2021

Competency-based training in the supervision of relational telemental supervision

Paul Springer
University of Nebraska-Lincoln, pspringer3@unl.edu

Richard Bischoff
University of Nebraska-Lincoln, rbischoff2@unl.edu

Nathan C. Taylor
University of Northern Iowa, nathan.taylor@uni.edu

Vanessa Neuhaus
University of Nebraska-Lincoln, vanessa.neuhaus@unl.edu

Cassandra Leow
University of Nebraska - Lincoln, cassandra.leow@huskers.unl.edu

Received: 4 September 2020 | Accepted: 10 March 2021

DOI: 10.1111/jmft.12513

JMFT Journal of Marital and Family Therapy

ORIGINAL ARTICLE

Competency-based training in the supervision of relational telemental supervision

Paul R. Springer[1] | **Richard J. Bischoff**[2] | **Nathan C. Taylor**[3] | **Vanessa Neuhaus**[1] | **Cassandra Leow**[1]

[1]Department of Child, Youth and Family Studies, University of Nebraska-Lincoln, Lincoln, NE, USA

[2]Institute of Agriculture and Natural Resources, University of Nebraska-Lincoln, Lincoln, NE, USA

[3]School of Applied Human Sciences, University of Northern Iowa, Cedar Falls, IA, USA

Correspondence
Paul Springer, Department of Child, Youth, and Family Studies, University of Nebraska-Lincoln, Louise Pound Hall 211F, Lincoln, NE 68588-0364, USA.
Email: pspringer3@unl.edu

Funding information
U.S. Department of Agriculture

Abstract

Supervision has long been considered essential to developing effective mental health practice, especially among COAMFTE accredited training programs. But with telemental health rapidly being accepted as a standard treatment medium for couple and family therapy, there is little guidance about how to supervise clinicians who are engaged in telemental health practice. This paper presents an important step toward increasing the effectiveness of the supervision of therapists who are delivering relational therapies online through the identification of relational competencies unique to this delivery medium. These competencies have been adopted and integrated into a COAMFTE accredited master's degree program that has been providing training in telemental health since 2008. The competencies are described, and supervision strategies that can be utilized and developmentally assessed throughout the program will be detailed.

KEYWORDS
clinical, couples, families, populations

COMPETENCY-BASED TRAINING IN THE SUPERVISION OF RELATIONAL TELEMENTAL HEALTH

Supervision has long been considered critical to the development of competent and effective clinicians (Bernard & Goodyear, 2014). The standards for Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accreditation underscore the importance of supervision through some of the most rigorous program training requirements in the mental health industry (Commission for the Accreditation of Marriage and Family Therapy Education, 2017). The amount of supervision received by graduates of COAMFTE accredited programs is unparalleled. Also unparalleled are the training and qualifications to become an Approved Supervisor. It is clear that supervision is a hallmark of training in couple and family therapy.

Telemental health

Rapid advancements in technology, and most recently, restrictions in response to flattening the curve of infection of Covid-19, have hastened momentum toward changes in how mental health treatment is delivered. Mental health clinicians, who in 2019 and early 2020 would not have ever even considered delivering mental health treatments via technology, are now doing so out of necessity—the necessity of their clients and of their own livelihoods. Telemental health has quickly, and unexpectedly, become a standard of care practice.

Telemental health refers to using electronically based communication technology as a medium for delivering mental health care (Bischoff et al., 2004). This includes modalities such as telephone calls, texts, emails, mobile applications, and videoconferencing. Telemental health, in its broadest sense, can include both interactive (e.g., contact with a therapist) and static (e.g., material or feedback made available through an app or web site). Interactions with therapists through telemental health can be synchronous (e.g., a real-time written or verbal conversation with the therapist) or asynchronous (e.g., messages, typically written through email or text, in which therapist or client respond at their convenience). Each modality and variation on that modality (i.e., intractive vs static, synchronous vs asynchronous) has unique strengths and limitations and considerations that require unique skills and strategies for its effective use. In this paper, we do not have sufficient space to consider the clinical and supervisory considerations of all modalities and variations. We limit our discussion to the competencies needed in using video conferencing in the delivery of couple and family therapy and the supervision of the same. In this paper, we treat the terms telemental health and video conferencing as synonymous. Of all telemental health modalities and variations, video conferencing most closely approximates face-to-face interactions because it provides therapists and clients to the most access to visual and auditory cues in real-time interactions. The competencies described in this paper may or may not apply to the use of nonvideo conferencing modalities.

Fortunately, telemental health, while new to most clinicians and clients, is not new to the field. The earliest published article about telehealth bears a publication date of 1961 and describes a program of delivering group therapy through two-way television to rural residents of Nebraska by psychologists at the Nebraska Psychiatric Center (Witson et al., 1961). Due to the availability of technology, it took four decades for research and practice to gain further traction related to telemental health via video conferencing (Bischoff et al., 2004).

Video conferencing is a particularly effective medium for delivering mental health care. There is mounting evidence suggesting that treatments delivered through video conferencing are as effective as face-to-face treatment for a variety of mental, emotional, and behavioral health conditions that are

mild to moderate in severity (Doss et al., 2013; Dunstan & Tooth, 2012; Simpson & Reid, 2014). Also, telemental health is an efficient and cost-effective way of improving access to care for many who are underserved because of a dearth of providers in their own communities (Springer et al., 2020).

Now six decades from the first publication describing the use of telemental health, we still know little related to the use of video conferencing modalities to treat couples and families. Despite couple and family therapy emerging from a tradition of challenging the treatment status quo with innovative approaches to treatment and treatment delivery, marriage and family therapists have been late adopters of telemental health care (Akyil et al., 2017; Springer et al., 2020; Baltimore, 2000; Hertlein et al., 2014; Hertlein et al., 2015; Pickens et al., 2019). There are, perhaps, many factors that have influenced the reluctance of adopting telemental health as a treatment medium for couple and family therapy. Two of these reasons may be (a) the complexities related to couple and family therapy, including seeing couples and family members together in counseling, and (b) COAMFTE accreditation standards that have explicitly discouraged academic training programs from providing students with training experiences in telemental health.

