with are often driven by variables beyond our control. However, because of the ubiquity and low cost of most of these technologies, we are able to autonomously make important decisions about which ones to use while addressing the ethical and professional challenges posed by clinical supervision.

E-Supervision

An obvious advantage of e-supervision is the opportunity to work together while you and your supervisee(s) are at different geographical locations. There are areas in the United States where finding a family therapist supervisor is prohibitive or not accessible. A bright intern on a tight budget ready to start her internship and doing family therapy outreach in Williamsport, PA, would need to drive 100 miles every week if she were to obtain all her supervision hours in the traditional format. E-supervision fits perfectly well in making the seemingly impossible possible and expanding our services into areas that really need them. Another example of e-supervision’s possibilities is a supervisee, able to obtain supervision or consultation from an expert in an area of expertise not available in her state or locality. Again, having access to e-supervision would enhance the growth of this clinician and the quality of the services provided to her patients.



Greenwalt asked in 2001 if it was ethical to carry out supervision in this way. A question of whether it should be done and not whether or not it could be done. Today, virtual supervision in human and health services occurs quite often. But there is a difference between 2001 and now. Many of the limitations that existed a decade earlier have disappeared, in part because of the phenomenal advances of communication technology and the massive adoption of digital, mobile, and virtual devices. We are not limited to text only as we were a decade ago. With e-supervision today, we can even abstain from using text as a medium of communication and tap into other mediums. These additional mediums allow us to examine the ethical dilemmas posed by Greenwalt through a more general supervision and not just an e-supervision lens. There is today a clearer recognition of concerns about elements of supervision in general, such as confidentiality, autonomy, fidelity, beneficence, and nonmaleficence. These elements are not so different in the contexts of e-supervision as in traditional supervision. Technology with

all mediums, not just text only, provides better ways to ensure high professional and clinical standards.

A third dimension of our profession should be discussed when considering e-supervision. We have become much more alert in the last few years. We as a profession still focus on the traditional components of the supervision relationship: the setting, quality of relationship, self of the therapist, theoretical model, accountability, time, evaluation, liability and ethical issues, etc. But, we are taking our awareness into new focus with the advent of the family therapy competencies and more generally the learning outcomes movement becoming core in training. Plus evidence-based clinical work is becoming a demand in clinics. Supervision as well as e-supervision will have to be measured against these criteria.

If one were to measure supervision on the basis of the question of how it is making a difference in the professional development of the therapist and the resolution of the issues that bring patients to consult with the therapist,

traditional supervision is as challenged with a positive response as e-supervision. What are the competencies that define good professional and ethical supervision? How are we measuring what we assume is appropriate supervision? We know that e-supervision is technically possible. It may not replace the “experience” of traditional supervision, but even traditional supervision is an experience that is difficult to fully grasp when looking at the supervisees competency development and clinical outcomes. E-supervision can offer opportunities that traditional supervision may not. A focus on what e-supervision may not replace assumes that what we know as supervisors is the appropriate experience. What if e-supervision were to offer some of this experience and also provide the opportunity for other know-how?

What many digital immigrants—those of us who learned about computers as young adults or later—believe is that what occurs virtually is somehow devoid of “a personal touch” or information that is central to understand one another.

What we may be missing is that for many others, in particular those who are becoming our supervisees and part of the digital native generation, there is not such a impermeable border in interactions that occur in the virtual versus the “real.” In other words: geographical distance may be slowly becoming irrelevant as a measure of closeness or distance in how people construe personal relationships. Why would the supervisory relationship be any different? In the meantime, with the rate of the adoption of social network technologies and e-technologies, we need to pay close attention to the potential of e-supervision for enhancing the value of what we may consider ethical and professionally appropriate supervisory work.

