

Psychotherapy supervision conducted by videoconferencing: a qualitative study of users' experiences

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Summary

Psychiatry residents in Norway have 70 hours of mandatory psychotherapy supervision to develop insights into the therapeutic relationship. Six supervision pairs (six candidates and two supervisors) conducted five videoconferencing-based supervision sessions (384 kbit/s) and five face-to-face sessions alternating weekly for 10 sessions. Following completion of the 10 sessions for candidates and supervisor B, and the 50 sessions for supervisor A, all subjects completed a semi-structured interview within two weeks. The eight subjects reported a wide range of experiences and attitudes. The results suggested that the quality of supervision can be satisfactorily maintained by using videoconferencing for up to half of the 70 hours required. The precondition for this estimate is that the pair in question have met face to face and established a relationship characterized by mutual trust and respect. Further studies, which include supervision pairs not having previously established relationships, are needed in order to indicate the generality of this precondition. The most obvious implication of this study is the potential for implementing decentralized models for recruiting and educating psychiatrists.

The 70 hours of mandatory psychotherapy supervision for psychiatry residents in Norway is designed for them to develop insights into the therapeutic relationship. While approval of the candidates' supervision is formally based on the subjective assessments of the respective supervisors, efforts have been made to define general characteristics of a qualitatively sound psychotherapy supervision process. It is assumed that a good working alliance characterized by confidence, trust and mutuality of goals is as essential in achieving the aims of psychotherapy supervision as it is in psychotherapy¹. The supervisor must be able to build a stable framework within which the candidate can openly seek an understanding of the complex interaction between the patient and therapist^{2,3}. The supervision process must encourage candidates to relate their personal experiences in their therapeutic relationships by exposing their personal emotions and reactions⁴.

Can the quality of these processes be maintained when the supervisor and candidate communicate by way of videoconferencing? Staff at Asgård Psychiatric Hospital received approval from the Norwegian Psychiatric Association to carry out a systematic study of this question. The study was organized in collaboration with staff of the department of telemedicine, University Hospital Tromsø. The interview material presented in this article is based on one of three methods used in the project to assess the effect of videoconferencing on the quality of psychotherapy supervision. The

focus of the interview study was on the attitudes and experiences of participants.

Methods

Six supervision pairs (six candidates and two supervisors) were recruited for the study. All eight subjects were medical doctors ranging in age from 31 to 49 years. The six candidates' general work experience in psychiatry ranged from 1.5 to 14 years. The two supervisors had 9 and 22 years' experience in psychiatry, and supervised one and five of the candidates. The pairs were at varying stages of the 70-hour supervision process at the start of the study, having completed 13–60 hours. Earlier experience with videoconferencing ranged from 1 to 10 sessions for candidates, and 3 and 10 sessions for the supervisors. All but one of the candidates (who commuted two hours by boat and taxi) lived at the Asgård Hospital.

Procedure

Five videoconferencing-based supervision sessions and five face-to-face sessions alternated weekly every other session for 10 sessions. The supervisors used the videoconferencing equipment at the hospital, while the candidates used videoconferencing equipment a short distance away from the hospital. Following completion of the 10 sessions for candidates and supervisor B, and the 50 sessions for supervisor A, all subjects agreed to be interviewed within two weeks. The semi-structured interview guide was based on factors used in social

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psychology communication research⁵ and characteristics describing a qualitatively sound psychotherapy supervision process. The same guide was used for all subjects with minor adjustments for candidates and supervisors, and the interviews took an average of 50 min to complete. An organizational psychologist with six years' experience in developing and evaluating telemedicine applications conducted the interviews. In all but one of the interviews, the interviewer was accompanied by one of two observers (a psychiatrist and a graduate psychology student). The observers' role was to aid the interviewer by asking supplementary questions if clarification was needed, to make independent notes, and to participate in analysis and discussion of the material. The interviews were tape-recorded.

Both sites were equipped with basic roll-about videoconferencing units connected at 384kbit/s by ISDN.

