

# The Use of Technology in Supervision

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## Author Biographies:

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DeeAnna Merz Nagel, LPC, DCC is a psychotherapist, consultant and international expert regarding online counselling and the impact of technology on mental health. She specializes in text-based counselling and supervision via chat and email. DeeAnna's expertise extends to assisting individuals and families in understanding the impact of technology in their lives from normalizing the use of technology and social media to overcoming internet and cybersex addictions. Her presentations and publications include ethical considerations for the mental health practitioner with regard to online counselling, social networking, mixed reality and virtual world environments.

### Stephen Goss

Stephen Goss, PhD, is a Lecturer in Counselling at the University of Abertay Dundee, UK. He has been involved in counselling and psychotherapy for over twenty years and has been publishing on uses of technology within that field since 1999. He co-edited *Evidence based Practice in Counselling and Psychotherapy* (Routledge, 2000) and *Technology in Counselling and Psychotherapy: a Practitioners Guide* (Palgrave, 2003) and has written a number of book chapters, conference and journal papers, articles and research reports. His other professional interests include research methodology, pluralism in the practice and study of counselling and psychotherapy and innovative practice methods.

### Kate Anthony

Kate Anthony, MSc runs [OnlineCounsellors.co.uk](http://OnlineCounsellors.co.uk), a training company for mental health practitioners who wish to work with clients online, and is joint-CEO of the Online Therapy Institute ([www.onlinetherapyinstitute.com](http://www.onlinetherapyinstitute.com)). She is the author of several articles and chapters on the use of email, bulletin boards, IRC, videoconferencing, stand-alone software and more radical innovative use of technology within therapeutic practice, such as virtual reality. She co-authored the 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> Editions of the BACP *Guidelines for Online Counselling, Psychotherapy and Supervision*. She presents at an international level at conferences and is co-editor of *Technology in Counselling and Psychotherapy: a Practitioners Guide* (2003) and *The Impact of Technology in Mental Health* (2009). She is co-author of *Online Therapy* (2009) and *Clinical Supervision in Mental Health: Best Practice for Online Applications* (in press). She is Past-President and Fellow of the International Society for Mental Health Online, and Fellow of the British Association for Counselling and Psychotherapy.

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### Introduction

Technology has been utilized to enhance clinical supervision – to some extent at least - for several decades. While we will offer a cursory overview of assistive technologies that have been in the counsellor educator mainstream for some time, our primary focus will address clinical supervision that is delivered via technology developed largely since the late 1980s and early 1990s. In short, we will move past what by now may be considered traditional uses of technology in supervision to more advanced ways in which technology can be utilized to deliver clinical supervision.

### Technology Assisted Supervision

Transcription, tape recorders, “Bug-in-the-Ear”, audio-visual recordings, and video-taping are all terms that, historically, have encompassed the use of technology in supervision. For instance, we have used one form of technology or another to capture verbatim transcripts or other recordings of counselling sessions for later review by supervisors. Transcription is still used in clinical and university settings to capture the actual interview or counselling session. So much can be processed and discussed with the actual transcript in hand. Studies (e.g. Arthur & Gfroerer, 2002) have supported the use of transcription as a method for feedback during supervision. The actual session is transcribed through transcription apparatus or word processing. Thus, the spoken word is captured and can be analysed for content and

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therapeutic style, and even pauses are accounted for in the transcript. The use of technology for transcription purposes has been in place for decades.

Along with transcription devices, audio and visual technological assistance can be used to capture para-linguistic cues. Historically this has been accomplished by using a tape recorder or by what may now seem like even more archaic technology such as phonographic disks. As long ago as 1942, when record players were still something of a rarity, Carl Rogers noted with enthusiasm the (then) remarkable benefits of being able to actually hear the words and tone used by both counsellor and client in sessions:

“These recorded interviews have proven extremely valuable in the training of advanced students... they give a vivid and clear-cut picture of various client attitudes which is much more meaningful than anything the counselor can obtain through abstract descriptions... Probably the most significant use of our recordings is in the process of supervision. It is the unanimous testimony of counselors that they have gained a great deal and have been able to correct many mistakes ... [allowing] the inexperienced and experienced counselor alike a new understanding of the therapeutic process.’ (Rogers, 1942, pp. 429-431).

Rogers concluded that, “the use of these relatively new mechanical devices provides for the first time a sound basis for the investigation of therapeutic processes, and the teaching and improvement of therapeutic techniques. Therapy need no longer be vague, therapeutic skill need no longer be an intuitive gift” (p.434).

Today we use digital technology to record such ‘priceless raw material’ (Rogers, 1942, p. 431) and have a plethora of technologies from which to choose, all of which are far simpler to use than acetate covered metal disks. With the advent of video recorders, we have added visual components as well. In most cases, transcription and audio/visual recording can be used to capture the supervisee’s session with a client and afterwards, the written word and/or the audio/visual recording can be used in clinical supervision to discuss the supervisee’s abilities, strengths and areas requiring improvement. With the advent of video CD, DVD or hard disk, instant review is available. The use of technology has allowed supervisors to guide and teach supervisees in ways that were not possible decades ago. Properly used, technology can add to the supervisor’s skill set and enhance his or her theoretical orientation. The supervisor who is guided by theory should use adjunctive technology such as videotaping in a purposeful manner (Pelling & Renard, 1999) and in such a way as not to interrupt the rich process between supervisor and supervisee.