The complexities related to couple and family therapy

Treating couples and families is complex. Not only is one needing to attend equally to multiple individual perspectives, experiences, and histories but the astute provider also needs to attend to the patterns of interactions between people within an intensely emotional context. The stakes are high for both the individual and the relationship in couple and family therapy. Progress toward a positive outcome by one person can quickly be mitigated by another person in the relationship or by the entrenched patterns of interaction. A slight look, behavior, or the way something is said that might go unnoticed by a casual observer can carry a lifetime of meaning, either positive or negative, to a family member or partner. The therapist needs to be constantly engaged with the couple or family and attentive to emotions, cognitions, behaviors, and interactions. This is hard enough when meeting with a couple or family face-to-face. When meeting with them via distance technologies, the complexity is exacerbated (Springer et al., 2020; Wrape & McGinn, 2019). The therapist has less control over the client environment and loses the ability to see and hear subtle nuances. Their field of view is limited to what the camera picks up, which may also limit the number of people they can have in the "room" at any one time (Wrape & McGinn, 2019). Couple and family therapy via telemental health has sufficient differences that will require training and supervising students using this modality in unique ways.

Coamfte accreditation standards and telehealth

COAMFTE accreditation standards have explicitly prohibited programs from counting telemental health clinical contact hours. Prior to 2020 and the restrictions in meeting face-to-face due to the global Covid-19 pandemic, this proved to be a great disincentive to program faculty to provide training and supervision in telemental health and to encourage graduates to incorporate telemental health in their practice of couple and family therapy. While it is true that professional development and learning is a career-long pursuit, it is equally true that the academic program provides a socializing function. The student's graduate program introduces them to the field; it is their first socialization experience. As is true of any first socialization experience, it often has the most powerful and enduring effect. Failure to expose students to the future realities of mental health practice, including telemental health,

is a serious flaw in training programs, as students lack the skills that many mental health agencies are looking for in meeting the needs of their clients. This prohibition of the COAMFE to count experience with telemental health has also been a disincentive to clinical faculty to learn for themselves the intricacies of relational telemental health practice sufficient to be able to supervise therapists in the same.

However, despite this prohibition, even before the pandemic, some pioneering researchers and clinicians started highlighting best practices in the online practice of couple and family therapy (Bischoff et al., 2017; Blumer et al., 2015) as well as video conferencing-based telemental health (American Psychiatric Association and American Telemedicine Association, 2018). Most of this literature provides guidelines in ethical considerations, the need for new ethical codes, selecting appropriate video conferencing platforms, and data related to the overall effectiveness of this modality. Unfortunately, these best practice guidelines fall short in describing the process by which clinicians develop competencies, skills, and supervision related to the delivery of this modality. This has greatly hindered the interest and growth of telemental health delivery, especially among MFT's (Pickens et al., 2019). For example, some beginning groundwork for the development of specific competencies for online practice in MFT has been done by Blumer et al. (2015). The most significant recommendations from this study were that the field needs to develop core competencies around the practice of technology as well as ethics in using this modality. Bischoff et al. (2017) similarly recommend that AAMFT invest in partnering with other Associations to create a consensus of standards across the profession; yet to our knowledge, nothing substantive around telemental health competencies has been published. Our accredited Master's program began offering telemental health in 2000. Drawing on our experience supervising and training master's degree students in delivering couple and family therapy through this modality, in 2008, we began identifying relational competencies needing particular attention in training therapists in telemental health. We were doing this without the help of the practice guidelines that have since been published in 2017 (Bischoff et al., 2017) and 2018 (American Psychiatric Association and American Telemedicine Association, 2018). Our intent was and is to be selective of those competencies needing particular attention given the strengths and limitations of technology-mediated (in this case, videoconferencing) therapeutic assessment and intervention when working with couples and families.

Like Nelson et al. (2007) who identified core competencies on behalf of AAMFT, the competencies we identified are pantheoretical. They are competencies that apply to all therapeutic models of couple and family therapy. For example, regardless of theory, therapists need to know how to diffuse and de-escalate emotionally intense interactions. This is a pantheoretical competency. The theory or model informs the therapist “how” to do this, but the competency—de-escalation of emotionally charged situations—cuts across all approaches. Unlike Nelson et al. (2007), we have chosen not to be inclusive of all competencies. What we have presented are only the therapeutic intervention competencies, based on over 20 years experience supervising and training therapists in the delivery of couple and family therapy through videoconferencing, that deserve special attention in the unique video conferencing environment of telemental health.

Supervision of telemental health practice

While there are some helpful resources about the delivery of supervision using video conferencing or other technologies (telesupervision; Sahebi, 2020), we could not find any publications addressing best practices in supervising individuals who are providing telemental health. Inman et al. (2019) identified and reviewed 35 published studies that looked at telesupervision in the mental health field. The general finding across all these studies is that face-to-face supervision and supervision via video

conferencing were equally effective (see also Bender & Dykeman, 2016; Inman, Bashian, et al., 2019; Jordan & Shearer, 2019; Reese et al., 2009) with similar or greater levels of satisfaction for both supervisor and supervisee (Bender & Dykeman, 2016; Reese et al., 2009). Each of these studies were about using technology as a medium for providing supervision of face-to-face delivery of mental health care. None were about providing supervision of telemental health care. Given the rush to telemental health in the face of the global Covid-19 pandemic, what is needed, more now than ever before, is guidance for supervisors who are supervising students and others in the use of telemental health care. Given the complexities of providing couple and family therapy via technology, this guidance is particularly relevant and important for supervisors of couple and family therapists.

Competencies in the delivery of relational telemental health care

In the last 20 years, competency-based education and approaches have gained increased attention in the mental health field (Falender & Shafranske, 2014), with MFTs being early adopters to this approach (Northey & Gehard, 2020). In 2004, COAMFTE identified 128 core competencies that were expected to be implemented in every training program (American Association for Marriage and Family Therapy, 2004). Unfortunately, the level of complexity and abstraction as well as the sheer number of competencies made implementation incredibly difficult (Brooks & Northey, 2011; Northey & Gehard, 2020). This resulted in graduate programs needing to develop their own resources and instruments so they could formally assess competencies that were historically taught informally (Northey & Gehard, 2020).

