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Computer Monitor Supervision: A Clinical Note

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Live supervision requires communication while the supervisor is guiding the trainee therapist through the one-way mirror. With the use of computer technology, additional communication procedures that have been developed are briefly presented adding new possibilities to live supervision. Using the computer as a supervision tool, therapy can be influenced by the supervisor while minimizing disruption. Successes and pitfalls in a master's level practicum course in family therapy are presented.

Over the years there has been a steady development of different ways to guide a trainee during a therapy session with live supervision. In the 19th century, hypnosis, the primary therapy of the time, was taught by live supervision. The teacher first demonstrated with a case and then observed while guiding the trainee's work with a client. As hypnosis was used less and psychoanalysis became popular, therapy became confidential. The teacher was not observed at work and the therapist was not observed by others. The trainee therapist's description of the therapy interview was the only source from which the supervisor could gauge the trainee's effectiveness. Supervisors objected to any violation of the confidentiality rule and so condemned any observation of an interview.

In the 1950's, the one-way mirror arrived and once again the therapist could be observed in action. Although quite expensive, films were often used for later study. With the one-way mirror, the supervisor could know what was happening during the interview rather than be given a verbal summary later. A group of trainees was often positioned behind the mirror who would take turns going into the room to interview their clients. The supervisor would plan the session with them, and once they were in the

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room the teacher could watch them at work. The problem was how the supervisor could communicate with the trainee who was interviewing on the other side of the mirror. The supervisor could see the trainee making simple errors or not following the plan and would like to advise the trainee, but could not do so from the supervisory side of the one-way mirror.

Often the therapist would like some help and could not get it until the interview had been completed. In order to circumvent this difficulty, the supervisor could enter the therapy room to assist and guide the trainee. It could be helpful to the therapy, but it could also be disruptive and cause a hierarchy problem since it defined the trainee as not in charge and needing an expert (Haley, 1978, 1996). An alternative was for the supervisor to knock on the door and call the trainee out for a consultation. This often rescued trainees in difficulty, while taking time for a discussion outside the presence of the client. However, the interruption was also disruptive and the family or client was aware that the therapist needed help which could also affect the trainee's status in the room.

The next innovation in this process was to install a telephone in both the therapy and supervisor's room. While observing through the one-way mirror, the supervisor could call the trainee and make suggestions. An instruction to guide a therapist to an appropriate action could be quickly communicated. Often the suggestion was as brief as saying that the therapist was ignoring the father in an interview and should include him more. An experienced trainee could easily answer the telephone, listen, hang up the phone, and continue the interview. Typically, the supervisor tried to minimize the telephone interruptions and speak as briefly as possible. Rather than ringing, the phone was often equipped with a light so there would be no interruption by a ringing phone.

Another innovation was the "bug in the ear" (Neukrug, l991). With a small earphone placed in the trainee's ear, advice could be given without the client knowing that suggestions were being made. The supervisor could have more to say in that arrangement and, therefore, offer more guidance. However, this could also be a problem. The supervisor could talk more than needed because it was so easy to do so. If mishandled, the arrangement could be like a robot being instructed. It could also interfere with empathy as the therapist attempted to simultaneously attend to both the client and the supervisor while developing glazed eyes in the process.

THE COMPUTER ARRIVES

With the arrival of the computer, new opportunities became possible. Several variations have been described in the literature using the technology. In general, the arrangement is based on having a monitor in the interview room that the therapist can see and the clients cannot. Behind the one-way mirror

the supervisor can see the monitor and communicate to the therapist by typing a message that is displayed on the computer monitor. This private communication allows different types of communication to the therapist.

Among the first of these is the "bug in the eye" (Klitzke & Lombardo, 1991). In this technique a computer monitor located in the therapy room is visible only to the therapist and to the supervisor who is situated behind the one-way mirror. Because the trainee therapist need only glance at the message typed by the supervisor, this technique is less intrusive than the other methods described (Neukrug, 1991).

Another procedure has been to show the trainee therapist a real-time line graph with the line rising for satisfactory performance and falling for less satisfactory performance (Follette & Callaghan, 1995). This device reinforces behavior by presenting feedback, but no specific suggestions are made.

In another usage, 14 icons, each corresponding to categories of therapist responses as specified by the Hill counselor response system (Hill, 1986), are presented on a computer screen (Tracy et al., 1995). Smith, Mead, & Kinsella (1998) speculate that the presence of 14 icons may be too overwhelming to the therapist who is also trying to attend to the client.