Recordings of therapy sessions, and supervisory ones, allow detailed analysis of critical moments in the process. Since the excitement surrounding audio recording noted in 1942, specialist supervisory techniques have been developed extending the depth and detail available to practitioners. An example is Interpersonal Process

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Recall (IPR) (Kagan, 1980; Gimmestad and Greenwood, 1974), a recording based technique that has in itself led to significant enhancements of the supervisory process and, in research settings, notable refinements of our understanding of even the most fundamental elements of counsellor competence, such as the meaning of congruence or transparency (Grafanaki and McLeod, 2002; Grafanaki, 2003). IPR requires counsellor and client, or supervisor and supervisee, to revisit critical moments in their sessions by reviewing video or audio recordings. The supervisor's role is to function as a source of support and expertise to both parties by inquiring about their experience and facilitating their exploration and description of each moment or segment of a session selected for in-depth examination. As a result of what Kagan (1980) identified as a tendency among counsellors to be overly diplomatic, their unassisted account of their work may be incomplete or inaccurate whether through behaving as though they had not properly understood the depth of implications in client statements by 'feigning clinical naivety' so as to avoid areas towards which they are aversive, or simply by 'tuning out', which Cashwell (2001) describes as being the result of the counsellor becoming 'engrossed in their own thought process [while] trying to decide what to do next. The result is that the counsellor misses messages from the client, some of which may seem obvious to the supervisor' (p. 1) when reviewing the recorded session. Although now very familiar to many counsellors and supervisors, and well established, such extensions of supervision, that would otherwise rely on the practitioner's more or less biased or selective clinical memory, have proved highly effective in extending and enhancing the process of learning from clinical experience that is the basis of supervisory work. The relative objectivity achievable through any systematic use of audio or video recordings offers a clear advantage.

### **Enhancing Use of Video and Audio through Analytical and Research Software**

Increasingly, software tools have been developed that allow analysis of audio or recordings of sessions in more sophisticated ways than simply watching or listening to them as they occurred. Despite being primarily intended and developed for research purposes, tools such as NVIVO (Richards, 1999, Walsh 2003) allow supervisors and supervisees to take on a more sophisticated role as investigators of clinical practice. Audio or video recordings of sessions can be replayed while a transcript and annotations scroll by on screen synchronised with the recording as it plays. Once segments of the session have been coded according to content, affective expression or, indeed, to highlight any other features of particular interest, specific sections can not only be retrieved for targeted review, but also similarly coded sections of other recordings can be collated and their themes and characteristics studied at whatever level of detail may be required.

Thus, a counsellor or supervisor could readily examine the practitioners' habitual responses to, say, expressions of anger or aggression, discussions of

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specific family dynamics, examples of transference/counter-transference, interpersonal processes or problematic emotional expression and so on. Where aspects of practice have been identified as requiring particular attention, it is a relatively straightforward, if time consuming, process to build a library of recorded segments for comparison and more detailed review and to demonstrate developing counsellor competence over time. In this way, the benefits of supervision can be extended well beyond the time available for direct contact between supervisor and supervisee.

This is, perhaps, especially appropriate for trainee counsellors who may be expected to invest more time in examining aspects of their work in detail whether in preparation for supervision sessions, or to examine problematic areas of practice or particular aptitudes and successes. However, there is perhaps much potential in their use for qualified practitioners as a routine part of their continuing professional development.

As software becomes both more readily available, less costly and easier to use, this kind of detailed processing of sessions becomes increasingly accessible for practitioners as an extension of their practice as a matter of routine, wherever supervisory or developmental needs warrant the time and effort involved. Tools such as VideoPaper (Concord Consortium, 2005) are now available free of charge, and while affording less sophisticated analysis than programs developed for research purposes their relative ease of use makes them commensurately more readily used by non-specialists, requiring very little more expertise than a word processor. Such applications have been used in counsellor training with some notable successes (Trahar, 2008) and can be readily applied in supervisory settings throughout a practitioner's career.

### **Extending Direct Observation**

While observation of practice is commonplace in training settings, direct access to counselling sessions in routine practice is generally both impractical and in many circumstances may be considered unacceptably intrusive. However, where it is appropriate, it is not necessary for an observer to remain in the same room with counsellor and client, immensely reducing the impact of such observation. Originally, supervision methods using technology involved the use of two-way mirrors to view the supervision session while the supervisor wore headphones to listen actively. The supervisor intervened by knocking on the door. The supervisee answered the door, received the verbal input and implemented the strategy with the client. This technique has been enhanced with what is known as "bug-in-the ear" technology, involving more advanced headsets and transmitters for both the supervisor and the supervisee. This has allowed for better continuity during the session and does not alert the client to the supervisor's immediate presence (Borders & Brown, 2005).

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Miller, Miller and Evans (2002) summarize another form of technology that is used during live monitoring of the counselling session known as BITE or “bug-in-the-eye.” This computer equipment is used to provide instant feedback during the session. A computer is located two to three feet from the supervisee and another computer is available to the supervisor who is in another room. When the supervisor desires to interject a comment or suggestion, he/she uses text that appears on the supervisee’s computer and is not visible to the client. Budget constraints have caused universities to avoid costly BITE systems, but today a similar process could be simulated utilizing encrypted instant messaging between the supervisor and supervisee. The supervisee would place the computer screen at such an angle so that the client could not view the messages coming in or use a privacy screen that would not allow viewing of the text on the screen from different angles.