Analysis and presentation

As a guideline for analysis and presentation, criteria to describe qualitative methods were followed: identification, description and explanation-generation⁶. The interviewer's notes were used by the interviewer for initial identification of central recurrent factors. These included: types of responses (e.g. positive and negative) to each question; issues (e.g. themes, ideas, explanations/hypothesis); and possible relationships between subject characteristics (e.g. age, experience in psychiatry, earlier videoconferencing use, length of supervision). Based on the initial identification process, a decision was made to focus analysis and presentation of the material around the major recurrent issues. Data and quotations illustrating types of responses and subject characteristics were used only when useful in describing the identified issues.

Following the initial identification process, the observers compared their own notes and general impressions with the issues and descriptions made by the interviewer. Based on input from the observers and the audio-tapes, the interviewer reorganized identified issues, 'quantified' responses and elaborated descriptions with both factual and paraphrased quotations. The effort to quantify responses was evident in formulations such as: 'Most subjects...', reflecting majority experiences and attitudes; 'Some subjects...', reflecting variations; and, 'One candidate...', reflecting unique experiences or attitudes.

Results

Based on the analysis described above, the eight interviews resulted in an identification of the following eight issues:

- (1) general appraisals;
- (2) verbal and non-verbal communication;
- (3) preparation and structure vs spontaneity and free associations;
- (4) associations with related technology;
- (5) difficult emotional content vs neutral intellectual content;

- (6) social and emotional presence;
- (7) videoconferencing as a teaching tool;
- (8) individual characteristics.

Discussion

The eight subjects in the present study reported a wide range of experiences and attitudes which help in assessing the effects of videoconferencing on the quality of psychotherapy supervision. The major dislikes and concerns reported were related to reduced non-verbal cues, and the effects this was felt to have on spontaneity, expression of personal emotional material, and experience of social and emotional presence. These reports coincide with Rutter's⁵ 'cuelessness model', which predicts that as we move through four conditions—face-to-face, curtain (physical presence minus visual cues), closed circuit television (CCITV) and telephone—the smaller the available aggregate of social cues, the more task-oriented and depersonalized the content, which in turn leads to a more deliberate, non-spontaneous style, as well as particular types of outcome.

How then does cuelessness affect users' ability to achieve the goals of supervision as described in our introduction? Several factors complicate attempts at answering this question. First, our study focused on ongoing relationships (rather than experimentally construed interactions) in which the participants play real-life roles and share common goals. Indeed, when subjects explained why they did not think videoconferencing seriously affected the quality of supervision, references were made to the quality of the previously established relationship. Since our study did not include a comparison group with pairs not having previously established a relationship, we are unable to indicate how cuelessness may affect the relationship-building phases of supervision. Second, several believed that factors unrelated to videoconferencing (e.g. being video-recorded) compounded the reported effects of reduced non-verbal cues such as reduced spontaneity. Third, several reported an increased ability to overcome the limitations imposed by videoconferencing as experience accumulated.

The most surprising factor reported by subjects was that videoconferencing had some positive effects on the psychotherapy supervision process (e.g. verbalization, structure, self-representation, potential as a teaching tool). These effects were, paradoxically, related to the limitations imposed by videoconferencing. Further, some of the positive effects were not related to videoconferencing as such, but were imposed by the conditions of the study (e.g. better preparation due to a journey time of 10 min, not being interrupted by the supervisor's telephone, having a delineated, neutral space separate from the supervisor's office).