Because the standard of care up until early 2020 was mental health treatment delivered face-to-face, it can be assumed that these competencies (published in 2004) relate to the face-to-face delivery of couple and family therapy. It would be a mistake to assume that everything that works in a face-to-face environment will work equally well in a virtual environment. While it may be that there are more similarities than differences, there are still notable differences that require unique competencies. If those differences are not attended to, the effectiveness of the treatment may be compromised. We must, therefore, assume that some competencies need to be modified and others added to accommodate the unique skills needed for delivering couple and family therapy via telemental health.

Prior to the publication of this paper, the only guidance for supervisors and clinicians related to telemental health was found in our professional codes of ethics, which focused on the need for training and supervision in telemental health in order to protect the public (American Association for Marriage and Family Therapy, 2015) as well as suggestions for best practices for online couple and family therapy (Bischoff et al., 2017). Yet this need for supervision and training has been disregarded in the flight to telemental health on the onset of the Covid-19 pandemic. In the absence of guidance and qualified supervisors, couple and family therapists, out of necessity, were left to bring their ingenuity and problem solving to bear to figure it out on their own. There was an immediate need for solutions at a time when the infrastructure for supervision and training did not exist. However, as the field transitions from the reactive state of first finding itself in crisis to a state of new relative normality, what is needed is a measured identification of guidelines for supervisors and training programs about the competencies needed for telemental health practice in couple and family therapy. As has been true in the past when it comes to establishing guidelines for supervision, training program faculty must lead out in determining best practices for supervision and competency achievement.

COAMFTE accredited programs are at an important crossroads related to telemental health and must adapt so they are preparing students for the reality of everyday practice. This includes supervising students in telemental health practice and ensuring that supervisors have the adequate training

to ethically meet our codes of ethics. In order to accomplish this, competencies focused on relational telemental health supervision and training must be identified, as well as the relational skills and learning strategies necessary to implement them in a developmental way. It is our belief that AAMFT approved Supervisors (trained in telemental health) are best equipped to assess the clinician's mastery of relational telemental health skills and provide support when these benchmarks are not met (Calvert et al., 2017). These competencies must go beyond modeling and role playing microskills such as active listening and conflict resolution but extend into supervision of telemental health practice where these relational skills are observed, and feedback and guidance can be provided directing their implementation.

The purpose of this paper is to fill an important gap in the literature by identifying specific competencies of students (and others learning how to deliver couple and family therapy via telemental health) who should be able to achieve in order to demonstrate that they can effectively deliver treatment through videoconferencing. Below, we identify seven competencies specifically germane to couple and family therapy and telemental health. These competencies have been identified through research (our own and others) and through their implementation in our COAMFTE accredited master's degree training program since 2008. These relational competencies have been adapted from the 2004 AAMFT core competencies and implemented in a way to ensure that students supervised in relational telemental health can demonstrate mastery of these skills.

SUPERVISION AND TELEMENTAL HEALTH COMPETENCIES

One of the challenges for supervisors is the lack of studies identifying the skills needed to deliver relationally based telemental health treatment (Springer et al., 2020). Previous studies in telemental health have been able to identify the benefits associated with using this modality such as cost-efficiency (Antonacci et al., 2008), symptom reduction (Dunstan & Tooth, 2012), and ability to foster therapeutic alliance (Singh et al., 2007). However, currently, only one published study identifies the skills and training therapists needed in order to deliver relationally focused telemental health (Springer et al., 2020), with another study identifying ethical considerations and guidelines for working with couples and families using this modality (Wrape & McGinn, 2019). Additional research has also confirmed that MFT programs have failed to integrate telemental health training and education in their programs (Pickens et al., 2019), resulting in a lack of quality training and supervision research in this area.

Recognizing the need to establish competencies in telemental health care for couple and family therapy, we applied for and received USDA/NIFA Higher Education Grant award in 2008. This funding facilitated the development of a training model and guidance for supervisors, including the identification of competencies in telemental health practice for MFTs. This paper describes these competencies and guidance. The seven competencies are in two categories: (a) competencies related to telemental health and (b) relational competencies for working with couples and families within the virtual environment of telemental health.

Competencies related to telemental health

The two competencies in this category are critical in ensuring that all students are prepared for the realities of mental health care practice by training them in the responsible use of video conferencing as a medium for delivering mental health care services. The two competencies related to the use of

technology are as follows: (1) competencies in the technical use of equipment and (2) competencies in professionalism and client management.

Competencies in the technical use of equipment and technology

The goal of this competency is to ensure that the trainee is competent in operating the equipment, able to instruct others, and trouble-shoot in the face of problems with the technology. The five skills measured in this competency are as follows: (1) competency with the technology, (2) providing instruction to clients and end user site personnel in how to use the equipment to facilitate treatment delivery, (3) trouble-shooting in the face of problems throughout treatment, (4) developing technology usage protocols with the end user site personnel, and (5) articulating the limitations and benefits associated with communication technologies.

Supervisor assessment of this competency can minimize challenges and anxiety related to technology. Assessment of this competency can include supervisors reviewing client intake instructions to ensure the inclusion of information related to this technology. Additionally, observations of first sessions should include assessment of the therapist describing protocols for technological problems, such as the computer freezing, disruptions in internet service, or audio-related challenges. Supervisors can help therapists explore possible problems and solutions to better prepare provider and client to utilize technology.

Professionalism and client management when treatment is delivered at a distance

The purpose of this competency is to evaluate how effectively the clinician is able to manage outside of therapy communication to coordinate care and make ethical decisions that minimize client risk. In our case, this is both with the client and medical providers and other end user site personnel. The fact is that with the distance delivery of couple and family therapy, extra care must be given to coordination of the treatment with clients and if appropriate with others. A total of four skills are assessed in this competency: (1) managing communication regarding scheduling, (2) demonstrating understanding of the client's community resources, (3) ethical decision making that emphasizes the safety of clients, and (4) minimizing risk to clients.

Supervisors play a critical role in ensuring that the therapist has a working knowledge of the local resources of the client. One may not initially feel that this is the role of the therapist; however, this is an essential competency to enhance treatment and ensure client safety. For example, during treatment a therapist may feel a need to refer a client to a health care or other related professional for care relevant to treatment. Without a working knowledge of available resources in their community a client is less likely to follow through with this referral.