### **Delivering Clinical Supervision via Technology**

Regardless of theoretical orientation, clinical supervisors are trained first as counsellors and understand the importance of the relationship. Rapport building, trust and positive regard are universal components in establishing a counselling relationship with a client. Likewise, these components are essential in establishing the supervisory relationship as well. We will discuss several ways clinical supervision can be delivered via technology. It is important to understand that clinical supervision via technology, referred to as cybersupervision, online supervision, e-supervision and other similar terms, is not a theory or a technique, but rather delineates other pathways for the relationship to be experienced.

As a helpful framework, consider that counsellors now offer counselling and psychotherapeutic services via distance technology as either adjunct or as a stand-alone service. Counsellors may use phone, email, instant messaging, chat, videoconferencing or virtual world platforms to deliver services. The counsellor may choose one delivery method or combine several forms of technology to accommodate the client’s needs. For instance, a counsellor may see a client face-to-face and offer intermittent between-session emails. Or a counsellor may offer text-based services that are through email, instant messaging or a combination. The use of webcams has also enhanced the online counselling process. With platforms that are increasingly available and with some actually tailored to the counselling profession, secure instant messaging, document and link sharing and the sharing of digital media during a videoconferencing session is now available as part of the suite of services a counsellor may offer. These varied examples illustrate the use of technology in counselling but may certainly extend to the provision of clinical supervision as well. We will summarily discuss each method of delivery as applied to the clinical supervision relationship.

#### *Phone*

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The telephone, whether formally or not, has been used in clinical supervision and direction in many settings throughout the years. Many mental health practitioners have worked in settings whose direct or clinical supervisor was either available at regularly scheduled times or during cases requiring immediate or as-needed consultation. Mobile phones (also known as cell phones or handy phones in some parts of the world) have replaced pagers and beepers for many professionals and are used for similar purposes with regard to supervision and consultation.

Formal use of the phone for purposes of clinical supervision requires an understanding of the therapeutic and supervisory relationship without visual cues. While excellent listening skills are necessary in traditional counselling and supervision settings, the need for listening skills is heightened with the lack of visual cues. The supervisor must listen attentively without the benefit of facial expressions or body gestures that might further confirm an emotion. The tone of voice and pacing of the conversation as well as the moments of silence require more attention than traditional face-to-face settings. The ability to ask for clarification to avoid misunderstandings is essential. Creating an atmosphere that is conducive to phone conversations without the interruption of outside noises from either party's environment must be considered. The differences in the use of mobile phones versus landline phones must be understood. When the supervisor or supervisee uses mobile phones, each party may encounter differences in voice cadence and tone such as echo, tenor, buzzing and other static noises. When more than two people are on the line, as in a conference call, the same concerns may apply. It should also be considered that the same conversation via landline phones may cause different interpretations in the emotionality of the parties than when carried out on mobile telephones, not least because of the relative levels of privacy available, quality of connection and issues relating to ensuring use of telephones in circumstances appropriate to the needs of the conversation (Monk *et al.* 2004; Walsh and White, 2006). Consider also that scheduled phone calls allow for forethought and intentionality with both parties having time to prepare. Impromptu phone calls involving a crisis or immediate supervisory issue may leave the supervisor and supervisee feeling unprepared for the interaction. Being caught "off guard" may change the person's tone of voice. One party may hear an element of surprise in the other's voice. Tendencies to rush conversation or end the communication in cases of emergencies must be understood and not misinterpreted as either abrupt or casual responses to a situation.

Supervisors and Supervisees may also utilize SMS text messaging as an added form of communication using a mobile phone. While texting is often a brief form of communication, some may find the immediacy of a text message useful.

### *Email*

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Delivering clinical supervision via email is not a new concept. While many clinical settings incorporate email into traditional forms of clinical supervision, still other settings use email casually, and use this delivery method to staff cases and offer feedback to supervisees. A supervisor may see a supervisee face-to-face and add email as adjunct between supervision sessions. Adjunct emails may be used so that the supervisee can write about his or her experience in between supervision sessions. The supervisor may send additional information for the supervisee to consider via email at the close of a session. The supervisor may also utilize email as a way to check in with supervisees particularly regarding difficult cases. The use of email has become so common that most people understand email etiquette. Still, a basic understanding of the components of an email will assist both the supervisor and supervisee. All aspects of email communication should be considered. From the email subject line to the body of the email to the email closure, each part of the email has the potential to carry expression and meaning. Conveying empathy and emotion through email text using emoticons, parenthetical expression, emotional bracketing, and quoted text are but examples of the richness of communicating in this medium (Suler, 2003).

Supervisors may construct emails differently and with different purposes depending from which theoretical orientation the supervisor is operating. Email is akin to letter writing in that both parties have a chance to be reflective and think through thoughts and suppositions during the composition. Because email is an asynchronous form of communication, an immediate response should not be expected. Supervisors have an opportunity to posit questions to the supervisee and the supervisee can answer with researched or spontaneous thought.

### *Bulletin Board/Forum/Listserv*

Bulletin boards and forums are similar in set up and are usually hosted on a webpage wherein parties can log in with a user name and password. The moderator of the forum can determine who has access to it and offer a pre-screening/registration process or allow individuals to sign up at will. Listservs are similarly moderated. While forums are viewed by topic and each topic may have a thread of responses, listservs are generally delivered as an email response or as a group of responses at the end of the day. Preferences for either forums or listservs vary. Forums and listservs can be useful to the clinical supervision process offering asynchronous group supervision or peer consultation. A forum can be set up to be moderated by a clinical supervisor who may choose to “screen” each post before allowing the post to appear on the forum. The supervisor may alternatively allow postings by supervisees without prior screening and intercede as necessary to redirect or correct. Most listservs have fewer moderator features.

