**Comparing In-Person Supervision and Telesupervision:
A Multiple Baseline Single-Case Study**

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Abstract

The COVID-19 pandemic has precipitated the unplanned, widespread adoption of telepsychotherapy by mental health care professionals. Psychotherapy supervision is also undergoing a rapid shift to telepractice, though questions remain about the efficacy and regulatory standing of telesupervision. A critical unanswered question is: How does telesupervision compare to traditional in-person supervision? This study (completed before the COVID-19 pandemic) used a multiple baseline single-case design to compare the relative effectiveness of in-person supervision and telesupervision. For the small sample of supervisee participants, in-person supervision and telesupervision had equivalent outcomes; there was no significant decrease in participant-rated *supervision satisfaction* or *supervisory working alliance* after participants switched from the initial in-person supervision format to telesupervision. In follow-up interviews, participants discussed four themes which may be relevant to mental health care professionals adopting telesupervision: (a) differences between modalities, (b) characteristics of an effective supervisor, (c) the role of technology, and (d) personal preference. These results add to a small but growing evidence base that suggests telesupervision is a viable alternative to in-person supervision. Practical recommendations for telesupervision during the COVID-19 pandemic are also discussed.

Keywords: psychotherapy supervision, telesupervision, telepsychotherapy, COVID-19

Comparing In-Person Supervision and Telesupervision: A Multiple Baseline Single-Case Study

The COVID-19 pandemic has profoundly disrupted daily life for providers and consumers of health and social services while also placing an unprecedented burden on the health care system. As the World Health Organization (WHO), U.S. Centers for Disease Control and Prevention (CDC), and other public health agencies around the world issue physical distancing and shelter-in-place guidelines, mental health care professionals are adapting practices to meet the unique challenges of this crisis. Many clinicians are responding to these challenges by implementing or expanding their use of telepsychotherapy in order to safely maintain continuity of care (Brown, 2020). Mental health care providers may emerge as leaders among the health professions during this transition, as many are experienced with telepsychotherapy and have used technology to serve hard-to-reach clients (such as clients in rural areas) for years prior to the current crisis. In the early days and weeks of the COVID-19 pandemic, professional organizations and regulatory bodies directed their members to longstanding guidance on the use of telepractice in mental health care (e.g., Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013).

Psychotherapy supervision is also undergoing a rapid unplanned shift to telepractice; however, *telesupervision*—remote psychotherapy supervision using technology—is less studied and less regulated compared to telepsychotherapy in general. As large numbers of mental health care professionals adopt telesupervision, supervisors and supervisees are faced with a critical question: *How does telesupervision compare to traditional in-person supervision?* Determining the relative effectiveness of in-person supervision and telesupervision will have implications for practice during and after the COVID-19 pandemic. This study, which was completed prior to the

current public health crisis, was designed to compare the relative effectiveness of in-person supervision and telesupervision. We investigated how a transition from in-person supervision to telesupervision affected two outcomes that are important to both supervisors and supervisees: *supervision satisfaction* and *supervisory working alliance*. This study used a multiple baseline single-case experimental design, which can demonstrate causal intervention effects like a randomized controlled trial (RCT; APA Presidential Task Force on Evidence-Based Practice, 2006). Follow-up interviews with supervisee participants also provided qualitative information about how supervisees may experience telesupervision. While widespread changes in telepractice are likely to continue during and after the COVID-19 pandemic, this study offers evidence and guidance to mental health care providers and policymakers evaluating their use of telesupervision.

Telesupervision Research Before COVID-19

Many benefits of telesupervision were well documented prior to the COVID-19 pandemic, particularly in rural and developing areas, where telesupervision can increase access to remote supervisors with specialized knowledge and reduce financial constraints and lengthy travel (Abbass et al., 2011; Conn et al., 2009; Jordan & Shearer, 2019; Reese et al., 2009; Wood et al., 2015). Telesupervision can familiarize supervisees with telepractice more generally, which is important for their ability to effectively provide clients with telepsychotherapy services. The WHO has recommended telesupervision as a useful tool for low- and middle-income countries expanding mental health care capacity (WHO, 2018). However, telesupervision can involve unique challenges. For example, it may be harder to maintain strict client confidentiality while in non-traditional supervision settings, unexpected technological issues may impede supervision, and the telesupervision process may feel unfamiliar or intimidating.

Telesupervision remains understudied despite awareness of its benefits. Martin et al. (2017) conducted a systematic review of telesupervision research for health professionals, including mental health professionals. They identified eight themes relevant for effective telesupervision: supervisee characteristics, supervisor characteristics, supervision characteristics, communication strategies, technological considerations, environmental factors, prior in-person contact, and supervisory relationship. Martin et al. described “a huge gap in primary research in telesupervision” and “a need for high-quality and robust studies to further the much-needed evidence in this area” (p. 279). Of the eight studies reviewed by Martin et al. which focused on telesupervision for mental health care professionals specifically, a majority of the studies focused on applications in rural areas ($n = 6$), were at least ten years old ($n = 7$), did not collect quantitative supervision outcome data ($n = 6$), and did not include a direct comparison between in-person and telesupervision outcomes ($n = 5$). This study was designed to address these limitations.