Safety issues are also more pronounced when doing telemental health, which requires gathering important information related to client safety and location. For example, one ethical consideration is to have clients disclose their location at the onset of the session. This is important because it is not uncommon to be working with a client who exhibits suicidal ideation and even suicidal intention. If the therapist does not know where the client is receiving services, and the number of the local police department or hospital, the therapist cannot make decisions that emphasize safety to the client. It is the supervisor's job to demonstrate with the therapist how to role play these potential scenarios, as well as how to discuss the consideration for protecting confidentiality via this modality.

Relational competencies for working with couples and families through telemental health

The aforementioned COAMFTE accredited program identified clinical competencies from among the list of 128 identified by the AAMFT task force that have particular relevance to the practice of couple and family therapy via telemental health. These competencies have been elaborated on and modified so that we can capture the uniqueness of delivering couple and family therapy using this medium. These are the following: (1) defuse intense and chaotic situations, (2) deliver interventions in a way that is sensitive to the needs of the client, (3) engage each family member in the treatment process, (4) establish and maintain appropriate and productive therapeutic alliances with clients, and (5) determine the effectiveness of clinical practice and techniques (Table 1).

Defuse intense and chaotic situations

A recent study of student therapists' experiences providing telemental health care found that couples' treatment was often difficult due to challenges in intervening into the couple dynamic when emotions became heightened (Springer et al., 2020). Key challenges for trainees are recognizing early the signs of emotional escalation and timing their intervention in a way that diffuses harmful negative

TABLE 1 Relational competencies and skills for telemental health supervision

Competency	Skill	Example
1. Diffuse intense and chaotic situations to enhance the safety of all participants (4.3.7)	Recognizing cues without the use of the five senses and setting up ground rules early in how to intervene when escalation occurs	Predetermine intervention strategies that can be used to de-escalate a client, such as playing music or putting up a picture on the screen
2. Deliver interventions in a way that is sensitive to special needs of clients (4.3.2)	Develop cultural awareness of the community or population as well as adapting interventions for telemental health	Take time to plan for interventions ahead of time to ensure clients have materials needed. Ask more questions, have clients use the camera to show you the work they have done
3. Engage each family member in the treatment process as appropriate (4.3.5)	Recognizing that family treatment should be limited due to the size of the room, or capacity to see all of the participants	Work with Supervisor in determining the dyads and triads that should be present in treatment
4. Establish and maintain appropriate and productive therapeutic alliances with clients (1.3.6)	Slowing down the therapy process to listen, hear, and understand the problem before moving into solutions building	Have clients take pictures of things within their home that represent their life, their relationship, or the challenges they are experiencing
5. Determine the effectiveness of clinical practice and technique (6.3.4)	Find a simple way to collect outcome based data that clients can fill out, as well as identify software that will allow you to record all sessions, and have supervisor anonymously attend live sessions	Student therapists were required to track all data and plot it. This included the outcome rating scale, the session rating scales, as well as additional scales that were collected at key points in the treatment process

consequences by disrupting the cycle of negative escalation. We have found this to be particularly challenging for student therapists using telemental health because of the limitations of the technology to give the therapist full access to sensory data. The technology mutes nonverbal cues that are readily apparent otherwise, let alone those that require experience and expertise to discern. Add to these even slight delays in response time due to technology signal delays, and the complexity of intervention becomes more apparent. As a result, the therapist often has little indication or time to respond when a client becomes angry or emotionally triggered in session. Attention to this competency is particularly important when supervising and training telemental health clinicians.

Relationally trained supervisors should work with therapists to become more aware of the cues of emotional escalation. For example, cues of emotional escalation common in telemental health are (a) agitated client movements, (b) avoiding looking at the camera or their partner, (c) avoiding answering questions, and (d) difficulty restating or validating their partner's perspective without getting defensive. Because of the technology, other tale–tale signs of escalation will probably not be seen or heard, such as fidgeting in one's seat, shaking one's leg or feet, changes to body posture or facial expressions, or subtle changes in intonation. It is the supervisor's responsibility to help their supervisees recognize cues despite the lack of access to multisensory stimuli because of telemental health. Supervisees may need to be coached on asking more questions about their clients' feelings and emotions than they would when meeting face-to-face so they can better gauge their clients emotional states. We have found that being able to watch video of sessions with the supervisee is critical to helping them recognize early signs of emotional escalation and to formulate questions that allow them to properly assess and intervene. Well-formulated question also help encourage client self-monitoring and de-escalation. For example, if a supervisee is unable to discern subtle nuances in facial expressions or other similar cues, the supervisor should assist the therapist in being more intentional in regularly asking questions aimed at gauging the emotional temperature of the room. Supervisors can also help supervisees acknowledge the cues they normally look for in determining emotional escalation and to look for alternative cues that are more readily discerned given the limitations of the technology. If a client is not looking at their spouse, or is constantly looking away, saying something like "It's hard to tell because of the technology, but it appears that you are having a hard time looking at your partner right now. Is that the case? What are you feeling right now?" Stating these kinds of observations and asking these kinds of questions provide opportunities for the client to articulate how they are feeling before it potentially leads to negative cycles of escalation. While these questions are appropriate when conducting treatment face-to-face, they need to occur earlier and with greater frequency online.

When working with couples, it is inevitable that therapists will experience situations where emotions will escalate toward intense and emotionally charged conversations. What is most difficult in these situations is that the therapist is not physically present in the room and is limited by how the technology mediates their interactions. In telemental health with couples, we instruct supervisees to anticipate this kind of escalation with every case. Do not wait for it to happen before establishing ground rules for how to deal emotional outbursts. We have our supervisees acknowledge in the first meeting with their clients that the technology will prevent them from discerning the early signs of emotional escalation and what will happen when it occurs. This creates agreed upon intervention strategies that are used when the therapist recognizes negative interaction patterns and when things become chaotic. Creatively, the technology itself can be used to facilitate this intervention. For example, one of our student therapists worked with their clients to identify a picture the therapist would show on the screen when she saw the beginnings of unproductive escalations (e.g., a funny picture or beautiful location). The picture would be enough to disrupt the escalation and remind the client to slow things down. Another therapist worked with their clients to identify a song that carried a particular meaning that the therapist could share through the technology that would interrupt the negative pattern. For

another, it was simply the therapist blacking out their screen so the clients could no longer see them. In each instance, the technology was used to send a clear message to the client that they were engaging in a negative cycle and was often enough to facilitate therapist intervention.