It should be noted that with email and forums, the supervisee may have the opportunity to state in rather bold terms, what is on his or her mind; in this way, the asynchronous nature allows for emotional venting. The emotion can be released

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and the writer of the message can simply “walk away” with no expectation of an immediate response. Munro (2002) accurately refers to this phenomenon as “emotional hit and run.” The message may be particularly critical or may appear to have been written without forethought. The supervisor in turn has the opportunity to engage the supervisee in processing this material.

### *IM/Chat*

Utilizing Instant Messaging and Chat (internet relay chat) is an effective way to process clinical supervision issues either as a stand-alone experience or as adjunct to face-to-face supervision and/or other technology delivery methods. Supervisors can schedule formal sessions with supervisees weekly, replicating the typical clinical supervision hour familiar in most face-to-face settings. Supervisors who are offering direction and supervision in an agency setting may choose to be available for immediate contact, using symbols that are offered in most chat programs to signify availability e.g. Available, Away, Busy, Do Not Disturb). Boundaries for impromptu contact should be established between the supervisor and supervisee so that a clear understanding exists regarding the need for immediate contact. Supervisees, with the proper established boundaries, may experience comfort knowing their supervisor is accessible regardless of the supervisee’s intent or need to make immediate contact.

IM/Chat is synchronous, occurring in real time. The tendency for the supervisee to use text for emotional venting as with asynchronous forms of communication is less likely. Still, the lack of visual and auditory cues may prompt a supervisee to state information of a personal nature that is not relevant or that might be more detailed than he or she would ordinarily share in a face-to-face session. The supervisor should be aware of this possibility and assist the supervisee in remaining focused on issues pertaining to clients and the therapeutic work setting.

Similar to the use of phone, IM/Chat can be different than face-to-face sessions in terms of pacing and moments of silence. While many IM/Chat programs offer a prompt that alerts the person that a response is forthcoming (e.g. *Sally is typing a response...*) other programs do not offer a textual cue to alert that the person is typing. Silences should be expected and, with proper pacing, addressed. In the context of a therapeutic chat session, the supervisee might benefit from the use of emotional bracketing to describe to the supervisor what feelings have been evoked during the clinical supervision session. This technique is certainly beneficial during psychoanalytic/psychodynamic supervisory sessions.

### *Videoconferencing/Webcam*

Videoconferencing as a supervision training tool is being utilized in counsellor education programs and other allied health programs to enhance clinical insight. When visual and paralinguistic tools are considered necessary, the use of videoconferencing for group or individual supervision is a viable alternative. Many Nagel, D.M., Goss, S. & Anthony, K. (2009). The use of technology in supervision. In Pelling, N., Barletta, J & Armstrong, P. (Eds.) *The Practice of Supervision*. Australian Academic Press: Australia

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formal education programs and internships require a face-to-face component and in lieu of the literal face-to-face meetings, the use of video technology can be a viable substitute. This solution also accommodates rural internship sites when face-to-face meetings are not feasible due to travel costs and time. Greater flexibility in scheduling and enhanced collaboration between the university program and the off-campus setting are also benefits (Dudding & Justice (2004).

For clinical supervisors who do not work in an educational setting, the use of webcams can be added as a way to offer supervision with a visual component. The clinical supervisor can use a webcam with a supervisee for scheduled or impromptu appointments and can combine webcam with chat and email as previously discussed.

### *Virtual Worlds*

Virtual worlds such as Second Life are being used for many purposes including entertainment, education and psychotherapy. With this in mind, it is not too difficult to imagine a clinical supervision session taking place in a virtual world.

Virtual worlds offer the ability to create a different “self” referred to as an avatar. The avatar is how a person presents themselves in the virtual world. For some people, the presentation is a representation of the person’s perceived self. For others, the avatar is a representation of how the person would wish to be perceived. To provide clinical supervision in a virtual world is to add a visual component that is enhanced by imagination. The opportunity may simply provide a visually appealing component for the supervisor and supervisee or, depending on the theoretical orientation of the supervisor, avatar supervision may add more information to the process. For instance, a supervisor may have a better understanding of the supervisee after seeing and experiencing an avatar that is based on the supervisee’s preference of perception.

Virtual world counselling and supervision offers Instant Messaging and chat and platforms like Second Life allow for blocking off a space, property or in this case, virtual office from anyone who may “teleport” to the location. Additionally, proprietary software exists to allow for higher levels of secure communication. The supervisor’s office can be created in the likeness of the supervisor’s real life office, or the supervisor can create a different ambiance with the option of offering educational materials and web links inworld.

### **Considerations for the use of Technology in Supervision**

#### *Review of Current Standards*

In 2001, the British Association for Counselling and Psychotherapy (BACP) published their first *Guidelines for Online Counselling and Psychotherapy* (Goss et al, 2001). In 2005 these were updated to include guidance for online supervision

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(Anthony and Jamieson, 2005) and further updated these with a 3<sup>rd</sup> edition after only another four years (Anthony and Goss, 2009). While the pace of change in the uses of technology in supervision and therapy is likely to continue to require such relatively frequent redrawing of ethical guidance, at the time of writing, the authors are unaware of any other formal standards, guidelines or ethical codes related to online clinical supervision.