What do a supervisor and supervisee(s) need to work together virtually? The hardware on both ends requires at a minimum a computer connected to the Internet, a camera, microphone and speakers (now, a standard part of laptops and netbooks) or a headset. Even the acquisition of software may not be

needed since effective web-based software for all basic activities is free. Alternative ways of communicating in the case of a breakdown are advisable—i.e., wireless phone access, another computer, etc. It is no longer necessary to have the latest or top of the line computer. One does not need a large hard disk or screen, and sophisticated cameras or microphones to participate or lead a Web conference, share materials, upload a piece of video in a secure password protected server, participate in a chat, work simultaneously on a document, or respond to a survey.

Web 2.0 technologies are innumerable. They could be categorized into productivity tools (writing, spreadsheets, file storage), show and tell (blogging, microblogging, links, wikis, Web sites) synchronous (Web conferencing) and asynchronous communication (threaded discussions), learning management systems, social networking tools, enhanced reality and virtual reality software (Bacigalupe, 2009). This categorization is fluid since the various tools can serve various functions and can be integrated. The supervisor has to feel comfortable and be knowledgeable about the use of technology that by its nature evolves, changes, fails, etc. Employing digital and Web-related technology is a continuous learning process. Adopting one technology today does not ensure that it will be the same in the short term, nor does it always prove to be the best for a particular purpose.

For the purpose of supervision, the most predominant technological need is software that allows for Web conferencing and in some cases professional networking. The ability to use synchronous communication via Web conferencing has shown exponential growth in terms of ease, security, and interoperability (the ability for different people to interact across different computer brands, devices, software platforms, etc.). Some of these synchronous communication tools are as simple as in the example of Skype*, a cheap, easy to use, and fairly reliable software application that allows for talk and chats from a computer to another computer or to a phone conferencing tool. There are many

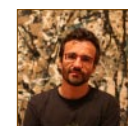
Web conferencing tools that not only offer voice communication but also include video, chats, and presentation areas. Sophisticated platforms combine voice, video, a chat room, a “white screen” to share presentations, draw or write. Conversations can be recorded if needed. The supervisor can break some supervision group members off in different teams to observe others while the supervisor gives instructions to a subset of supervisees, etc. These collaborative tools, allow me, as an e-supervisor, to construct a genogram with my supervisees having them add information simultaneously while we discuss a case.

Ensuring that our communication with supervisees is confidential and maintains the clients’ confidentiality continues to be core and e-supervisors face similar challenges to the challenges faced by supervisors in a clinic or academic setting. Even though I know the site is secure, I still ask supervisees to change client family members’ names and keep a “cheat sheet” sent via another medium with real names and consent forms. Similarly, I encourage the use of email in ways that protect everyone’s confidentiality. Names, dates, places, and any other personal data should be left out of some documents to prevent the potential of these confidential items being mistakenly forwarded to others. In my work with interns, all clinical reports for analysis in supervision should not include real names and should be submitted in the way a professional journal would accept clinical case descriptions.

Most importantly, as technology’s ability to keep a secure communication and verify who is participating has existed for a long time, what has improved tremendously is the ability to use more than written words (text) and more than basic verbal clues. Web conferencing tools offer ways of being able to actually see and hear the other person in ways that are similar to traditional supervision. I would suggest, that e-supervision may offer the opportunity for the supervisor to create learning and reflexive opportunities that are unique to the e-supervision set up. For example, employing a text chat to coach a

supervisee in a simulation of an interview in which other supervisees role play the patients can be very helpful. Another possibility is for a supervisor to coach the therapist remotely while the supervisee works with the family—replicating the learning experiences afforded by the use of the one-way mirror in live supervision.

In conclusion, rather than construing e-supervision from a perspective of deficit, I propose to start seeing it from a strength-oriented view that rescues its possibilities, all of which may inform traditional supervision. As discussed neither form of supervision has proven empirically how it contributes exactly to the growth of supervisees or what aspect of the clinical outcome can be attributed to our role as supervisors. With this lingering question it may be time for researchers to pay serious attention to the practices of e-supervision and to curiously explore what e-supervisors are thinking, doing, and reflecting as they pursue their work. ■



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