

Webconference Supervision for Advanced Psychotherapy Training

Webconference Supervision for Advanced Psychotherapy Training: A Practical Guide

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Abstract

The advent of readily accessible, inexpensive webconferencing applications has opened the door for distance psychotherapy supervision using video recordings of treated clients. Although relatively new, this method of supervision is advantageous given the ease of use and low cost of various Internet applications. This method allows periodic supervision from point to point around the world with no travel costs and no long gaps between direct training contacts. Webconferencing permits face-to-face training so the learner and supervisor can read each other's emotional responses while reviewing case material. It allows group learning from direct supervision to complement local peer-to-peer learning methods. In this article we describe the relevant literature on this type of learning method, the practical points in its utilization, its limitations and its benefits.

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Introduction

Supervision is essential to developing professional competencies and maintaining standards for mental health professionals (Bernard & Goodyear, 2009). However, the distance between supervisors and supervisees can limit access to training (Buist, Coma, Silvas, & Burrows, 2000). Others may struggle to access these resources due to travel costs and disruption to work commitments.

Although the earliest form of distance supervision likely involved written correspondence between Freud and his colleagues (Gay, 1998), more modern distance supervision approaches relied on the telephone, which limited communication to verbal dialogue and excluded the benefit of visual cues and subtleties (Wetchler, Trepper, McCollum, & Nelson, 1993). Email increased the ease of distance communication, yet there was considerable room for error and miscommunication with only the written word available and no access to subtle communication of speech and body language (Watson, 2003).

More recently, e-Learning tools (e.g., discussion forums, text-chat) available within learning management systems (e.g. Blackboard ®) have also been used for distance supervision. There is some evidence to support these real-time methods. In their investigation of the efficacy of a 12-week, online text-chat, peer supervision group for school counsellor trainees, Butler and Constantine (2006) found that the trainees who participated in the web-based group reported significantly higher collective self esteem (i.e. positive feelings in identifying as a school counsellor) and case conceptualization skills than did their counterparts who did not participate in web-based

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supervision. Conn, Roberts and Powell (2009) examined the relationship between type of supervision (i.e., a hybrid model of face-to-face supervision [F2FS] and online text-chat, compared with F2FS only) and attitudes toward technology, future use of technology in professional practice, and the quality of supervision among a sample of school counselling interns. They found that the use of the hybrid model of supervision was positively related to attitudes toward use of technology in counsellor education, and the use of technology in future professional practice. They further found that perceptions of supervisory rapport and of client focus did not differ between the hybrid group and the F2FS group. Additionally, satisfaction with the supervisory experience did not differ for students in the hybrid model of supervision and the F2FS group. Finally, they found that use of the hybrid model of supervision correlated with attitudes toward the quality of supervision, substantiating earlier research (Gammon, Sorlie, Bergvik, & Hoifodt, 1998) that a hybrid model of supervision might enhance the quality of supervision.

Although these developments in distance supervision were useful, most would agree that psychotherapy supervision is optimized when participants can communicate through speech, body language, and paralinguistic channels, particularly during advanced training (Weingardt, Cucciare, Bellotti, & Lai, 2009). Videoconferencing systems permit two or more individuals to interact simultaneously via audio and visual transmissions using dedicated telecommunication technology. Although these systems have been used in various health care settings, they typically have substantial equipment and operating costs and require significant user training and ongoing technical support (Jarvis-Selinger, Shan, Payne, Plohman, & Ho, 2008). More recently, web-based videoconferencing or webconferencing applications have become available

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for supervision to be conducted across the country or the world (Olson, Russell, & White, 2001).

Empirical basis for Videoconference or Webconference psychotherapy supervision

Studies comparing videoconference-based supervision and F2FS have predominantly focused on the supervisor and supervisee experiences. For example, Sorlie, Gammon, Bergvik and Sexton (1999) compared supervisor and supervisee experiences of both approaches. The participants were supervisor-supervisee dyads who had engaged in over 70 supervision sessions, half of which were videoconference-based. Self-report data on the quality of communication, the alliance and disturbing elements in the supervision sessions were collected from self-report questionnaires completed after each session. The researchers found no differences in the variables between the two types of supervision except on the variable defined as 'disturbance'. This variable measured 5 items such as "Supervision session was frustrating" or "Session felt distant" by questionnaire. Trainees' experience of disturbance was significantly higher in the videoconference conditions when compared to face-to-face sessions; however, supervisees' ratings on this scale diminished over the duration of the study. At the time of this study, videoconference communication often involved audio delays which affected the quality of the communication and may have contributed to the "disturbance" variable. The authors concluded that the supervisor's ability to "diminish the negative effects of 'transference' reactions to the videoconferencing

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supervision,” was probably the most decisive factor affecting quality of supervision (Sorlie et al., 1999, p. 459).