Deliver interventions in a way that is sensitive to needs of the client

There are two aspects of this competency that are particularly important when working with those learning to use telemental health for couple and family therapy. The first concerns how to assist and support the therapist in demonstrating cultural competence and sensitivity to clients. The second relates to developing interventions that are culturally acceptable, which may require greater preparation and flexibility in adapting and setting up the delivery of these interventions.

This competency is particularly important for therapists using telemental health who are using this modality to increase access to care among clients who are cultural minorities and who are underserved through traditional face-to-face modalities. For example, our urban-based student therapists are providing couple and family therapy at a distance to residents of rural communities. Rural communities have a unique culture that differs from their urban counterparts (Bischoff et al., 2014), and therapists who hail from urban environments often have unacknowledged biases that influence how they provide care to people living in rural communities. Perhaps in large part due to these cultural differences, many rural residents are distrustful of outsiders and require trust to be earned. Supervisors help supervisees learn about and appreciate the unique culture and nature of life in rural communities and the challenges and benefits that are associated with that. As a result, our students are expected to learn about the rural community where their clients reside as well as immerse themselves in the rural mental health literature. A program requirement is that student therapists spend time in the rural community they serve. At least once a month, the therapist is required to visit the rural community to meet with clients face-to-face, better understand local resources, collaborate with local providers, and get a feel for the community in which the clients reside. During this site visit, they are encouraged to do things like eat at local restaurants, shop at the grocery store, and attend sporting or other community events. The supervisor then debriefs these experiences with the student helping them to better appreciate the culture and to engage their clients with more empathy and understanding.

Another example that is particularly timely is providing telemental health services to Black, indigenous and people of color (BIPOC). Systemic racism has disproportionately placed racial and ethnic minorities in the United States at greater risk of not being able to access health and mental health services, including telemedicine and telemental health (Campos-Castillo & Anthony, 2020). Issues such as systemic bias and discrimination, stigma, and cultural mores affect perceptions of mental health and mental health care and are issues that therapists need to address (Campos-Castillo & Anthony, 2020; Mental Health America, 2020). This may require supervisees to spend more time with clients in developing a therapeutic relationship, acknowledge racial and social justice issues, and allow BIPOC clients to express concerns they have in receiving therapy via this modality. Supervisors may need to help trainees identify cultural brokers (or serve in this role themselves) and help supervisees see how the traditional models of couple and family therapy that have been developed through working with urban middle- to upper-class clients may need to be modified for clients with different racial, ethnic, cultural, or socio-economic backgrounds.

In addition to helping students understand their clients' culture and context, supervisors should help supervisees explore and understand their own cultural context, which could include their familiarity with and access to technology. This is particularly important when working with students trained in telemental health delivery, because each of them has their own biases and beliefs about the efficacy

of this delivery modality. In a review of psychotherapy via video conferencing it was found that one's belief about telemental health could be a significant barrier to effective delivery (Springer et al., 2020; Chherawala & Gill, 2020).

Supervisors should also help supervisees explore and discover how to effectively deliver interventions so that they are sensitive to the needs of the client and appropriate to the online format. Supervisees will need to understand that they will need to do more work on the front end to prepare for and to set up the interventions. This includes ensuring that clients have materials in place for experiential activities, writing, assessment, or other activities, and taking more time describing to the client what needs to be done or helping clients manipulate the camera so that the therapist can see what they have been working on (Springer et al., 2020; Chherawala & Gill, 2020). In most cases clients will need more time and help from the therapist to articulate more fully their experiences of the intervention, as well as the descriptions of the sand tray, sculpt of drawing they created. In many instances it might be necessary to ask a partner or parent to assist in setting up the intervention for the therapist or to hold the camera as a silent observer. This is particularly useful when working with children, as the parent can participate in the delivery of interventions, including how to set it up, and what items should be brought to session. Regardless of the intervention, the therapist has to develop trust with the client, which will put the client more at ease prior to performing the intervention. Supervisors can help therapists think through these things.

We have found that a critical role of supervision is to help therapists think outside of the box, so they have permission to do interventions differently than described in books or articles that are based on assumptions of face-to-face treatment modalities. For example, doing a family sculpt will require one family member to hold the camera or to describe more in depth positioning of family members and stances they are taking. This allows supervision sessions to focus on how interventions can be adapted to overcome the traditional telemental health barriers so the desired outcomes can be achieved. For example, simply asking a therapist how they would intervene with their clients if they were seeing them in-person can be catalyst to adapting the intervention to telehealth or to exploring similar interventions more conducive to the virtual environment that will assist in achieving similar goals. Therapists in training need to know that interventions may not only take more time in delivering but in processing the clients' experience. We have found that one of the most powerful effects of any intervention via video conferencing is having the client describe in detail what they experienced and why they did what they did. Also, helping therapists plan the types of interventions they use also serve as a prompt for them to get materials to clients or to request in advance that the client come prepared for the next session.

Engage each family member in the treatment process as appropriate

There are obvious limitations when using technology as a treatment medium to engaging multiple people in treatment. While there are many computer-based cameras that have a wide enough angled lens to capture two or more people comfortably in the video, many built-in laptop computer, tablet, and cell phone cameras have limited field of view capabilities. We assume that most people have had similar experiences as we have, where when using a cell phone or tablet for a video call with more than one person, we have had to invade one another's personal space in order for two of us to be seen by the person we are talking to. Even with larger field-of-view cameras, couples or family members need to sit much closer together than they may have if they were meeting with a therapist face-to-face and much closer together than they might feel comfortable with. Increasing emotional intensity by manipulating the distance between people is inevitable when doing couple and family therapy

remotely. It also increases the challenge of simultaneously meeting with and engaging each family member in treatment. Because of how challenging this is, some of our student therapists, without realizing it, find themselves gravitating toward meeting with individuals, even when the presenting problem is directly related to couple and/or family functioning. Supervision is critically important in helping supervisees explore reasons for including and not including others in treatment and to developing strategies for making it work despite the limitations imposed by the technology.