A recent implementation of computer-assisted supervision described by Smith et al. (1998) is intended to be a less complicated system of providing information about the trainee's and client's current behavior, while specifying the expected target behavior of the therapist. This system also includes the capability of data collection for research. However, it is not clear how the client's clinically relevant behaviors, expected therapist behaviors, and the results of the behavior are presented to the therapist during the session. While this methodology may be useful, it seems complicated for the supervisor and trainee to use, even though trainees being supervised with this method report positively on the experience.

Each method of communication with the trainee has its merits and drawbacks. Should a complicated intervention be necessary, or if a disagreement is evident, the therapist can still be called out of the room for a discussion. A phone call can still be used in conjunction with the computer, as can a knock on the door if it becomes necessary to reverse a plan during the interview. These direct interventions in the therapy process can easily become too disruptive. Should there be too many call-ins or door knocks, the client may become impatient with the interruptions; therefore, supervisors need to be brief and to the point.

THE COMPUTER MONITOR METHOD

A group of six master level students in practicum training began live supervision using the "knock on the door" and "call-in" techniques with one of the coauthors (JH) as supervisor. The trainees found it difficult to simulta-

neously attend to both the client and the light on the phone. Not liking the "knock on the door" the trainees found it too disruptive in many cases. Because of this dissatisfaction, the other coauthor (CRS), also a trainee, decided to attempt using a computer monitor as a supervision device. Imagining that new ground was being broken, he placed a computer monitor in the therapy room where messages and suggestions from the supervisor could be read by the therapist with minimal disruption to the flow of therapy. Monitor supervision was attempted as an impromptu experiment during one session. It proved so successful it was used for the remainder of the practicum.

Prior to the beginning of the practicum class, all the therapists had had at least some experience with live supervision and each had between 150 and 300 hours of client contact. The clients consisted of individuals, couples, and families who sought assistance at a social services agency for a variety of difficulties. All except one of the live therapy sessions were supervised by JH who has had extensive experience supervising directive therapy. The director of the university's marital and family therapy program, also a experienced supervisor, supervised one session. Neither of the supervisors had previously used the method of computer monitor supervision.

Monitor Arrangement

Two 14-inch color monitors were used, one located in the therapy room and one in the supervision room. Each monitor was connected to a single personal computer via an A-B switch. When in the "A" position, the monitor's display in the therapy room was active; in the "B" position, the supervisor room monitor was active. Both computer monitor screens were black as if powered off when inactive. The monitor in the therapy room was placed on a cart with rollers so that it could be easily moved. During supervision, the monitor was located slightly in front of the therapist and off to the side with the screen remaining out of the client's sight.

The clients were informed that the purpose of the monitor was to receive suggestions from the other room behind the one-way mirror. This was acceptable to the clients. Because the clients could not see the messages, the monitor was ignored.

During the session, one of the trainees in the supervisor room who had adequate typing skills was assigned the task of typing the message into the computer's word processing program. The word processing program was configured to use all upper case characters with an 18-point font making the messages readable without forcing the therapist to strain while reading. The supervisor approved the message, the operator moved the switch to the "A" position, and the message was displayed for the therapist. The switch remained in "A" position until it was clear that the therapist had received the message. At the end of the session, the document was saved on the computer's hard disk for later analysis. Several of the sessions were videotaped, permitting a detailed review of the sessions.

RESULTS

Over the 10-week quarter there were eight live supervision sessions. The number of messages sent ranged from six to 17 for the one-hour sessions. Twenty-one messages were sent during the 90-minute session. The majority of the directives were between seven and nine words in length. Most of the directives were implemented within seconds, and in some cases nearly simultaneously with the display of the supervisor's directive.

Except for one session, the clients gave no indication that they noticed a message being displayed, even though they had been notified before entering the therapy room that messages would be sent in. The one exception was a client who apparently had remarkable peripheral vision. He was viewing the messages while appearing not to do so, perhaps seeing them reflected in the mirror, much to the distress of the therapist when this was discovered.

Having experienced the "knock on the door" and "call-ins" in previous supervision sessions, the trainee response to this way of supervising was overwhelmingly positive giving them a feeling of increased autonomy. The supervisors also found computer monitor supervision to be useful. Generally, the shorter the message, the more likely it was to be acted upon.

While the supervisors' experiences were highly positive there were some problems noted. Occasionally, a suggestion could not be typed and transmitted quickly enough to be effective. In cases like this, the directive was not displayed for the therapist or was ignored by the therapist if the message was sent. There were also a few occasions when the therapist misinterpreted or misunderstood the supervisor's instruction.