Xavier, Shepard and Goldstein (2007) investigated the effects of videoconference supervision and training provided by a supervisor in an Australian hospital, to a group of psycho-oncology staff working across various state wide clinics. Participants were provided monthly videoconference training, consisting of eight one-hour presentations, followed by a one-hour case discussion. These were supplemented with individual telephone-based supervision. Self-reported ratings revealed an increase in confidence in assessing and treating pain in people with cancer, an increase in knowledge in the field, and a 25% increase in sense of effectiveness in managing psychological distress. The authors concluded that while participants indicated videoconferencing was an effective means of supervision and training, the lack of a comparison group limited interpretability of the data.

Another group examined counseling students' experience of F2FS versus videoconference-based supervision (Reese, Aldarondo, Anderson, Lee, Miller & Burton, 2009). No differences were found in satisfaction with both the quality of supervision and the quality of the supervisory relationship between the two conditions. The students' self-efficacy in their counseling skills increased over the course of the supervision study. While they did not evaluate differences in skill improvement between F2FS and videoconference supervision, the authors concluded that trainees' supervisory needs were met via both formats. Further, they recommended videoconferencing as a viable format for supervision; however, they suggested such a format requires augmentation

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by occasional in-person contact to maintain the emotional connection in the supervisory relationship (Reese et al., 2009).

Our survey of the literature leads us to concur with Hailey, Ohinma, & Roine (2009) that there has been limited research evaluating videoconference psychotherapy supervision, especially as it relates to efficacy and client-based outcomes. For example, the available evidence does not clearly indicate whether the format impacts clinical outcomes, which frequency is optimal (e.g., monthly, weekly, quarterly) or which dosage (e.g., number of hours each time) is most effective.

Technical and Practical Issues in Applying Webconference Supervision

We will describe one approach we use to conduct webconference supervision that has minimal technical and financial demands. Our goal is to provide a basic guide to key features of this mode of supervision rather than to promote any particular technological system.

Video recording of treatment sessions

A core feature of our particular supervision approach is the review of psychotherapy session video recordings. The treatment method we study, Intensive Short-term Dynamic Psychotherapy (ISTDP, Davanloo, 2000) emphasizes moment-to-moment examination of somatic experience of emotions, anxiety discharge pathways, and verbal and non-verbal defenses against emotions. Thus, this method and other emotion-focused treatments are taught, researched and supervised through the use of video recording and review (Said, 2000, Abbass, 2004). An inexpensive recording setup can capture the client-therapist interaction by simply positioning a mirror behind or

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beside the client, who sits facing the therapist and video camera; the image of the therapist is captured through the reflection in the mirror. The overall cost of this basic recording set up is below \$1000 USD. Alternatively, split-screen software using separate cameras presents a more expensive option to capture therapist and client events. Either option provides adequate recordings of therapist-client activities for supervision purposes.

Selecting a Webconference Application

A review of all webconferencing applications is beyond the scope of this paper and of little value because of the speed with which new services continue to evolve and enter the marketplace. Some these systems include Elluminate® (<http://www.illuminate.com/>), Wimba Classroom® (http://www.wimba.com/products/wimba_classroom), GotoMeeting® (<http://www.gotomeeting.com/fec/>), Skype® (<http://www.skype.com/>) and Adobe ConnectPro®, (<http://www.adobe.com/products/acrobatconnectpro/>) with each system having slightly different features, but many similarities. The majority of these webconferencing solutions use the participants' web-browser to present the webconference content. The ability to share slides, desktops, as well as presenter/participant video, audio, and text-chat communication through the web browser requires only that the participants keep their software up-to-date. Many of these systems use Java software within the web-browser and are available for both PC and Mac operating systems however being Java based may pose challenges in hospital offices where the software is often prevented from updating due to use for supporting patient records. Adobe ConnectPro® does not use Java, and also has the benefit of

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permitting multi-site video that mimics face-to-face group meetings. For further information regarding the applications refer to the manufacturer's website listed above.

Application Set Up

The necessary components for webconferencing include a basic microphone and webcam equipped computer that is connected to the Internet. Skype® is the system we use for web-based supervision, and it provides free services such as audio-visual transmission, instant messaging, and desktop sharing. To use the Skype® application, we first downloaded the free dedicated software from the company website (Skype.com). This software includes encryption of video and audio content, therefore providing assurances for privacy and security.