A "more is better" interpretation is often given to this competency. However, in telemental health, the therapist can only be as effective as the technology and the physical environment of the client will allow. Depending on where the clients are physically located and the capabilities of their technology, the number of people the therapist meets with may need to be adjusted. Our supervisors regularly help student therapists think through these issues, including how to engage multiple family members in treatment when they may not be able to be simultaneously involved in any given session. This may seem counterintuitive when doing family treatment, in which you may want to see how all family members engage with one another. However, it is better to ensure that the therapist can influence the use of space and emotional environment and that they have access to the nonverbal and other observational information that they need, and to do so with telemental health may mean that the number of people in a session is reduced rather than expanded. Supervisor assistance in strategically choosing the individuals, dyads, or triads to include in any one session is vital to avoid triangulation or unhealthy family structures. It is the Supervisor's job to ensure that the therapist remembers that their responsibility as a relational therapist is to bring others' perspectives into the room, even if they are not physically present.

Now a word of caution. We have had multiple occasions, and probably more that we do not know about, in which our therapists have serendipitously discovered that a spouse, partner, or family member was listening in on the session outside of the view of the camera. We have found supervisors to be an invaluable resource in helping therapists anticipate, proactively address, and navigate these types of situations when the occur. For example, it is common practice now for our therapists to begin sessions asking their clients who else is present in the room. It is also not uncommon to ask clients to use their camera in showing them whether someone is present or to familiarize the therapist with the client's virtual environment.

Establish and maintain appropriate and productive therapeutic alliances with clients

While the literature has shown that the therapeutic alliance can be equally strong with telemental health as it is with face-to-face delivery of psychotherapy (Backhaus et al., 2012), little is known about the intricacies of the formation of the therapeutic alliance when using telemental health. One qualitative study found that therapists perceived the therapeutic alliance via telemental health as taking more time to develop than traditional face-to-face treatment and concluded that therapists should take more time getting to know their client prior to moving to interventions (Springer et al., 2020).

We found the adoption of this relational competency to be particularly critical for telemental health given the stable finding that the therapeutic alliance accounts for the majority of client change (Sprenkle & Blow, 2007). The supervisor's role is to help the supervisee think through the pacing and timing of intervention in light of the therapeutic alliance. We have found that the mediating effect of technology on the therapeutic alliance has actually helped our student therapists be more attentive to the processes involved in developing it than we were ever able to achieve when supervising face-to-face treatments. Supervisors can help supervisees look for evidence of trust and readiness for change.

They can help supervisees give themselves permission to take more time building a relationship with their client and in understanding their perspective of the problem and their experience of treatment.

Slowing down the therapeutic process is a skill that has assisted our telemental health therapists in not only having a better understanding of the problem but also in the rural clients feeling that the therapist genuinely cared about him/her. The consequence of this is it helped the client and therapist move out of the "cognitive" and into a more emotional state of sharing information. It also assisted the therapist to not move too quickly into solution building or rush into unnecessary interventions until the overall goals of treatment were identified. An example of things that serve both alliance-building and intervention functions is encouraging clients to take pictures (and bring them to session) items in their home that represent their life, relationship, or the challenges they are experiencing. This intervention allows the therapist to learn more about their clients while asking important probing questions that facilitate a different perspective and understanding of their clients' life.

Determine the effectiveness of clinical practice and techniques

While this competency should be expected of every MFT, it is especially relevant when using an unfamiliar treatment medium such as videoconferencing. The role of the supervisor is to ensure that appropriate information is being considered to determine the effectiveness of what the therapist is doing and to help trainees learn how to monitor the effectiveness of treatment themselves. Conducting couple and family therapy using telemental health can pose some unique challenges, including being able to observe the therapist doing therapy and collecting feedback from clients using psychometrically stable instruments.

While on first blush it may seem as though live and recorded observation of therapy would be easier when using this medium, depending on the software used, it may be more complicated than it might appear. When we initially began providing telemental health in 2008, we did not have software that allowed us to directly record sessions. We had to videotape using an external camera pointed at the screen or conduct live supervision with the supervisor sitting in the room outside the view of the camera or behind a one-way mirror as though the therapy were being conducted face-to-face. With advanced technology, we can now record the session directly from the computer and/or conduct live supervision with the supervisor viewing the session anonymously from their own computer remotely. Regardless of whether live supervision occurs with the supervisor in the room or anonymously, it is our recommendation that clients are made aware and reminded that this is part of the therapeutic process. We have found that the more transparent our therapists have been in affirming the confidentiality of treatment, and the use of supervision and data, the more comfortable our clients feel.

Most HIPAA compliant video conferencing software programs now have recording capabilities which can make sharing video of the session with a supervisor convenient. However, similar to what was described above, clients may be distrustful, either consciously or subconsciously, about when recordings are being made, for what purposes, and with whom they are being shared, as clients can see when sessions are recorded. Again, our recommendations are for transparency; inform clients that recording of sessions is a possibility, that recording will not be done without their awareness, and how the recording will be used. We have found that it is not sufficient to just have this disclosure identified in a therapy agreement. Because of the prominence of the technology to treatment, it is important that the therapist talks about this with their clients. Clients know that the recording feature exists and that it could be used with or without their awareness, and this knowledge, especially if not acknowledged up front, could negatively impact treatment.

Collecting data about the effectiveness of treatment from clients poses unique challenges when using telemental health. When we began providing services to rural communities via telehealth, all of our assessment instruments were collected in hardcopy. We would mail hardcopies to clients or deliver the paper copies to medical clinics in rural communities where clients would come to receive telemental health. This took considerable planning and effort on the therapists' part to coordinate this effort with unreliable and untimely results. Today, however, our assessment instruments are online, allowing clients to complete them by computer, tablet, or cell phone and for therapists to have more timely feedback about their effectiveness.