In the USA, the National Board of Certified Counselors (NBCC) has created a document that contains a statement of principles for guiding the evolving practice of Internet counselling, and offers a certification designation of Approved Clinical Supervisor (ACS) with its own code of ethics – however - neither document addresses specific ethical issues related to online supervision.

Also applicable in the US, the National Association of Social Workers and the Association of Social Work Boards (2005) has developed standards for the use of technology in social work practice. This document briefly addresses supervision issues regarding acquired technological skill through supervision or consultation and awareness of pertinent laws which may restrict or allow the use of technology.

The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association, has established a Code of Ethics but reference is not made to technology or online supervision. ACES has however, established Technical Competencies for Counselor Education with the latest revision completed in 2007 by the Technology Interest Network.

These are but three examples of various organizations that, while addressing clinical supervision and technology, have not yet addressed the delivery of clinical supervision via technology with formal standards, guidelines or codes of ethics.

### *Contracting/Informed Consent*

Anthony and Goss (2009) address the following issues warranting negotiation in the contracting/informed consent process.

- Various methods of delivery exist and the mode of communication should be agreed upon prior to beginning supervision.
- Technical breakdowns, while not common, are unavoidable. Therefore, clearly established steps should be implemented when technological glitches occur.
- Boundaries regarding scheduling of sessions and immediate availability should be established.
- Record keeping methods including storage and disposal should be stated.

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- Misunderstandings are inevitable and the contract should state how misunderstandings will be negotiated.
- Clearly established rules and sanctions for group supervision should be stated in the contract.

Confidentiality should be addressed and specifics related to the use of technology should extend to the client of the supervisee. While the supervisee may not be utilizing technology with his or her client, the client has a right to be informed about whether or not case details will be discussed with a supervisor via distance technology applications. As reflected in the new BACP guidelines and later in this chapter, encryption or equivalent levels of security should be incorporated into transmission of communication via the internet. In addition, supervisors should also be aware of confidentiality issues when using mobile phones for conversation or SMS texting.

### *Ethical/Legal Concerns*

Clinical Supervisors must practice within their realm of expertise. The primary purpose for clinical supervision is to teach, assist and mentor a mental health practitioner who requires guidance in order to provide the best standard of care to his or her clients. If the clinical supervision process is one that is fraught with technological glitches, pauses and general unease due to a lack of proficiency, the richness of the supervisory process will be lost. It is incumbent upon the supervisor to ensure that the supervisor and the supervisee possess the competencies necessary to engage in online clinical supervision. Following such standards as the aforementioned Technical Competencies for Counselor Education assures that within college and university settings, supervisors and supervisees have an expected level of competency with regard to the use of technology. These competencies will be discussed later in this chapter.

In addition to competency and proficiency with the technology, Dudding and Justice (2004) suggest that issues related to portability, versatility, ease of use, and cost effectiveness should be addressed. By attending to these concerns prior to implementing technology into the supervision process, the integrity of clinical supervision and the quality of care to the client can be maintained.

Beyond ease of use, other ethical concerns relate to the authentication of the supervisor and supervisee. If the supervisor is practicing in a university setting this issue may not be as relevant but for independent clinical supervisors who may practice with people with whom a face-to-face relationship has not been established, authentication of identity is paramount. Likewise, the supervisee should be able to verify the supervisor's credentials and experience (Anthony & Goss, 2009). Supervisors can provide information on their websites that delineate experience by posting a *curriculum vitae* and providing links to credentialing and licensing bodies.

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Supervisors can verify a supervisee's identity by asking for a copy of school transcripts, a driver's license number and other information during the informed consent and contractual process.

Consideration should be given to the supervisor's licensing laws and scope of practice. Laws may dictate who may provide clinical supervision in certain jurisdictions. Along with legal concerns and risk management, supervisors should consider carrying liability (malpractice) insurance and inquire with the insurance provider about coverage when the service is delivered via technology.

### *Encryption/Confidentiality*

In supervision, training and counsellor education, we have become accustomed to "blinding the record"; ensuring that identifying information is revealed on a "need to know" basis. Clinical supervisors may discuss cases with other peer professionals. During group supervision and supervisees may come from various and different clinical settings to discuss cases. Most group supervision practice involves the understanding that case information is to remain confidential. The same concept applies to supervision delivered via technology. Encrypted services should be considered for all clinical supervision sessions involving the technology discussed within this chapter. Encryption, while not required by any set of laws, has been incorporated into guidelines and codes of ethics as best practice regarding the transmission of confidential client information. If encryption is not possible and provided your code of ethics allows for exceptions, the lack of encryption and risk to confidentiality should be made a component of the informed consent process.

### *Verbatim Material*

Verbatim written records of counselling or supervision sessions can be generated by transcription or from email, chat or other text-based forms of distance provision (Goss and Anthony, 2003 and 2009; Anthony, 2003; Chechele and Stoffle, 2003; Colon and Friedman, 2003). The ease with which records of any kind can be copied, distributed and re-distributed simultaneously opens the possibility of consulting for routine supervision or to access specialist expertise across any distance. However, there is a significantly increased need to pay attention to data protection issues and issues of confidentiality. Such detailed records must, of course, be treated with immense care and their creation brings clear risks and responsibilities for those affected. Transmission of any verbatim records, even when carefully and thoroughly anonymised, must always preserve privacy for both client and counsellor and any others directly related to the matter under discussion and, indeed, the supervisor where relevant. It is essential, for example, that any records sent over the Internet are securely encrypted. Now that encryption software is widely available, can be free of charge and is easy to use (see Hushmail.com, for example), this should be considered a basic and required extension of the usual ethical requirement to protect the content of therapy from unwarranted intrusion. Failing to

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take sufficient measures to protect confidentiality may now be considered a basic lapse in the ethical judgement of the practitioner or supervisor. Ruled out, for example, is the use of publicly accessible or unencrypted websites, blogs, chat or email for detailed case discussion or supervision, just as it does for the provision of distance counselling itself.