Skype® currently allows for cross-platform (i.e., Windows®, Mac OS X®, Linux®) video webconferencing at no cost. Minimum computer system requirements generally include a 1 GHz processor with 512 MB RAM for the Windows® and Mac OS X® platforms used in our situation. This application requires basic broadband (high data rate transfer) Internet access. The Organisation for Economic Co-operation and Development (2008) define a connection as broadband if data transfer rates exceed 256k/bits per second (256,000 bits per second), while the United States Federal Communications Commission (2010) has recently defined "basic" broadband as having a minimum data transfer speed of 4 Mbps per second (4,000,000 bits per second) downstream (from the internet to the user's computer) and 1 Mbps per second upstream. To confirm the speed of your Broadband connection several options are available, the simplest being an online speed test at <http://www.speedtest.net/>.

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Streaming vs. Sharing Video Files

We use two methods to share the actual recordings of psychotherapy sessions during supervision. First, the live streaming approach uses the share screen function in the Skype® application that permits an individual to view the display of another individual's computer, including a DVD or video file that is being played. During a webconference call, screen sharing can be initiated via the Share button in the call window toolbar. Alternatively, go to the main application menu, open the Call menu and select Share screen. Users also have the ability to open this function within the chat window if this is open during the call. Although the live streaming approach is quite simple, it is vulnerable to slower data transmission speeds during peak usage periods on the Internet. The second approach involves playing the video file at each user location during the webconference in a synchronized manner. This requires the interview file to be sent ahead of time to the supervisor using file sharing applications, such as Apple's® iDisk (<https://www.me.com/idisk/>) and Filedropper® (<http://www.filedropper.com/>). This approach is slightly more time intensive requiring recordings to be uploaded to a secure server the day before supervision in order to allow the supervisor time to download the file to their computer. To do this, the supervisee accesses the online file host's server and uploads his or her supervision file using a web browser (e.g., Internet Explorer, Safari, etc.). Following this, the supervisee sends an email to the supervisor with the URL link and a password for access to the file. The supervisor then accesses the online file server, enters the password and clicks on the link to download the file to their computer. Typically, we reduce our file sizes using free compression software (e.g., VideoMonkey®).

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http://videomonkey.org/Video_Monkey/News/News.html or MPEG Streamclip®

<http://www.squared5.com/>) to around 350mb for a one hour video file. Instructions on how to use these applications are available at each of the links provided above.

Shrinking files to this size still allows adequate video and audio quality to clearly see and hear major aspects of the session. This approach offers a remedy for occasional internet speed difficulties (See Table 1).

Technical Support Issues

There are numerous software applications relevant to our approach to supervision, including various webconference, file sharing, video file compression, and security applications. Both the rapid pace of ongoing software innovation (e.g., version updates) and even user interface differences within some of these applications (e.g., OS X® vs. Windows® versions of Skype®) make it difficult to provide a straightforward set of explicit technical instructions that will remain relevant even in the short term. For instance, Skype® announced a major application development involving 10-user group video transmission capacity during this paper's preparation (http://blogs.skype.com/garage/2010/09/50_beta_2.html).

Nonetheless, we certainly recognize the utility in providing some practical recommendations for technical support issues given that we did not have any formal technical expertise while implementing our webconference supervision approach. First, we recommend the use of contemporary application review websites (e.g., <http://download.cnet.com/webware-apps/>; <http://www.webconferencing-test.com>) and relevant online magazines (e.g., <http://www.pcmag.com>; <http://www.macworld.com>) for general information about various applications available online. Second, we recommend

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tutorials, help or support sections, and user discussion forums found on most application websites as the primary sources of basic instruction overviews and specific troubleshooting information. Third, basic instructional videos are available on the YouTube® website (<http://www.youtube.com>) and can complement official application tutorials as a means of familiarizing oneself with programs. Fourth, we recommend conducting trial runs with all webconference participants aimed at troubleshooting any procedural or technical issues. Finally, formal information technology (IT) support is always recommended if one has ready access to these resources.

Catching the Wave

Supervision participants must establish an agreeable conference schedule that may cut across multiple times zones. In our case, a discrepancy of at least 13 hours between Melbourne, Australia and Halifax, Canada time called for flexibility. On winter mornings the frosty Canadian supervisor was often annoyed at his Aussie supervisees in shorts with “shrimps on the barbie” during their simultaneous warm summer evenings, but that all changed 6 months later! There is also an advantage to avoiding conference times that overlap with respective peaks in internet usage in order to optimize data transmission speed. We have found that 0700 to 0900 EST, before most of North America is awake, while much of Asia is going to sleep, and while it is late evening in Australia, is a very good transmission time. The same morning times yield good signal when going from east coast to west coast North America if the supervisee doesn't mind being up at 0600 before the continent goes to work.

