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To cite this article: Paula A. Bernhard & Joshua S. Camins (2020): Supervision from Afar: trainees’ perspectives on telesupervision, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2020.1770697

To link to this article: https://doi.org/10.1080/09515070.2020.1770697

Published online: 25 May 2020.
Supervision from Afar: trainees’ perspectives on telesupervision

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ABSTRACT
Telesupervision, or supervision at a distance, has become more widely used due to its many practical and economic benefits, with research suggesting it is as satisfactory as traditional, in-person supervision processes. Particularly as a result of the global pandemic COVID-19 limiting in-person contact, use of telesupervision has even become mandatory for some training sites. In the current article, two doctoral-level clinical psychology student trainees provided their perspectives on participating in telesupervision during practicum training at a telepsychology clinic prior to COVID-19 and briefly highlighted how it has applied to their work in the current environment. Their experiences are discussed in conjunction with relevant supervision literature, as well as the impact on the trainees’ development. The trainees’ perspectives support the notion that telepsychology can be a positive component of training, irrespective of public health concerns, and specific positive factors of using telesupervision are discussed.

Introduction
Telesupervision, also known as distance supervision, is clinical supervision in which the supervisor and supervisee are in different geographical locations. It can occur synchronously (at the same time, such as videoconferencing) or asynchronously (with a time lag, such as e-mail or discussion boards). As a result of the COVID-19 global pandemic, many counseling and psychology training sites are limiting in-person supervision or requiring telesupervision in adherence to social distancing practices and shelter-in-place regulations. Telesupervision was becoming more widely used even prior to COVID-19 (Wood, Miller, & Hargrove, 2005), particularly in rural communities, but has quickly progressed into an immediate necessity for many trainees and supervisors. Telesupervision has always had many practical benefits, such as increased access to non-local supervisors with specialized knowledge and reduced financial constraints and lengthy travel (Abbass et al., 2011). This form of supervision is a low-cost and convenient option for both supervisors and supervisees. Additionally, using telesupervision methods can familiarize a trainee with using telepsychology more generally, which is particularly important for trainees’ ability to understand the experience of clients who utilize telepsychology services.
Telesupervision is not without its challenges. Some obvious challenges include maintaining strict client confidentiality while in non-traditional supervision settings, troubleshooting unexpected technological issues, and trainees and supervisors feeling unfamiliar with the telesupervision process (Wood et al., 2005). Another challenge is maintaining local support in times of client crisis or when need for consultation or immediate supervision arises (Abbass et al., 2011). Supervisors may not always be available if not on-site, and some situations may be too time-sensitive to wait to contact a telesupervisor. Additionally, some have speculated that establishing a supervisory alliance is a challenge of using distance supervision, although research has not adequately supported this concern (Brandoff & Lombardi, 2012).

Thus far, research has suggested that telesupervision is at least as satisfactory as traditional, in-person supervision (Inman, Soheilian, & Luu, 2018; Wood et al., 2005). In one study examining the effectiveness of telesupervision on supervision quality, half of supervision sessions were conducted in-person and half used videoconferencing between supervisors and psychiatry residents. Results showed that using videoconferencing for half of all supervisions maintained satisfactory supervision, although all supervisory pairs in the study met in-person first to establish a relationship (Gammon, Sorlie, Bergvik, & Hoifodt, 1998), making it difficult to discern the impact of meeting in-person at least once. Conn, Roberts, and Powell (2009) explored the relationship between type of supervision (a hybrid model of in-person and online chat, compared with in-person only) and various attitudes toward technology and quality of supervision among school counseling interns. Researchers found that perceptions of supervisory rapport did not differ between the hybrid group and the in-person supervision only group. Additionally, satisfaction with the supervisory experience did not differ between the two groups. Technology may even improve the supervisory relationship by lowering some social inhibitions and eliminating barriers to communication through diminishing supervisor-supervisee hierarchical issues and encouraging more open discussion (Wood et al., 2005). Some research has also suggested that telesupervision prompts supervisors to have greater intentionality in fostering a positive working alliance with supervisees (Inman et al., 2018). While further, more nuanced research is greatly needed on this topic, the existing research is encouraging, as it suggests that telesupervision is a useful and at least satisfactory form of clinical supervision.