We believe that the most constructive approach to this study is to focus upon its practical implications for improving the quality of supervision independent of the specific use of videoconferencing. Several subjects, including both supervisors, found it inspiring to be confronted with a new mode of communication, and thus also a new awareness of the

importance and limitations of face-to-face communication as a mode for psychotherapy supervision. Placing the quality of communication on the agenda (e.g. how the presence and lack of various cues affects communication, how our fantasies and associations with communication technology affect transference/countertransference processes, how consideration of these factors may affect the supervisors' work in developing a teaching diagnosis) may stimulate potentially valuable insights into the role of communication in building relationships. Furthermore, our study indicates that some may profit from taking a critical look at the surrounding conditions for supervision. Measures like moving supervision to a neutral space separate from the therapist's office and allowing a 10 min mental adjustment period before plunging from the hectic day into supervision may be simple but important steps towards improving satisfaction and the quality of psychotherapy supervision.

Further research into the effects of technology on psychotherapy supervision will need to look more closely at the relationship between process variables—which characterize today's descriptions of qualitatively good supervision—and outcome variables (e.g. relationship skills, abilities to apply their acquired understanding to therapeutic work). Our subjects periodically touched on the process–outcome issue by indicating, for example, that satisfaction did not necessarily coincide with suitability. What you like is not necessarily good for you. The introduction and evaluation of new technologies in new fields often confronts decision makers with the challenge of operationalizing their primary goals in terms of outcome measures. Such measures are not developed for psychotherapy supervision. This is also the case for clinical supervision which, interestingly, many claim is better suited to videoconferencing use than psychotherapy supervision. One approach to the development of such measures may be adaptation of measures that have proven successful in predicting therapeutic outcome for patient–therapist pairs. Working alliance measures⁷ is an example that may be useful, and has been adopted as a methodological approach for the quantitative parts of this study, the results of which will be published in separate articles.

Conclusions

We feel confident in using this study as a basis for claiming that the quality of supervision can be satisfactorily maintained by using videoconferencing (384 kbit/s) for up to half of the 70 hours of required psychotherapy supervision. The precondition for this estimate is that the pair in question have met face

to face and established a relationship characterized by mutual trust and respect. Further studies, which include supervision pairs not having previously established relationships, are needed in order to indicate the extent to which this precondition is necessary.

The most surprising result of this study is that the limitations imposed by videoconferencing may stimulate the development of insights and communication abilities which, paradoxically, contribute positively to the quality of psychotherapy supervision, also in a face-to-face setting. This itself may represent a fruitful field for future research in human communication, both in psychotherapy and supervision processes, independent of the practical applications of videoconferencing.

The most obvious implication of this study is the potential for implementing decentralized models for recruiting and educating psychiatrists. In parallel with further studies aimed at providing guidelines for quality maintenance in health-care services and education, organizational issues must be addressed. Educational and health-care institutions will need to develop strategies for utilizing videoconferencing and other communication technologies in order to improve access to their resources, particularly for rural communities lacking qualified health-care personnel.

Acknowledgements: This study received financial support from the Norwegian Research Council. We thank Dr Paul McLaren, Division of Psychiatry and Psychology, Guy's Hospital, London, for valuable comments. Parts of this study were published in the *Nordic Journal of Psychiatry* and appear by permission.

References

- 1 Lorentsen S, Sørli T, Ellefsen EP, eds. Psychotherapy training in the Norwegian programme for specialisation in psychiatry. *Nordic Journal of Psychiatry* 1995;suppl. 34:49
- 2 Dahl AA. Obligatorisk psykoterapiveiledning—målsetting og innhold. *Tidsskr Nor Lægeforen* 1987;9:885–6
- 3 Ekstein R, Wallerstein R. *The Teaching and Learning of Psychotherapy*. New York: Basic Books, 1958
- 4 Szecsydy I. *The Learning Process in Psychotherapy Supervision*. Stockholm: Karolinska Institutet, 1990
- 5 Rutter DR. *Looking and Seeing: The Role of Visual Communication in Social Interaction*. Clevedon: Wiley, 1984
- 6 Crabtree BF, Miller WL, eds. *Doing Qualitative Research: Research Methods for Primary Care*, Vol. 3. Newbury Park: Sage, 1992
- 7 Tracy T, Kulkovic AM. Factor structure of the Working Alliance Inventory. *Psychological Assessment* 1989;1:207–10