Group Set-up and Technical Issues

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While individual supervision is easily conducted via a web camera equipped laptop or personal computer, setting up group supervision requires more planning. Because the Skype® application has up to now only permitted video webconferencing between two computers at one time, the small group supervision format used in our case required all supervisees to be in the same physical location to webconference with the supervisor. This format requires adequate video display size, where both the therapy video and the supervisor (or supervisee if you are the supervisor) can be clearly viewed. While a standard sized monitor will suffice in a one-to-one supervisor-supervisee arrangement, in group format either a large monitor that enables all participants to be clearly seen in the one image, or the ability to focus the camera on each supervisee as they have their turn, is required. A multi-site supervision session would have multiple video images, suggesting a larger screen would be required at each site to simultaneously accommodate all images. The video display used at this group supervision location was a 50" high definition plasma monitor with 1080p resolution. This size was ample as it allowed for simultaneous display of three windows including video display of the supervisor and the session playback along with the chat window. The standard font size of the chat window was changed due to the supervisee's being unable to read the text from a distance of 4 metres to a font size of 24. This enabled viewing from that distance but could have been increased further for people with visual difficulties. While smaller displays may be used, the windows sizes would be reduced along with the need to be closer to the display. This in turn may restrict the number of supervisees able to participate at the one time due to the compromise between size and the ability to view the display.

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Two different video capture (camera) devices were used at the supervision location. The first capture device trialled was a standard consumer digital video Handycam® (Canon MD 120 Digital Video Camera). This was connected to an Apple® MacBook Pro through the firewire port. The camera could be positioned to focus on the entire group or on each individual when it was their turn. This required one of the supervisee's to manually operate the zoom function on the camera and to adjust the settings. This proved to be onerous and the group opted to use the built in camera on an Apple® MacBook Pro to reduce the amount of equipment needed and to preclude the need to manually operate equipment during the session. However, this resulted in a fixed picture of the entire group throughout the supervision session. While this did not reduce the effectiveness of the supervision format, it resulted in the supervisor only being able to see the group from a fixed distance and ideally it would have been better to have simultaneous views of the group and the individual receiving supervision. This could be achieved with the purchase of additional equipment, but the costs of this equipment are prohibitive and would not outweigh the current drawbacks.

For clear conversation between supervisor and supervisees, a low proximity condenser microphone that is specifically designed for use in a group environment, placed two to three feet in front of the group would be ideal, however, we used the built-in microphone in the Apple® MacBook Pro computer through which we conducted the Skype® session and found this to be sufficient. The system was placed at a distance of about 2 metres from the supervisees. The position of the system was adequate and allowed for both audio and video capture of the group and no issues arose that required the purchase of additional devices.

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Preparation by Supervisee

For the supervisee, webconference preparation involves a focused review of psychotherapy recordings beforehand, including efforts to engage in self-supervision and to identify relevant sections for review with the supervisor. Ideally, this review includes specific diagnostic information (e.g., client's anxiety tolerance, defensive functioning), technical issues regarding the timing, selection, and application of specific interventions, evaluation of client response to interventions, and efforts to monitor the supervisee's internal responses while working with the client. Afterwards, the supervisee has a set of review notes corresponding to specific sections of the psychotherapy recording ready for use during webconference supervision. One or two sessions are typically reviewed in a 30-minute webconference supervision session. Thus, being prepared for a focused review optimizes the use of supervision time.

Session Scheduling and Structure

Supervision in the individual format is held every one-to-two weeks and is 30 to 60 minutes in duration. In these sessions, one or two cases are reviewed. If supervision were less frequent, such as monthly or quarterly, a one or two-hour slot would be allotted to each supervisee.

In our Australian group of four psychologists, each was allotted 30 minutes of a two-hour session held every two weeks. This group used a turn-taking arrangement that had each member presenting for 30 minutes per session during which the video recording of one therapy session was reviewed. Groups must decide whether questions or comments from other members are allowable during the supervision of an individual's case: the segment belongs to that supervisee to use as he or she wishes. In

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this group, observers were free to make generally judicious and quite supportive comments. Each supervisee thus had 30 minutes of direct supervision and 90 minutes of indirect supervision in each block. This enabled a broader range of supervisory experience with more exposure than would be possible with a one-to-one review. However the 'depth' of personal supervision on therapy issues and therapy practice is less compared to a one-to-one supervision of the same duration. In a group setting, we believe 30 minutes is the minimal time that should be allotted for direct supervision to each group member, meaning supervision groups are limited to 2 active members per hour. Others can observe the supervisory process with the free consent of the group however.

In-Session Process

During the webconference, both supervisor and supervisee(s) examine the recording together and strive towards co-supervision of the recording. Each party's computer display includes Skype® windows with their colleague's live video call and instant text messaging, as well as a larger window playing the psychotherapy recording under review. While the recording plays, each party is free to make verbal comments and suggestions, or to raise questions about the client-therapist events unfolding before them. In this sense, the supervision is approached as a shared task depending on the developmental level of the individuals involved (Stotenberg, 2005).