The trainee perspectives below highlight unique supervisory experiences which occurred prior to the outbreak of COVID-19. Specifically, Trainee 1 received six months of in-person supervision followed by 6 months of telesupervision. Trainee 1 had method-specific supervisors (i.e., in-person supervisor followed by a different distance-supervisor). In contrast, Trainee 2 was supervised by the same clinician throughout both the in-person and distance-supervision components of the practicum. Further, although Trainee 1 provided teletherapy throughout the duration of the practicum, Trainee 2’s switch to telesupervision coincided with a transition from teletherapy to in-person therapy. Trainee 1 describes the experience of engaging in solely distance-based supervision, while Trainee 2 describes the initial in-person supervisory relationship and the shift in trainee development that occurred following the transition to telesupervision. From these qualitative descriptions, the authors aim to provide perspectives and ideas for telesupervisors and telesupervisees alike related to different options and tools for telesupervision,
challenges faced, the process for both trainees adapting to these new experiences, and similar factors resulting in positive telesupervision experiences.

Trainee 1’s perspective

I participated in telesupervision for approximately six months while completing practicum training at a telepsychology clinic in southeast Texas. My supervisor worked at a Veterans Affairs clinic three hours away from where I was doing my training. We engaged in weekly videoconference supervision sessions using Cisco WebEx software. While my supervisor was located in his office, I usually participated in supervision from the comfort of my home outside of typical work hours. Prior to this experience, I had training and experience conducting therapy via telepsychology (videoconferencing and telephone), but no formal training or experience with telesupervision.

Utilizing a variety of instructional formats through telecommunication applications can enhance a supervisee’s learning experience (Wood et al., 2005). Our supervision incorporated various technological means aside from videoconferencing, such as a weekly Google form used for pre-supervision agenda setting, a Google Drive for group supervision discussion with other trainees and shared resources, an encrypted shared drive on the telepsychology clinic computers for paperwork and video review, and the shared screen feature of WebEx in order to view PowerPoint presentations my supervisor had prepared. Taking advantage of these technological offerings seemed to break down barriers of distance supervision, as we were able to achieve most of the supervision experiences that occur during traditional in-person sessions, such as video reviews, presentations, and other instructional formats.

While agenda setting and structure in supervision sessions is always useful, it became even more crucial during telesupervision. For example, it allowed my telesupervisor to orient himself to my clinical experiences that week, for which he had not been present. I filled out a weekly Google form with information such as initials of clients seen that week, whether or not all progress notes had been completed, most pressing issues to discuss in supervision, and the client initials of the preferred video for the supervisor to view prior to supervision. Agenda setting is a technique used to manage time, allow for trainees to contribute to supervision at a developmentally-appropriate level, and to introduce cognitive-behavioral skills (Cummings, Ballantyne, & Scallion, 2015). The use of this asynchronous technology to set an agenda was particularly helpful during telesupervision because my telesupervisor did not know the daily happenings at the clinic. The Google form was like a weekly review for both parties and was used to structure the supervision session. While I appreciated agenda setting and structure, it required much forethought on the part of the supervisee. I was responsible for loading videos to the shared drive immediately after sessions to allow for the supervisor to have adequate time to view them, and strong communication was necessary because I needed to alert the supervisor if any paperwork in the shared drive needed to be signed.

Another unique aspect of telesupervision was consultation outside of regular supervision hours. Typically in emergency or crisis situations I would consult my supervisor in person, but because my supervisor was at a distance and not always available to be immediately reached, the telepsychology clinic had local support available on-site in case of crisis or emergency, which is advisable to ensure compliance with ethical and
professional guidelines (Abbass et al., 2011). There was an informal support hierarchy in place, such that supervisees may receive immediate support from on-site professionals in times of acute crisis, followed by consultation with the telesupervisor by telephone or videoconference if available. There was a previously established professional relationship between the telepsychology clinic director and my telesupervisor, which facilitated communication between them about my progress and, if necessary, feedback about the immediate consultations I requested at the telepsychology clinic.

I did encounter some challenges during the course of telesupervision. Some technological issues created frustration. For example, the first session of telesupervision was delayed because of unexpected issues with the webconferencing software; therefore, time was lost that would not have been with in-person supervision. It may be helpful to do a “practice run” supervision session to test the technology, check in with supervisees’ comfort about the process, and begin building rapport. Another challenge involved more intentional thinking to ensure client confidentiality when using telesupervision. For example, I often participated in supervision sessions in the spare room of a small apartment that I shared with a roommate. When my roommate was home, it was particularly important to use de-identified language and take precautions to comply with ethical and professional guidelines concerning client privacy when discussing cases. Ethical considerations related to confidentiality and record-keeping were discussed with my telesupervisor early in our telesupervision sessions.

