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, supervisors, 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 (Web 1.0) 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. 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 a 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 interacting and 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.
What we may be missing is that for many others, in the case of case management, new forms of supervision are possible for a supervisor to coach the therapist remotely while the supervisee works with the family—replicating the live experiences afforded by the use of the one-way mirror in live supervision. In conclusion, as constraining 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 supervisors or what aspect of the clinical outcome can be attributed to our role as supervisors. With this in mind, I encourage researchers to pay serious attention to the practices of e-supervision and to curiously explore what e-supervisors are doing, thinking, and reflecting as they pursue their work.

References

Fialkov, C. Haddad, D., & Gagliardi, J. (2001). Face to face on the line: An invitation to the Internet, a camera, microphone and speakers (now, a standard part of
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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 2.0 technologies), synchronous (Web conferencing) and asynchronous communication (threaded discussions), lean 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 content 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 chat from a computer to another computer or to a phone conferencing tool. There are many how to work together virtually?
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