Diverse therapy approaches may have different approaches to video review. The psychotherapy model we study entails following a series of processes that accumulate into therapeutic events later in the session. Hence, we start supervision from the first point of contact in the session and proceed from there. When appropriate, the

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supervisor or supervisee indicates that the recording should be stopped for an in-depth discussion. At times, however, the supervisor provides ongoing “microanalytic-intervention by intervention” commentary without stopping the recording via brief verbal feedback or instant text messaging within the Skype® application. See Figure 1 for a sample of Instant Messages during a supervision segment. In addition to supervisee notes taken during the webconference, the supervisor’s instant messaging commentary highlights specific therapy events on the recording for subsequent review. At times, the supervisor may show PowerPoint® slides with diagrams to highlight specific technical issues (such as timing of a “pressure” versus a challenge” intervention) and goals (such as emotional experiencing, recapitulation afterward) through the Skype® “share screen” function, which enables the supervisee to observe the contents of the supervisor’s computer desktop.

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Figure 1: Sample string of instant messages provided by supervisor during videotape case review *.

In this segment, close to 25 minutes of tape is watched in 30 minutes with minute to minute feedback provided. Supervisee has this as record to reflect on later if desired.

[8:37:34 AM] Dr Allan Abbass: ID TRY A RECAP OF WHAT YOURE UP TO AND SET STAGE FOR THE WORK [suggested start point of session given how patient arrived to session]

[8:38:45 AM] Dr Allan Abbass: I LIKE YOUR STANCE HERE. YOURE COVERING HER RANGE OF PATHOLOGY GENTLY

[8:39:18 AM] Dr Allan Abbass: HEAVY INTERVENTION! [refers to therapeutic challenge provided]

[8:39:28 AM] Dr Allan Abbass: REALLY HEAVY [refers to therapeutic challenge provided]

[8:49:29 AM] Dr Allan Abbass: SIGH! [patient response of unconscious anxiety in the form of muscle tension]

[8:50:28 AM] Dr Allan Abbass: HOW DO YOU FEEL NOW HERE WITH ME [suggested intervention]

[8:50:40 AM] Dr Allan Abbass: NOW [qualifying this moment in session]

[8:50:49 AM] Dr Allan Abbass: SHE MEANS BUSINESS NOW [patient becomes more engaged]

[8:51:26 AM] Dr Allan Abbass: LETS SEE HOW YOU FEEL HERE WITH ME? NO REPLY TO HER WORDS [focus to feeling and ignoring intellectual responses]

[8:51:57 AM] Dr Allan Abbass: RECAP LATER. FIGHT FIRST WIPE UP LATER [encouraging staying with the experience of rage for now until it is experienced]

[8:52:35 AM] Dr Allan Abbass: SHE ISNT SAYING ANYTHING [defensive silence]

[8:53:53 AM] Dr Allan Abbass: SOME EFFECT. SOME SIGHS [anxiety response]

[8:54:02 AM] Dr Allan Abbass: SOME IRRITATION COMING [feelings on the way]

[8:55:05 AM] Dr Allan Abbass: ITS GETTING INTELLECTUAL [defences pulling back]

[8:55:18 AM] Dr Allan Abbass: SHES STILL GOT HER ARMOUR ON [acquainting with defence]

[9:01:07 AM] Dr Allan Abbass: THIS IS MOSTLY RESISTANCE [acquainting with defence]

[9:01:30 AM] Dr Allan Abbass: SHES TENSE AND TALKING STILL [acquainting with defence]

[9:07:33 AM] Dr Allan Abbass: I THOUGHT GRIEF WAS COMING [feelings on the way?]

[9:08:31 AM] Dr Allan Abbass: EDGE OF GRIEF NOW [some grief has passed]

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[9:08:51 AM] Dr Allan Abbass: THAT'S ENOUGH TO CUT OFF A PHOBIA ACTUALLY [anxiety has been reduced with the emotional experience and it should reduce phobic avoidance of emotions thereafter, like any good exposure!]

[9:09:07 AM] Dr Allan Abbass: 2 DROPS OF GRIEF WILL DO THE JOB! [congratulating supervisee on good work]

* Typoes have mercifully been corrected for the reader.

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Troubleshooting

At times bandwidth is reduced and verbal communications can be delayed or "choppy", creating opportunities for miscommunication. However, in our experience, these problems are usually preventable (by having adequate computer memory, setting session times and sending files ahead versus sharing files) and minor (tolerable stop-start and shake) moments. If transmission is too poor to allow the conference to continue, the supervisor and/or supervisee should be prepared to call by telephone to continue the supervision session. In some cases, there is enough bandwidth to allow audio to be transmitted but not video, so this saves what could be an expensive phone call: therefore, before giving up on the Internet based call, we recommend switching off the video function to see if the audio improves. Further, the limitations of computer speeds and local bandwidth suggest that all other programs or computers accessing the Internet should be shut off while doing supervision. In a year of bi-weekly supervision from Canada to Australia, we have only once needed to make a phone call to continue supervision. See Table 1.