Telemental health is not in the best interest of every client. Research on the effectiveness of telemental health indicates that it can be effective for a variety of mental and behavioral health problems of mild to moderate severity. It is not as effective for high severity problems. Currently, we do not yet have reliable evidence of the effectiveness of telemental health in the treatment of relationship functioning. This does not mean that therapists should abandon the use of telemental health until we have effectiveness data. However, it does suggest that care should be taken to assess the appropriateness of the modality for each client and each presenting problem. Supervisors are particularly useful in helping therapists think through whether or not the modality is contraindicated for a particular client. It could be that a particular client does not respond or interface well to technology-mediated treatment. It could be that the nature of the problem and/or its unique expression in these clients is not compatible with telemental health. It could also be that some therapists are much better at telemental health than others. Supervisors are in a position to help, especially those who are new to telemental health; therapists figure out the appropriateness of the modality for the effectiveness of the therapy.

CONCLUSION

The importance of competency-based training and supervision for telemental health was never more needed than today. As more and more clinicians are moving to telemental health delivery out of necessity, it is our hope that COAMFTE accredited programs will adapt so they are prepared to train and supervise the next generation of marriage and family therapists in the provision of relationally based telemental health treatment. It is our belief that telemental health training and supervision coupled with training students in achieving relationally based competencies in telemental health is critical in achieving this goal. The most recent research published in the *Journal of Martial and Family Therapy* has presented compelling data that relationally based telemental heath treatment requires unique skills and training (Springer et al., 2020; Wrape & McGinn, 2019). These skills can be learned and overcome with quality telemental health supervision, training, and competencies. It may be that competency-based training in telemental health may only be as good as a supervisor's experience with telemental health. We need more AAMFT approved supervisors who are experienced with and trained in telemental health and who can supervise therapists in training in the necessary relational competencies and skills one needs to effectively provide quality couple and family treatment.

This paper provides an important framework and specific competencies (both technological and relational) that COAMFTE accredited training program can adopt when supervising student therapists in relational telemental health competencies. These competencies have been implemented in a COAMFTE accredited master's degree program that has been supervising student therapists in relational telemental health delivery since 2008. With the adoption of these relationally based competencies, students and supervisors can hone in on developing relational skills via telemental health and demonstrate mastery of these relational competencies. These students have been required to collect

session data in order to show whether clients are improving throughout the treatment process and use this to inform their direction in therapy. Live and video supervision of their telemental health sessions have become a mainstay as the program has adopted better software options.

FUTURE DIRECTIONS

It is clear that additional research testing the implementation of this work in MFT training programs is the next step. These competencies need to be applied in training programs and then revised where relevant so we are able to best meet the needs of our students, as they will need skills in providing relationally based telemental health in future practice. It is likely, since the Covid-19 pandemic, that training programs are now grappling with how to teach and train students toward relational competencies in telemental health, and these competencies can provide a strong foundation in which to move forward as a field. As we move forward as a field, clinical faculty and other supervisors will need to learn more about how each competency can be taught and learned (Nelson et al., 2007). It is likely that there exist many methods in promoting the training in telemental health that can be applied in ethics, psychopathology, and theories courses. Doing so will provide important opportunities to infuse telemental health training throughout a clinical training program.

Finally, additional methods need to be developed for assessing student outcomes. While our clinical training program has created a comprehensive rubric for each competency, other programs may need to adopt other methods. For example, in our program each student is evaluated at minimum once a semester by three individuals on these competencies by (1) the faculty member providing supervision of the telemental health practice, (2) the practicum supervisor evaluating face-to-face clinical work, and (3) the therapist in training. We have learned that having multiple evaluations provided more accurate reflections of the student's competency level and mastery. At the end of each semester aggregate data are used to identify trends in conceptual and practical skill development and in helping the student therapist understand the areas of ongoing development. These data have become an essential tool in assisting the telemental health supervisor in recognizing areas of growth and in ensuring that the clinician has the skills and resources to demonstrate these competencies. Finally, it is important to note that the competencies we developed should only be applied to video conferencing as the medium to providing services via distance technology.

ORCID

Paul R. Springer https://orcid.org/0000-0002-2362-9579
Richard J. Bischoff https://orcid.org/0000-0001-6810-4269
Nathan C. Taylor https://orcid.org/0000-0002-3897-9555

REFERENCES

Akyıl, Y., Bacigalupe, G., & Üstünel, A. Ö. (2017). Emerging technologies and family: A cross-national study of family clinicians' views. *Journal of Family Psychotherapy*, *28*(2), 99–117. https://doi.org/10.1080/08975353.2017.1285654

American Association for Marriage and Family Therapy. (2004). *Marriage and family therapy core competencies*. Author.

American Association for Marriage and Family Therapy. (2015). *Revised American Association for Marriage and Family Therapy code of ethics*. Retrieved from http://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Psychiatric Association and American Telemedicine Association. (2018). *Best practices in Videoconferencing-based telemental health*. Retrieved from https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-and-ata-release-new-telemental-health-guide

Antonacci, D. J., Bloch, R. M., Saeed, S. A., Yildiram, Y., & Talley, J. (2008). Empirical evidence on the use and effectiveness of telepsychiatry via videoconferencing: Implications for forensic and correctional psychiatry. *Behavioral Sciences and the Law*, *26*, 253–269. https://doi.org/10.1002/bsl.812

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services*, *9*(2), 111–131. https://doi.org/10.1037/a0027924

Baltimore, M. L. (2000). Ethical considerations in the use of technology for marriage and family counselors. *The Family Journal*, *8*(4), 390–393. https://doi.org/10.1177/1066480700084010

Bender, S., & Dykeman, C. (2016). Supervisees' perceptions of effective supervision: A comparison of fully synchronous cybersupervision to traditional methods. *Journal of Technology in Human Services*, *34*(4), 326–337. https://doi.org/10.1080/15228835.2016.1250026

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th edn). Pearson.

Bischoff, R., Hollist, C. S., Smith, C. W., & Flack, P. (2004). Addressing the mental health needs of the rural underserved: Findings from a multiple case study of a behavioral telehealth project addressing the mental health needs of the rural underserved. *Contemporary Family Therapy*, *26*(2), 179–198.

Bischoff, R. J., Reisbig, A. M. J., Springer, P. R., Schultz, S., Robinson, D. W., & Olson, M. M. (2014). Succeeding in rural mental health: Fitting in, collaborating, and developing new skills. *Contemporary Family Therapy*, *35*, 1–16.