Nonetheless, the potential value of verbatim records of therapeutic encounters should not be underestimated. The same applies, of course, to supervisory relationships conducted via any text-based means. Given suitable protection, it is possible for a supervisor to have access to the entire content of the therapeutic process. Both client and counsellor, or supervisor and supervisee, can readily review whole therapy or supervision sessions. The verbatim record can also be subjected to detailed textual analysis. A number of methods exist for this, often developed originally for qualitative research purposes, from grounded theory (Glaser and Strauss, 1967, Strauss and Corbin, 1990; Glaser, 1992, Mey and Muck 2007) to stanza analysis (Gee, 1986; 1991; 2005, McLeod, 2001) to narrative techniques (McLeod, 1997; Angus and McLeod, 2004). The potential utility of such analysis, whether relatively straightforward and impressionistic or more detailed and sophisticated, suggests that there is much that could be gained by individual practitioners willing to invest the time required and, by extension, for supervision and the counselling profession as a whole, especially where themes in case material can be collated and generalised conclusions drawn. Text-based therapy and supervision could open up whole new areas of research as well as increasing the level of oversight of practice available.

With the advent of technology and the ability of the supervisee to access actual verbatim material such as chat transcripts and emails, the supervisor is well advised that ownership of the clinical record be stated clearly in the informed consent process. This ownership agreement applies to client/therapist relationships as well. An example of the ownership inclusion is provided here:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Likewise, you are expected to keep our communications confidential and you understand that all records of communication between [CLIENT/THERAPIST or SUPERVISOR/SUPERVISEE] remain the property of [NAME OF THERAPIST OR SUPERVISEE]...I make every effort to keep all information confidential. Likewise, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. I encourage you to only communicate through a computer that you know is safe i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counselling sessions and emails...Due to the nature of the therapeutic process and the

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fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings...neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or any other proceeding, nor will disclosure of the psychotherapy records be requested...

(excerpted from [www.deeannamerznagel.com](http://www.deeannamerznagel.com))

By including such provisions in the informed consent process, the supervisee gains an understanding about the importance of guarding the client record; verbatim material is less likely to be carelessly used in litigation and the client's confidentiality is maintained. It is advised that counsellors and supervisors check with a legal authority within their country or jurisdiction to determine the applicability of such a clause as stated above.

### *Transference/Countertransference*

Transference/Counter-transference issues that develop during clinical supervision are often the sentinel moments supervisors and supervisees reflect upon. These moments are no less pivotal when they occur via distance using technology. One must first embrace the concept that the modalities we have discussed in this chapter all hold different but powerful characteristics and possibilities. Certainly text-based clinical supervision is different than clinical supervision that takes place via phone or videoconference. Synchronous versus asynchronous supervision engage the supervisor and supervisee in different ways. However different each delivery method may be, transference/counter-transference issues are no less remarkable, offering to the supervisory relationship an opportunity for growth and exploration. Fenichel (Goss & Anthony, 2003) relates as myth the idea that one cannot or does not develop strong feelings in online therapeutic relationships much like traditional transference and countertransference relationships.

The disinhibition effect should be considered as an influence to the transference and counter-transference processes that occur in online supervisory relationships. The disinhibition effect can occur in both therapeutic and non-therapeutic relationships particularly with text-based communication. While the following is a rather condensed summary of a complex theory (Munro, 2002; Suler, 2004), one can begin to appreciate the different subtleties that might even magnify transference/countertransference issues seen in face-to-face supervisory relationships.

- While the parties may be known to each other, without visual and/or auditory cues, a sense of anonymity still exists.
- Without paralinguistic cues, one can feel invisible, with no worry of how a facial expression or tone of voice may be interpreted.

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- With asynchronous communication, either party can state a feeling in the moment with no regard for what the immediate response might be.
- Without sensory cues, either party may begin to imagine the relationship as occurring inside one's head or imagining the relationship as unreal.
- When parties communicate online, a neutrality exists, with no perceived hierarchy.
- Personality tendencies and communication styles may be enhanced online via text-based communication.

As with online counselling, pacing, moments of silence, use of netiquette, emoticons and avatars, as well as how different forms of technology are combined will effect the supervisory relationship. How issues are interpreted, and how the supervisor perceives the supervisee and likewise, the supervisee perceives the supervisor are also considerations.

### **Suitability of the Supervisor**

#### *Technical Competencies*

The Association for Counselor Education and Supervision's Technical Competencies for Counselor Education (Jencius, Poynton & Patrick, 2007) includes twelve competencies that students and counsellor educators should possess. These competencies are reasonable expectations for students and educators who are working within a college/university setting that allows for acquisition of these skills. In summary, technological expectations are as follows:

- Ability to use productivity software to develop web pages, word processing documents, databases, spreadsheets and other forms of documentation.
- Ability to use audiovisual equipment such as video recorders, audio recorders, projection equipment and video conferencing equipment.
- Ability to acquire, use and develop multimedia software for use in presentations, training and practice.
- Ability to use statistical software to organize and analyse data.
- Ability to use computerized and/or internet-based testing, diagnostic, and career decision-making programs with clients.
- Ability to use email.
- Ability to help clients search for and evaluate various types of counselling-related information via the Internet.