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Table 1: Approach to Poor Audio-Visual Signal Transmission

Preventative Measures

Use adequate capacity computer (minimum Intel® Core™2 Duo Processor E440)

Use broadband (High-speed) Internet connection (minimum Broadband speed 7.0Mbps)

Turn off other computer programs

Turn off other computers if on a network

Send files ahead rather than share screen

Schedule webconference for off peak times

Ameliorating transmission problems

Stop and restart the video call

Shut off Video

Be sure other programs are shut off

Call over the Internet (audio only)

Call by telephone: always have numbers on hand

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Getting used to the format

In our case, it took around three sessions to begin working out the finer details of how to communicate through this medium with ongoing refinements occurring organically throughout the process. For example, it took time to train ourselves to look at the camera rather than the display when speaking with the supervisor so that there was eye contact with the receiver. To facilitate this, we positioned the camera between ourselves and the display in order to create the impression of looking in the camera's direction while still being able to clearly see the display. The angle of the web camera will also determine how much of the individual supervisor or supervisee is visible and we found it helpful to place the camera face on to the supervisor allowing us to view the upper torso and head. Not being able to see the other adequately reduces the ability to read the nuances of body language that could lead to occasional misinterpretations (Sorlie et al., 1999). As the number of supervision sessions has increased, we have become more familiar with each other and with webconference supervision and these communication errors virtually disappeared over the first few months.

Consent, Confidentiality, and Security Issues

Mental health professionals using webconferencing technology must conduct themselves in accordance with their respective ethical codes and practice guidelines just as they would during conventional face-to-face supervision. Although we were unable to locate specific professional practice guidelines regarding webconference supervision, we considered informed consent and confidentiality to be two important considerations in this supervision frontier. (See Appendix 1 for a broad list of guidelines relevant to mental health professionals and the Internet). Specifically, we highlight the

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importance of obtaining informed written consent from clients to share therapy recordings for the purposes of supervision, including a detailed release form outlining the videoconference process in plain language. It is important that clients understand that their release consent is voluntary and will not impact their access to psychotherapy (See Appendix II, for a sample consent form). Similarly, a premium is placed on client confidentiality and privacy by maintaining and viewing recordings in secure physical and electronic settings, including use of appropriate network and software security protocols, and user authentication procedures (e.g., password protected files etc.). File encryption is also strongly advised as is refraining from using any identifying client information during supervision or file transmission (Janoff & Schoenholtz-Read, 1999). Finally, we routinely reviewed (i.e., every three months) the FAQ section of each of the software vendors whose applications we used in order to stay up to date with advances in the software along with updating the software to overcome potential bugs.

Complementary Web-based Course

The basic principles of ISTDP have recently been taught through a video recording-based 10 week webconference course provided from Canada to a United States university. This course was 2 hours per week and included 12 psychiatry residents, teaching faculty and psychotherapists associated with the university at 2 conference sites. This course covered the basic theory and application of this model across the spectrum of suitable clients. Video recording content was File-dropped (by uploading files to a secure server which was then downloaded by the University at the other end) and viewed simultaneously on both ends. The webconference application allowed audio-visual conversation and didactic teaching with the use of powerpoint

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slides interspersed with showing videorecording segments to highlight key points. This university used a program called VPN Client (R) (http://www.cisco.com/en/US/products/ps5743/Products_Sub_Category_Home.html) for this webconference: this program required downloading to the teacher's computer and access to each session was password protected. One of these sessions was provided while the teacher was in Warsaw, Poland giving workshops! This course format began with an introductory overview of the evidence base and metapsychological basis of the approach. It then proceeded from the least (those with unresolved grief only) to most complicated patients (with borderline organization) suitable for ISTDP (Davanloo, 1995). The course was deemed acceptable and future supervision via webconference is being planned. This format can thus be used to supplement or set the stage for webconference psychotherapy supervision.

Limitations of Webconference Supervision

The limitations of webconference supervision include technical, practical, ethical and interpersonal issues.

Technical

Basic computer skills are a must in using this approach including ability to use a web browser and sign in to a website. One major technical issue involves avoiding and managing decreased Internet speed or computer processor speed causing poor images and sound (See Table 1). We have found that being familiar and comfortable with both the hardware and software applications involved reduced our anxiety when problems occurred. For example, when setting up the hardware to display the output to

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the large display, there were times when the equipment did not function as anticipated. It was identified that preparing the equipment at least one hour prior to the scheduled session provided ample time to problem solve technical issues that could arise. These ranged from not having the correct cables, to changing the preferences in the software applications, to adjusting to the environmental settings peculiar to each set up. As we identified the solutions to these problems we became more comfortable with the format but it was necessary to experience some of the technical glitches along the way to help us become confident with using the technology.