Bischoff, R. J., Springer, P. R., & Taylor, N. C. (2017). Global mental health in action: Reducing disparities one community at a time. *Journal of Marital and Family Therapy*, *43*(2), 276–290. https://doi.org/10.1111/jmft.12202.

Blumer, M. L. C., Hertlein, K. M., & VandenBosch, M. L. (2015). Towards the development of educational core competencies for couple and family therapy technology practices. *Contemporary Family Therapy*, *37*, 113–121.

Brooks, S., & Northey Jr., W. F. (2011). CFT faculty speak: The MFT core competency and outcome based education six years later. In *Poster presented at the 69th Annual Conference of the American Association for Marriage and Family Therapy*.

Calvert, F. L., Crowe, T. P., & Grenyer, B. F. (2017). An investigation of supervisory practices to develop relational and reflective competence in psychologists. *Australian Psychologist*, *52*(6), 467–479. https://doi.org/10.1111/ap.12261

Campos-Castillo, C., & Anthony, D. (2020). Racial and ethnic differences in self-reported telehealth use during the covid-19 pandemic: A secondary analysis of a US survey of internet users from late March. *Journal of the American Medical Informatics Association*, *28*(1), 119–125. https://doi.org/10.1093/jamia/ocaa221

Chherawala, N., & Gill, S. (2020). Up-to-date review of psychotherapy via videoconference: Implications and recommendations for the RANZCP Psychotherapy written case during the COVID-19 pandemic. *Australian Psychiatry*, *28*(5), 517–520. https://doi.org/10.1177/1039856220939495

Commission for the Accreditation of Marriage and Family Therapy Education. (2017). *Accreditation standard: Graduate & post-graduate marriage and family therapy training programs Version 12*. Author.

Doss, D. D., Benson, L. A., Georgia, E. J., & Christensen, A. (2013). Translation of integrative behavioral couple therapy to a web-based intervention. *Family Process*, *52*, 139–153. https://doi.org/10.1111/famp.12020

Dunstan, D. A., & Tooth, S. M. (2012). Treatment via videoconferencing: A pilot study of delivery by clinical psychology trainees. *The Australian Journal of Rural Health*, *20*(2), 88–94. https://doi.org/10.1111/j.1440-1584.2012.01260.x

Falender, C. A., & Shafranske, E. P. (2014). Clinical supervision: The state of the art. *Journal of Clinical Psychology*, *70*(11), 1020–1041.

Hertlein, K. M., Blumer, M. L. C., & Mihaloliakos, J. H. (2015). Marriage and family counselors' perceived ethical issues related to online therapy. *The Family Journal*, *23*(1), 5–12. https://doi.org/10.1177/1066480714547184

Hertlein, K. M., Blumer, M. L. C., & Smith, J. M. (2014). Marriage and family therapists' use and comfort with online communication with clients. *Contemporary Family Therapy*, *36*(58), 58–69. https://doi.org/10.1007/s10591-013-9284-0

Inman, A. G., Bashian, H., Pendse, A. C., & Luu, L. P. (2019). Publication trends in telesupervision: A content analysis study. *The Clinical Supervisor*, *38*(1), 97–115. https://doi.org/10.1080/07325223.2018.1528194

Jordan, S. E., & Shearer, E. M. (2019). An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in Professional Psychology*, *13*(4), 323–330. https://doi.org/10.1037/tep0000245

Mental Health America. (2020). *African American Communities and Mental Health*. Retrieved from https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health

Nelson, T. S., Chenail, D. J., Alexander, J. F., Crane, D. R., Johnson, S. M., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Martial and Family Therapy*, *33*(4), 417–438. https://doi.org/10.1111/j.1752-0606.2007.00042.x

Northey, W. F., & Gehard, D. R. (2020). The condensed MFT core competencies: A streamlined approach for measuring student and supervisee learning using the MFT core competencies. *Journal of Marital and Family Therapy*, *46*(1), 42–61. https://doi.org/10.1111/jmft.12386

Pickens, J. C., Morris, N., & Johnson, D. J. (2019). The digital divide: Couple and family therapy program's integration of teletherapy training and education. *Journal of Martial and Family Therapy*, *46*(2), 186–200. https://doi.org/10.1111/jmft.12417

Reese, R. J., Aldarondo, F., Anderson, C. R., Lee, S.-J., Miller, T. W., & Burton, D. (2009). Telehealth in clinical supervision: A comparison of supervision formats. *Journal of Telemedicine and Telecare*, *15*(7), 356–361. https://doi.org/10.1258/jtt.2009.090401

Sahebi, B. (2020). Clinical supervision of couple and family therapy during COVID-19. *Family Process*, Advance Online Publication, *59*(3), 989–996. https://doi.org/10.1111/famp.12591

Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *The Australian Journal of Rural Health*, *22*(6), 280–299. https://doi.org/10.1111/ajr.12149

Singh, S. P., Arya, D., & Peters, T. (2007). Accuracy of telepsychiatric assessment of new routine outpatient referrals. *BMC Psychiatry*, *7*, 55–68. https://doi.org/10.1186/1471-244X-7-55

Sprenkle, D. H., & Blow, A. (2007). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*(2), 113–251. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

Springer, P. R., Bischoff, R. J., Kohel, K., Taylor, N. C., & Farero, A. (2020). Collaborative care at a distance: Student therapists' experiences of learning and delivering relationally focused telemental health. *Journal of Marital and Family Therapy*, *46*(2), 201–217. https://doi.org/10.1111/jmft.12431.

Witson, C. L., Affleck, D. C., & Johnson, V. (1961). Two-way television in group therapy. *Mental Hospitals*, *12*(11), 22–23. https://doi.org/10.1176/ps.12.11.22

Wrape, E. R., & McGinn, M. M. (2019). Clinical and ethical considerations for delivering couple and family therapy via telehealth. *Journal of Marital and Family Therapy*, *45*(2), 296–308. https://doi.org/10.1111/jmft.12319

How to cite this article: Springer PR, Bischoff RJ, Taylor NC, Neuhaus V, Leow C. Competency-based training in the supervision of relational telemental supervision. *J Marital Fam Ther*. 2021;47:375–391. https://doi.org/10.1111/jmft.12513