I found that more than adequate rapport developed despite physical distance between my supervisor and I. Although my supervisor and I did not share daily interactions that could lead to an additional sense of closeness outside of supervision hours, allowing time for some rapport-building during sessions achieved a satisfactory supervisory relationship on par with in-person supervisory experiences. Similarly described by Inman et al. (2018), my telesupervisor seemed more intentional in rapport-building at the beginning of supervision sessions than I had typically experienced with in-person supervisors. My telesupervisor asked me to reflect on the week, asked questions to get to know me as a person as well as a supervisee, and showed an interest in my professional and personal development. The time set aside at the beginning and end of our supervision sessions for this rapport building seemed to alleviate any disadvantage we may have experienced by not being in close proximity to each other the rest of the week. While some research suggests an in-person meeting is necessary to establish a foundation for rapport (Brandoff & Lombardi, 2012), I do not agree it is absolutely necessary. In fact, my most meaningful and formative supervision experience has come from the one supervisor I had never actually met in-person. I found this to be a meaningful and formative supervision experience because I achieved my supervision goals (e.g., learning skills of a new therapeutic orientation, developing strong therapeutic relationships with my clients, becoming more comfortable as a therapist, and creating a positive professional relationship with a new supervisor) while also further developing general skills such as responsibility, communication, and consultation. When a telesupervisor is able to foster a strong working alliance as mine did, nonverbal cues should still be present, time should be intentionally spent building rapport, and supervisees should feel supported and challenged.

The benefits of telesupervision outweighed the challenges during my experience. I was able to take advantage of the specialized knowledge that my supervisor had to offer, which in this case was trauma treatment and Cognitive Processing Therapy. Originally,
I was interested in learning about interpersonal treatments, but I soon realized I should soak up as much as I could from my supervisor in his area of expertise. He shared his resources, supervised me on trauma-related cases, challenged my case conceptualizations, and provided support through learning a new modality. Additionally, telesupervision was meaningful because it allowed me put myself in my clients’ shoes. Most of my clients at the telepsychology clinic were new to using services via technology, and I gained a new sense of empathy for their concerns about technology, which seemed to create a stronger therapeutic bond. As supervision should model an ideal client-therapist relationship, using technology during supervision can enhance the therapeutic alliance with telepsychology clients.

**Trainee 2’s perspective**

I spent a year working at a telepsychology community clinic in southeast Texas. As part of the practicum, I completed multiple continuing education training courses, such as Law and Ethics in Telehealth, Managing Crises and Emergencies in Telehealth, and Treatment Considerations for Telehealth. For the first half of my practicum year, I provided teletherapy with in-person supervision, and in the latter half of the year I provided in-person therapy with telesupervision. Of note, during the second half of the year, I was the only mental health provider at a small satellite facility and received distance supervision from a supervisor at the main community clinic. If someone had asked me what I thought about telepsychology prior to my time at this site, I would have made a comment about it being financially practical but clinically complicated for therapeutic intervention. I had initial concerns about rapport, confidentiality, client safety, session structure, and homework. In retrospect, my experiences providing teletherapy and receiving telesupervision were positive and complemented each other, as I describe further below.

Depending on the modality used with therapy clients and with supervisors (distance vs. in-person), a trainee could have four broad types of experiences illustrated by Table 1. The most common scenarios are when both trainees use the same modality for both therapy clients and supervision (i.e., both in-person or both telehealth). However, complexity of providing treatment can potentially increase when both modalities are involved. In this section, I describe two practicum experiences involving scenarios of (a) teletherapy client and in-person supervision and, (b) in-person client and distance supervision. I also contrast and highlight important similarities and differences between experiences with these modalities.

During the first part of my practicum, I completed teletherapy sessions with a middle-aged woman living in rural Texas. She was referred by a community health provider, as she reported anxiety and mood-related symptoms. During my intake interview, it became apparent that she had a long history of mood swings, unstable relationships, identity disturbances, and thoughts of self-harm/suicide. We readily developed rapport and completed several additional teletherapy sessions focused on developing coping skills to address recent life stressors.

**Table 1.** Treatment and supervision modality scenarios.

<table>
<thead>
<tr>
<th>In-person</th>
<th>Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person</td>
<td>Both client and supervisor in-person</td>
</tr>
<tr>
<td>Telehealth</td>
<td>Teletherapy client, in-person supervisor (case #1)</td>
</tr>
<tr>
<td>In-person client, telesupervision (case #2)</td>
<td>Both patient and supervisor present by telehealth</td>
</tr>
</tbody>
</table>
During weekly in-person supervision, I was encouraged to focus less on diagnostic features and more on the therapeutic relationship through the lens of interpersonal process. My supervisor observed that “therapy is not always about providing a skill or implementing a plan. Sometimes we can help our clients by helping them understand the impact they have on others.” Armed with this perspective, I entered our next session ready to focus on the therapeutic alliance. The session began like all other sessions, but it quickly devolved. My client reported an increase in hopelessness, thoughts of suicide, and financial strain. Quickly we switched from a process orientation to a risk assessment. Despite my questioning, she declined to offer sufficient information to give me faith in her safety. I contacted my supervisor, who rapidly came to assisted me in ensuring client safety.