Consent Issues

Some clients may not consent to recording and sharing psychotherapy sessions in a webconferencing format for a variety of reasons, although we find only a 25% rate of refusal in our six practices. Our impression is that (younger) clients who are more comfortable with the internet are more willing to allow this supervision method than (older) clients less familiar with same but this observation warrants some study. While some clients may initially be reluctant to provide consent, revisiting this after a few sessions often resulted in clients providing consent: at that point the therapist could provide information specific to that client's treatment about why supervision would be helpful in his or her specific case.

Supervisee Anxiety

While supervisee anxiety during webconferencing is quite natural, there is little research evidence that the use of audio-video recordings (Huhra, Yamokoski-Maynhart, & Prieto, 2008) or webconferencing technology itself is the primary cause of trainee anxiety. Indeed, some have argued that supervisee anxiety regarding recordings used

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in supervision is more likely a generalized response to psychotherapy training itself (Schnarch, 1981). Regardless of the cause, a graded training exposure for supervisees with extreme anxiety may be warranted (Abbass (2004). This approach may include exposure to the supervisor and/or peers' video recordings prior to the trainee presenting his or her own recordings. Thus, small-group webconference training may be the best format to help achieve this goal.

Supervisee Personal Process

At times a supervisee may have difficulties in regard to his or her own emotional process interfering with the application of therapeutic technique (e.g., supervisee has history of similar trauma as his client and is highly anxious when the content arises in session: this leads to over-intellectualizing at the treatment point where emotional exposure may be warranted). In this situation, the Internet format may present a barrier to the open discussion of these issues that may not exist with F2FS, where more subtle cues may facilitate such a discussion. However, individual time at the end of the session or in between sessions could be employed in such a circumstance. We have not yet found this to be necessary with groups of cohesive professionals who have known each other for many years, but this could be necessary at times and the supervisor should be prepared to allot time for this.

Local Support

During times of need, such as a crisis with a client, local consultation and supervision is advisable to ensure compliance with ethical and professional guidelines. One example of this is a patient who expresses suicidal ideation or requires medical evaluation due to a question of a neurological syndrome. Accordingly, it is not feasible

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for an inexperienced therapist to rely solely on webconference supervision. Instead, he or she should build links to local mentors and consultants in order to access support and assistance when needed.

Supervisory Alliance

Olson et al. (2001) commented that it might be difficult to create and maintain a sense of connection or supervisory alliance that is so central to psychotherapy supervision (Ekstein & Wallerstein, 1958) through communication over the Internet. However, we have not found this to be the case. With this method, collaborative working alliances are achieved over time through the dedication of both supervisor and supervisees to openly examine the detailed processes in video recorded sessions. The supervisor can best contribute by being highly engaged and comfortable with the supervision structure. The feedback is grounded in the clinical data in front of the supervisor and supervisee with ample opportunity provided to clarify any differing perspectives.

The training relationship in our case is facilitated by annual in-person teaching through four or five day immersion courses, in which the supervisor shows recordings of his own psychotherapy practice. A built in element of these courses is an extensive social program with many opportunities for supervisor and supervisees to interact in person and get know one another better: here we will argue about which city or continent has the best beer and the worst weather!

Benefits of Webconference Supervision

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While we agree that in-person supervision is the ideal format, we have concluded from our experience that the overall benefits of webconference supervision outweigh its relative limitations.

Access, Cost-effectiveness and Convenience

Most professionals make regular efforts to review the literature, consult with peers, and attend periodic workshops to maintain basic competence in their psychotherapy practices. However, many face various personal and professional commitments, lengthy travel distances, and financial constraints that significantly limit their access to ongoing supervision aimed at maintaining or further developing psychotherapeutic competencies. For those seeking advanced or specialized psychotherapy training, weekly, bi-weekly or monthly webconference supervision offers more exposure with possibly greater educational effects compared to one or two workshops per year.

Visualizing the supervisee

The ability of the supervisor to identify non-verbal cues of the supervisee during a session can have important training implications (Jerome & Zaylor, 2000). Lack of visual cues may hinder the supervisor's ability to detect resistance in the supervisee, which can lead to issues within their working relationship and working alliance (Kanz, 2001). In our experience, the webconference application was more than adequate for the supervisor and supervisees to clearly observe the verbal and nonverbal aspects of each other's communication during training sessions. (e.g., interest, encouragement, challenge, humour).