EXAMPLES

The primary requirement for the success of this approach is that the supervisor exercise restraint by making all supervisory messages brief. The value of this way of intervening is to help inexperienced therapists to learn typical interviewing techniques. In one session, when the therapist became a bit to central, the suggestion "Have them talk to each other," was sent to the therapist. Another message sent along this line was "Find a way to bring the mother up . . . " These simple suggestions remind the therapist of something that has been learned but not remembered. For instance, in an interview with a couple, the following suggestion was sent, "Pay them some compliments on their progress."

At one point in this session the therapist received the following message. "Talk about something sensitive, like her mother." Because the context did not make sense, the therapist left the room for clarification, thinking that "something sensitive" meant an expression of intimacy. The supervisor clarified it by indicating that the couple was not married and that this fact may be a "sensitive" topic for the woman's mother.

The following example is verbatim. In an individual therapy session the client was talking about quarreling with her daughter, saying that the daughter is "difficult for a mother to deal with." The intent of the directive, sent while the therapist was speaking to the client, was to change the client's focus. The therapist was especially adept at speaking, noticing the monitor and incorporating the directive into therapy.

Therapist: I am looking at in three or four years from now there is a possibility your . . . your life will change and you might become a grandmother . . . and thinking about the emphasis that …
Directive: Does she know a grandmother that she admires???
Therapist: . . . you put on your looks, I am wondering in your . . . in your . . . life have you met someone that is a grandmother that you admired, you admire because she looked healthy . . .

The smooth incorporation of this directive changed the direction of the therapy by focusing the client on a goal to be attained rather than her current difficulties.

Occasionally, the therapist becomes aware that a directive has been sent but is unable to read it quickly enough before it was switched off. This happened when a longer-than-average directive was sent in a session with a couple.

Directive: Ask her if she could stop helping him so that he can become indepent . . . in a small way

In this case the therapist simply reached over and unobtrusively tapped on the screen, and the directive was redisplayed with no interruption of the flow.

During a bogged down therapy session with a couple who were tired at the end of a long day's work, the following directive was sent into the cotherapy team consisting of a male and female therapist.

Directive: Have the couple sculpt their relationship—paying attention to power dynamics.

Being displayed while the female cotherapist was speaking to the clients, the male cotherapist opted to ignore the message, because he did not want to participate in the implementation of the experiential directive. The other cotherapist, aware that a directive had been displayed, looked back at the monitor, which prompted the supervisor to redisplay the message. She began the sculpting (Sherman & Fredman, 1986) intervention, which got the session moving. The male cotherapist followed along, added family sculpting to his repertoire of interventions, while the team helped the couple to focus on one of the problematic aspects of their relationship. It is interesting to note that the computer monitor was used as a prop by the male client as part of his sculpture.

The sixth session had more than its share of difficulties which highlight the importance of the positioning of the monitors both in the therapy room and in the supervisor room. During a couples therapy session, when the women was being interviewed without her partner present, the therapist was directed to bring the women's partner into the session. When he entered the room, he unexpectedly took a seat where the therapist's monitor could be seen, rather than next to his partner where the monitor's screen was not visible. Noting this, care was taken to send the messages when he was not looking in the direction of the monitor. At first, this strategy seemed successful. Later in the session, the therapist came out for a consultation. The group could hear the male telling his partner that he could read the messages on the screen, and actually repeated a few of them verbatim. Further concern was raised when he said that he had seen the camera that was being used to videotape the session through his side of the mirror. After the session, it was found that the screen of the supervisor's monitor could be seen through the mirror even when the supervisor's room was darkened. It is hypothesized that he saw the silhouette of the video camera against the light of the computer room monitor as he entered the therapy room.

CONCLUSION

The use of the monitor supervision can be used in a variety of ways and is especially helpful with new trainee therapists. To maximize the usefulness of the technique, several ideas become apparent:

1. The directives displayed should be short, between seven and nine words in length.
2. The main task of the supervisor is to formulate messages as clearly as possible.
3. Care should be taken to arrange the therapy room so that the clients cannot see the monitor.
4. The supervisor monitor should be positioned so that its glow cannot be seen through the one-way mirror.

There are several opportunities that become available with this mode of supervision. These range from the simple idea of using color to indicate different classifications of messages to augmenting computer monitor supervision, using voice recognition technology so that the supervisor does not need a typist.

It is apparent that this method of supervision can be used with a variety of therapy ideologies, theoretical orientations, and supervisory methodologies. To be successful, it is most evident that directive be succinct while fitting the plan of therapy. Its usefulness is limited only by the imagination and skill of the supervisor.

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