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- Ability to subscribe, participate in, and sign off related listservs and other Internet based professional communication applications.
- Ability to access and use counselling-related research databases.
- Ability to use the Internet to locate, evaluate and use continuing education, professional development and supervision options in counselling.
- Ability to perform basic computer operation and maintenance tasks.
- Knowledge of legal, ethical and efficacy issues associated with the delivery of counselling services via the Internet.

These competencies help ensure that counsellor educators and mental health practitioners in training possess the necessary skills to enhance their ability to assist clients in this technological age. With these competencies as the foundation, additional skills can be developed. As we have discussed, each form of distance technology comes with its own set of nuances from text without paralinguistic cues, to differences in synchronous and asynchronous communication, to the subtleties of combining different forms of technology. Additional training and education will aid the clinical supervisor in determining which form of distance technology best suits a certain work setting, theory or supervisee. As with online counsellors, online supervisors may choose to limit their area of expertise to a certain form method and style of delivery.

### *Training and Education*

Training of clinical supervisors varies from country to country. In the United Kingdom, training and a qualification is required to become an accredited Supervisor with BACP, which also applies to becoming an accredited counsellor via a counselling course. In Australia all practising counsellors registered with the Australian Counselling Association (ACA) and the Psychotherapist and Counselling Federation of Australia (PACFA) are required to undergo ongoing clinical supervision to maintain their registration. In regard to supervisor registration, ACA has the only register for counsellor/psychotherapist supervisors in Australia. ACA requires all its registered supervisors to meet Clinical membership requirements and to have undergone formal supervision training through an ACA approved supervisors course. PACFA do not have a register for supervisors nor do they have any set standards for supervisors at this time. In the United States, uniform methods of training clinical supervisors do not exist in most of the counselling disciplines (Falvey, 2001). For instance, most licensed mental health practitioners are authorized to provide clinical supervision under his/her scope of practice. Some states require that the clinician who offers clinical supervision has held a license for an average of three years but not necessarily with any additional training. Theories and methods of clinical supervision vary across disciplines as well.

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With regard to the use of technology in supervision, when determining whether a requirement for additional training and education should exist, we should look to our codes of ethics as our standard for best practice. Most codes of ethics offer guidelines to practitioners stating that therapeutic services should only be rendered if the practitioner has the appropriate training and level of competence in a particular practice area. One might extend this concept to all areas of clinical supervision, including the use of technology. Nagel (Malone, Miller & Walz, 2007) suggests key components to becoming a seasoned distance counsellor. These components, slightly modified, may be extended to the concept of becoming seasoned as a clinical supervisor who uses technology:

- Acquire knowledge, both rudimentary and advanced, via formal training such as continuing education courses offered face-to-face and online), professional journals and other written materials.
- Integrate existing knowledge and skills with newly acquired knowledge and skills.
- Consider ongoing clinical supervision, peer supervision, or case consultation.
- Join organizations that offer peer support and/or disseminate new knowledge and advances in the use of Technology and Supervision.
- Once skill and experience are acquired, contribute to the field of clinical supervision about the use of technology by mentoring other supervisors, adding to the existing body of quantitative and qualitative literature, and educating licensing boards, legislative bodies and counsellor educators in university settings.

### *Other Suitability Considerations*

Use of technology to provide counselling or counselling supervision raises great opportunities for those with the skills to make use of the opportunity it affords. However, it is not always suitable for all practitioners and some important caveats will generally apply to their use.

Firstly, it is essential that sufficient training is undertaken to ensure that the pitfalls that exist for the unwary (such as the disinhibition effect, the potential damage of misunderstandings, and issues of acting out, etc) are avoided, and training programmes are available through websites such as [www.onlinecounsellors.co.uk](http://www.onlinecounsellors.co.uk) or [www.onlinetherapyinstitute.com](http://www.onlinetherapyinstitute.com).

All but the most established forms of technology are notorious for their potential to fail at least until they are sufficiently familiar and their use routine (Adams, 1999) and sufficient technical knowledge must exist on both sides of the

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relationship to ensure that both parties can make adequate use of it and that troubleshooting, for example where the technology fails and connection is lost, can be offered by the supervisor. Alternative means of contact should be available in such circumstances and local support for use in emergency situations is as important as in any clinical situation. Some case work requires particularly close supervision and consideration should always be given to the adequacy of the supervisory relationship that can be provided. It is also worth noting that, at present, much research remains to be done to establish clearly the limitations of at least the more novel forms of technological enhancements of routine supervisory practice. However, this is far from suggesting that supervision provided via any technological interface is less likely to be adequate than face-to-face consultation. Indeed there are likely to be distinct advantages, not least from the supervisory equivalent of disinhibition and the advantages of being afforded opportunities for both parties to reflect on their communications in detail, which would suggest that counsellors might be more willing to discuss the more problematic areas of their work when consulting at a distance.