Following the incident, I had the opportunity to process with my coworkers and supervisor. Although I had done everything “by the book,” I continued to experience a great deal of doubt. However, having a supervisor in close proximity allowed me the time and space to process and to express my own fears. Subsequent to this situation, my supervisor highlighted both my areas of current competence and growth in suicide risk assessment. Although researchers have identified supervisory strategies across multiple domains of suicide risk assessment and management, my supervisor emphasized that I demonstrated competence in many skill-focused areas (Rudd, Cukrowicz, & Bryan, 2008). Consistent with his theoretical orientation, most of our supervision focused on addressing my emotional reactions and how it had the potential to impede my already-developed risk assessment skills. My supervisor focused on helping me increase my awareness of my skills prior to my transition to telesupervision.

A few months after this exchange, I transitioned to the small satellite facility. In addition to seeing clients on-site for in-person psychotherapy, I acted as the sole mental health provider for the primary care practice. In contrast to my in-person therapy contacts, I now received supervision by secure videoconferencing software. Contact with my supervisor now had to be scheduled and was subject to the whims of our technology.

One of my duties on site was to triage immediate referrals from medical providers. These patient exchanges required me to act quickly, often without extensive consultation from my supervisor. During one such exchange, I was contacted by a nurse who indicated the client had become extremely dysregulated and required a psychology consult. A cursory evaluation highlighted frequent panic attacks and co-occurring depressive symptoms. I began a rudimentary suicide risk assessment; the client reported recent suicidal thoughts, access to means (medications), and increased psychosocial stressors.

My instinct, just as before, was to contact my supervisor. However, he was not readily available, and I found myself consulting with a fellow trainee and relying on my own clinical expertise. I reflected on lessons learned during in-person supervision and returned to the client. Taking a step back from my own nerves, I systematically reviewed her risk and protective factors, as well as her current ideation, plan, and intent. After careful consideration, I concluded she was not at imminent risk and would benefit from coping skills, safety planning, and future care. As such, I offered basic coping skills, created a safety plan, and scheduled her for services with our main community clinic. The patient left the session with a new sense of hope, while I left wondering, “Did I fail as a trainee by not consulting with my supervisor?”
Later that day, I was able to reach my supervisor, and we spent some time discussing the case. After hearing my description of the client and my actions, he affirmed that I had made the correct decision and commented on how my own self-awareness had changed. I expressed some concerns about him not being able to conduct the assessment and he affirmed that my actions were appropriate, and that supervision would have not changed the course of events or the outcome.

The two examples described above highlight that both in-person and telesupervision have unique strengths and weaknesses, particularly as it relates to handling risk assessment and management. In-person supervision allowed me immediate supervision and assistance, as well as greater immediate comfort. However, it did not allow me to develop autonomy or confidence in my abilities. In contrast, telesupervision allowed me to engage in developmentally appropriate autonomy and confidence, while still offering the support and consultation of peers, and post-facto supervisory encouragement.

Although these examples highlight differences between supervision methods, it is important to also discuss the mechanics of telesupervision and the role it played on professional and clinical development. Consistent with my supervisor’s theoretical orientation, supervision followed an interpersonal process framework. This approach was similar across settings (in-person and distance) and utilized process to gather “grist for the therapy mill” (Yalom, 2002, p. 70). The format of supervision was not hampered by the distance. In fact, consistent with the literature on telesupervision, we were able to maintain and improve our rapport, an essential element in any supervisory relationship (Jordan & Shearer, 2019). Furthermore, my satisfaction with the supervisory relationship did not decrease over telehealth mediums. Distance supervision afforded an opportunity for autonomy but also allowed for quality training and processing. In fact, my initial assumption that telepsychology is cold, impersonal, and inhibits the development of the alliance with a client or supervisor is in direct contradiction to my experiences. Although I did not know it at the time, the experience of providing teletherapy and receiving telesupervision would be invaluable as a clinician providing care during a pandemic for the reasons described above.