Video recording Review

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The use of actual psychotherapy recordings during webconference supervision is ideal for professionals seeking advanced psychotherapy training. Discerning such subtle cues and changes is fundamental to supervisory processes aimed at clarifying psychodiagnosis, therapeutic focus, treatment progress, and the range of technical issues typically encountered during advanced psychotherapy training.

Abbass (2004) has described a number of additional benefits of using video recordings for psychotherapy supervision that are relevant to this current approach. Video recording enables professionals to objectively study their psychotherapy practices outside of the demands of the actual therapy session. This can increase therapist self-awareness, self-supervision skills, and encourage life-long professional development. When combined with a supervisor's feedback about specific client-therapist interactions and other clinical phenomena in recordings, trainees acquire a catalogue of vignettes that they are free to review or use to teach others.

Benefits of the Small Group Format

There were a number of distinct benefits of the small group webconference format, including exposure to a wider array of clinical and training issues evident in group members' work. This group format is an experience multiplier where watching others' work prepares one for similar situations which he or she will inevitably face in the future. As well, group members have opportunities to observe supervisory practices, participate in peer supervision and learn a supervision method (Abbass, 2004).

Conclusion

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We are now well into the era where rapid and broad dissemination of psychotherapeutic techniques and skills is possible and inevitable. Inexpensive, widely accessible Internet-based training methods offer an array of benefits and few limitations. While further research is required to examine optimal schedules and relative effects of this method on client outcomes, we anticipate that webconference-based psychotherapy supervision will be the key vehicle providing global transmission of psychotherapy skills.

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Appendix 1. List of Guidelines for Mental Health Professionals Working with the Internet

Please Note: The following list is not exhaustive.

American Medical Association (2000). Guidelines for Patient-Physician Electronic Mail, available at: <http://www.ama-assn.org/meetings/public/annual00/reports/bot/bot2a00.rtf>.

American Mental Health Counselors Association (2000). Code of Ethics of AMHCA, Principle 14, Internet On-Line Counseling, available at: <http://www.amhca.org/code/#14>.

American Psychiatric Association (1998). Telepsychiatry Via Videoconferencing, available at: http://archive.psych.org/edu/other_res/lib_archives/archives/199821.pdf.

American Telemedicine Association (2009). Practice Guidelines for Videoconferencing-Based Telemental Health, available at: <http://www.atmeda.org/files/public/standards/PracticeGuidelinesforVideoconferencing-Based%20TelementalHealth.pdf>.

Canadian Psychiatric Association (2001). Telepsychiatry: Guidelines and Procedures for Clinical Activities, available at: <http://www.psychiatry.med.uwo.ca/ecp/info/toronto/telepsych/index.htm>.

Canadian Psychological Association (2009). Ethical Guidelines for Psychologists Providing Psychological Services via Electronic Media, available at: <http://www.cpa.ca/aproposdelascp/conseildadministration/comites/deontologie/ethicalguidelines>.

International Society for Mental Health Online (2000). Suggested Principles for the Online Provision of Mental Health Services, available at: <https://www.ismho.org/suggestions.asp>.

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National Association of Social Workers and Association of Social Work Boards (2005).

Standards for Technology and Social Work Practice, available at:

<http://www.aswb.org/pdfs/TechnologySWPractice.pdf>.

National Board for Certified Counselors and Center for Credentialing and Education

(2001). The Practice of Internet Counseling, available at:

<http://www.nbcc.org/ethics/Default.aspx>.

Ohio Psychological Association. (2010). Telepsychology Guidelines, available at:

<http://www.ohpsych.org/resources/1/files/Comm%20Tech%20Committee/OPATelepsychologyGuidelines41710.pdf>

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Appendix II. CONSENT TO RELEASE THERAPY VIDEO RECORDINGS

I, _____, a client of Dr. _____, hereby give my consent to release the contents of any or all therapy video recordings via a secure Internet webconferencing application (i.e., Skype™ videoconference) for the purposes of education, training, and consultation activities conducted by Dr. _____. I understand that healthcare information relevant to my therapy may also be released for the previous purposes, but that identifying information will be withheld or modified to maintain my confidentiality. I understand that the content of these recordings and relevant healthcare information will be released only to mental health professionals and trainees who are bound by law, professional college, or a confidentiality agreement to maintain client confidentiality. I also understand that my consent only permits other professionals to review the recordings and healthcare information with Dr. _____ and does not permit other parties to copy or retain possession of the previous information. Finally, I understand that my consent is completely voluntary and that I am free to withdraw my consent at any time while continuing to pursue the requested therapy services with Dr. _____. I also understand the recordings will be erased at any time I wish. I understand that the recordings are property of Dr. _____ and may be erased at anytime with no notice given to me. I will be given a signed copy of this Consent Form.

Client Signature and Printed Name

Date

Witness Signature and Printed Name

Dr _____ Phone 1-234-567-8910