### Conclusion

Technological developments will, inevitably, continue to occur. Despite the skills and insights of those specialising in the study of the future of innovation predicting the direction that these will lead us in, they will always be, to some extent, uncertain. What is obvious already, however, is that existing technologies have the potential to extend significantly the benefits of supervision for practitioners of all forms of counselling. With the caution appropriate for all innovations in clinical practice and support we can expect continued progression in the value, use and acceptance of technology in providing for the support and development needs of counselling practitioners.

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## Educational Questions & Activities

**Question 1. What level of specialist training and experience in online relating and online therapy is necessary in order to offer supervision online, whether for online therapy or face to face? Readers may wish to reflect on which forms of technology they would be comfortable using for supervision or other clinical applications.**

- a. It is an ethical requirement that anyone offering online therapy receives suitable and sufficiently in-depth training in order to equip them to do so. The same is true for offering online supervision. It is essential that both therapists and their supervisors are aware of the issues involved in online relating in general and online therapy in particular, including the issues particular to the modality used, such as disinhibition when working with text-only formats. Online work is **not** a specialism that is recommended for inexperienced practitioners at any level, especially those in training, and competence in face to face work must be assured before progressing to translating the practitioner's skills to the online environment. Furthermore, it must then be remembered that competence in one medium does not necessarily indicate competence in another. For example, communication via face to face modalities draws on verbal and non-verbal social communication skills whereas online work requires a more literary aptitude such as the ability to communicate with clarity in order to avoid misunderstandings while retaining the natural expression and spontaneity of any other form of communication. Specialist post-qualification training for online supervision should be sought wherever available. Further advice is available through a number of websites such as [www.onlinetherapyinstitute.com](http://www.onlinetherapyinstitute.com).

**Question 2. What concerns are there for therapists and supervisors in maintaining an online presence in social or professional networking facilities?**

- a. Social and professional networking facilities can be an excellent way of maintaining and creating relationships online. However, practitioners should be aware that their friends and acquaintances, or indeed their colleagues or clients, may post material or comments about them without their consent or control that will be visible by clients, supervisees and others online and that may be open to interpretations that they would not want. Mental Health practitioners should ensure

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that all their activities online are consistent with the professional persona they wish to project and that they may need to remind others of the importance of this. It is especially important to ensure that when contracting for online supervision (or therapy) that the supervisee (or client) is aware that the content of sessions should be treated as confidential, probably remaining the property of the practitioner offering the service. For example, while it can be entirely appropriate to write blog entries regarding one's experiences of supervisions or in therapy in general, any specific or identifiable reference to any individual (including those providing services as well as their clientele) should be avoided. You may also wish to consider what other boundary issues arise in online supervision.

**Question 3. What back up procedures should be in place for use in the event of technological breakdown or crisis/emergency situations and who is responsible for ensuring that they are adequate?**

- a. A back up system is required for when either person's computer crashes, or one or both parties lose their Internet connection, or the online tool being used fails during supervision. In such an eventuality, or if for any other reason either party to online supervision using synchronous communication tools loses their connection during the course of the meeting, there should be a pre-agreed procedure for re-connecting/rescheduling the meeting, for example the other party might wait five minutes for a reconnection to happen, and then use a telephone call or mobile text message in order to assess the problem and reschedule the meeting while any technology problems are addressed and rectified. It should be the supervisors responsibility for ensuring the systems are adequate and understood as part of the contracting process.

**Question 4. i) Is online supervision important for online therapy provision?**

- a. There is ongoing debate as to whether online supervision should be a requirement for online work, or whether face-to-face supervision would be preferable in giving a wider perspective of the issues and therapeutic process.

**Question 5. What issues arise in cutting and pasting client material from online sessions for the purposes of supervision and what safeguards are required?**

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- a. Supervisors and supervisees should agree whether and how communications will be stored or logged. Communications of any sort should not be forwarded, Cc'd (courtesy copied) or Bcc'd (blind courtesy copied) to anyone, either in their entirety or in part, without the explicit consent of all those involved in that communication. If consent for use of communications is obtained for supervision purposes, the safeguards that should be in place should be at least the use of passwords and encryption, the latter of which must be used whenever information not suitable for the public domain (eg details of any casework not in a form suitable for publication) are communicated over the Internet by any means.

### Selected Internet Resources

#### Online Therapy Institute

- [www.onlinetherapyinstitute.com](http://www.onlinetherapyinstitute.com)
  - designed for individuals and organizations who wish to enrich their knowledge about online counseling, clinical supervision and the impact of technology on mental health. Topics and issues of interest extend to internet and cybersex addictions, gaming, virtual worlds, social networking, SMS texting and online peer support.

#### DeeAnna Merz Nagel

- [www.deeannamerznagel.com](http://www.deeannamerznagel.com)
  - Clinical supervision and consultancy available regarding online counselling and the impact of technology on mental health.

#### OnlineCounsellors.co.uk

- [www.OnlineCounsellors.co.uk](http://www.OnlineCounsellors.co.uk) and [www.KateAnthony.co.uk](http://www.KateAnthony.co.uk)
  - offers training and consultancy on online counselling and online supervision
  - designed for clinicians and organisations who wish to enrich their knowledge about the impact of technology on mental health.

#### International Society For Mental Health Online

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- ISMHO.net
  - a multi-disciplinary association of students, teachers, researchers, clinical practitioners, online mental health professionals and other people interested in the field of mental health who meet online to discuss current issues in the field.

## References Related to the Internet & Psychology

- <http://construct.haifa.ac.il/~azy/refindx.htm>
  - Annotated references related to the internet and psychology.

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