**Telesupervision in the era of COVID-19**

Although both authors wrote about telesupervision experiences prior to the global pandemic, they were considered essential staff during COVID-19 and provided clinical services within their respective organizations (Trainee 1 as a postdoctoral fellow and Trainee 2 as a pre-doctoral intern). Below we present an update about our experiences with telesupervision in the midst of these uncertain times.

For Trainee 1, clinical work involved conducting court-ordered inpatient assessments via videoconferencing software (usually with live supervision through videoconferencing software as well), and additional telesupervision by phone and email. Telesupervision has not changed substantially compared to experiences prior to COVID-19; HIPAA-compliant videoconferencing software was used and emails with patient information were exchanged through a state-based, HIPAA-compliant email system. Telesupervision required more thoughtful scheduling and flexibility but was otherwise not substantially impacted in the switch from in-person supervision to telesupervision. Prior experience with telepsychology and telesupervision was useful for feeling comfortable and informed.
as these mediums became mandatory, but not necessary for a positive supervision experience.

For Trainee 2, clinical care and supervision was almost entirely transitioned to distance modalities and telesupervision. Although Trainee 2’s organization had long offered telepsychology services, telesupervision was previously prohibited. As such, supervisor and trainee made several modifications. Weekly supervision involved video calls via a commercial system. This method, although effective for communicating, prohibited the trainee from displaying audio and video from practice samples. Telesupervision began with a brief check-in, at which point the trainee shared a digital file for the supervisor to review. Supervision was terminated so that each participant could review the file, and then the call resumed to discuss the case material. Although somewhat cumbersome, this approach did not negatively impact the quality of supervision or patient care. As described above, despite initial misgivings, the telesupervision approach was, in the opinions of both Trainee 1 and 2, effective both for trainees providing treatment and managing risks.

Conclusions

This article provided two qualitative descriptions of different trainee experiences with telesupervision experiences prior to COVID-19 and an update following the global pandemic. Previous research has not qualitatively highlighted the different manners in which telesupervision can be implemented (see Table 1), differing supervisory tools and techniques (e.g., using Google forms, incorporating video reviews), and processes of trainees adapting to these new experiences. Although Trainees 1 and 2 had different telesupervisors and experiences with telesupervision, several similarities emerged. Both trainees acknowledged positive factors specific to telesupervision, such as intentionality in rapport building, fostering consultation with others aside from one’s immediate supervisor, and telesupervision surprisingly adding an enriching layer to supervision and the working alliance.

Telesupervision has many practical benefits for both supervisors and supervisees, although it is not without challenges. However, there is little research to suggest that telesupervision is any less meaningful for training clinicians than is traditional, in-person methods. Some states have, or propose to have, restrictions on the percentage of allowable telesupervision compared to in-person supervision. At this time, more research is needed to determine if these regulations have any merit, as telesupervision may be more similar to in-person supervision than dissimilar. In the wake of COVID-19, many telesupervision regulations have been relaxed, allowing (and often requiring) supervision at a distance for many trainees. Although an extremely difficult time for many reasons, the time surrounding COVID-19 may present an opportunity for researchers to further establish telesupervision’s place in supervision literature and for supervisors and trainees alike to familiarize themselves with distance technology and possibly incorporate it more readily in the future. Future research questions arose from both trainees’ experiences. For example, future studies may discern differences in working alliance between telesupervisors and telesupervisees depending on if the supervision was consistently provided through distance technology, or if supervision changed from in-person to telesupervision. Given the rapid nature of social distancing regulations as a result of
COVID-19, it would also be interesting to examine (qualitatively and/or quantitatively) supervisor and supervisee experiences with telesupervision employed quickly and possibly without preparation.

The perspectives of two trainees with different telesupervision experiences described above support the notion that telesupervision was a positive component of practicum experiences. Aside from some logistical advantages to in-person supervision (e.g., flexibility in scheduling, convenience of supervision from home), telesupervision differed very little from in-person supervision and fostered even more growth. As training clinicians, we are encouraged to learn new techniques, to push the bounds of our confidence, and to develop a unique perspective that is shaped by our training and worldview. Telesupervision was an additional enriching layer to our training that not only provided satisfactory supervision but may have actually led to more quality instruction than traditional, in-person formats. This was accomplished through intentionality in rapport building, increased supervision structure, and adapting to and overcoming new challenges (e.g., technology, nonverbal communication, increased structure and planning ahead, relying on support outside of supervisor). We were also able to learn from highly qualified supervisors that would have been unavailable to us without the assistance of distance supervision. For both trainees, telesupervision also complemented experiences providing teletherapy.

Disclosure statement
No potential conflict of interest was reported by the authors.

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