Method

Participants and Setting

Supervision outcome data were analyzed for three psychology doctoral student supervisees using a single-case multiple baseline experimental design. Data were collected between January and May of 2018. Supervisee 1 and Supervisee 2 were enrolled in an APA-accredited clinical psychology program, and Supervisee 3 was enrolled in an APA-accredited counseling psychology program. All three supervisees were enrolled in a clinical practicum at a nonprofit free health clinic that served mostly low-income uninsured community members. Each supervisee provided weekly psychotherapy sessions to a caseload of approximately eight clients whose presenting concerns included depression, anxiety, posttraumatic stress, relationship

problems, personality disorders, and other mental health complaints. All three supervisees had the same supervisor (the first author) for the duration of the study. Supervisee 1 and Supervisee 2 had previously worked with this supervisor during the semester preceding the study period; Supervisee 3 had not worked with the supervisor previously. All three supervisees began the study period in in-person supervision, then transitioned one-by-one to telesupervision. Supervisee 1 and Supervisee 3 received telesupervision primarily through videoconferencing, and Supervisee 2 received telesupervision primarily by phone.

Several other doctoral student supervisees were simultaneously enrolled in clinical practicums with the three participants; however, they were excluded from this study because they either (a) did not receive a combination of in-person supervision and telesupervision, or (b) they were assigned other clinical supervisors. Including supervisees who received both in-person supervision and telesupervision allowed for direct comparison of outcomes across supervision formats. By including only supervisees who shared the same supervisor it was possible to control for the influence of supervisor differences, a validity threat which has confounded other studies comparing in-person supervision and telesupervision (e.g., Jordan & Shearer, 2019).

Weekly Outcome Measures

Participants completed two outcome measures each week following their hour-long individual supervision sessions. Participants completed the *Supervision Satisfaction Questionnaire* (SSQ; Ladany et al., 1996), an eight-item Likert response measure which was adapted from the widely used Client Satisfaction Questionnaire (Larsen et al., 1979). The SSQ evaluates one factor, satisfaction (Nguyen et al., 1983), with items such as “How would you rate the quality of supervision you have received?” and “To what extent has this supervision fit your needs?” SSQ scores have demonstrated good internal consistency in prior studies ($\alpha = 0.96$;

Ladany et al., 1996). Each week, a mean SSQ score was calculated for each participant, averaging their eight questionnaire responses; SSQ scores could therefore range from 1 to 4, with higher scores indicating higher supervision satisfaction.

Participants also completed the *Supervisory Working Alliance Inventory: Trainee Form* (SWAI; Efstation et al., 1990), a 19-item Likert response measure designed to assess two factors, rapport and client focus (i.e., the supervisee's understanding of the client). Items that emphasize supervisor-supervisee rapport include "I feel comfortable working with my supervisor," and "My supervisor makes the effort to understand me." Items that emphasize client focus include "My supervisor encourages me to take time to understand what the client is saying and doing," and "When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client." SWAI scores have demonstrated good internal consistency in prior studies ($\alpha = 0.77\text{--}0.90$; Efstation et al., 1990). Each week a mean SWAI score was calculated for each participant, averaging their 19 responses; SWAI scores could therefore range from 1 to 7, with higher scores indicating better supervisory working alliance.

Experimental Design and Procedure

Single-case experimental methods may be unfamiliar to many researchers; however, as Barlow and Nock (2009) stated,

Although most psychological researchers have been trained in group comparisons designs and have relied primarily on them, exciting advances have been made in the use of idiographic methodologies, such as the single-case experimental design. The flexibility and efficiency of these designs make them ideally suited for use by psychological scientists, clinicians, and students alike, given that they require relatively little time and

few resources and subjects and yet they can provide strong evidence of causal relations between variables. (p. 20)

Single-case experimental designs have been described as “the best kept secret in counseling” (Lundervold & Belwood, 2000) because of their flexibility, rigor, and clinical relevance. The APA Presidential Task Force on Evidence-Based Practice (2006) similarly advised, “Single-case experimental designs are particularly useful for establishing causal relationships in the context of an individual” (p. 274). In this study, by implementing a planned single-case experimental design across multiple supervisee participants, we were able to compare the relative effectiveness of in-person supervision and telesupervision, and determine if the transition to telesupervision caused a significant change in either the participants’ supervision satisfaction or the supervisory working alliance.

This study utilized a multiple baseline single-case design. As in other types of single-case designs, participant outcomes in a multiple baseline experiment are systematically observed over time. Multiple data points are recorded during a baseline phase (in-person supervision), then additional data points are recorded during an intervention phase (telesupervision). In this way, by comparing baseline phase observations with intervention phase observations, participants essentially serve as their own controls and the relative effectiveness of the two supervision formats may be compared. In this study, all three participants received in-person supervision during a baseline phase of seven to 11 weeks; then, each participant switched to telesupervision for an additional four to six weeks. By staggering baseline-to-intervention transitions across participants, so that participants transitioned to telesupervision at different points in time, multiple baseline designs can test the causal relationships between intervention and outcome while controlling for historical threats to validity (Heppner et al., 2016).

All supervisees participated in semi-structured interviews after the termination of their practicum training and clinical supervision. Interview questions were designed to solicit supervisees' opinions about in-person supervision versus telesupervision. Participants were asked how the use of technology affected the supervision process, and what qualities might be important in a supervisor who utilized telesupervision. In order to encourage honest feedback about supervision experiences, the interviewer (third author) was not previously acquainted with participants. Interview guides were developed utilizing an emergent coding scheme. The final interview guide included 17 questions.

Quantitative Analysis

In-person supervision and telesupervision outcomes were compared with a combination of visual and statistical methods, consistent with established standards for single-case data analysis published by the Institute of Educational Science's *What Works Clearinghouse* (Kratochwill et al., 2010). For the visual analyses, time-series data were graphed for each participant, and graphs were then inspected to determine (1) if data in the in-person supervision (baseline) phase were sufficiently stable to compare with data in the telesupervision (intervention) phase, (2) if level, trend, and variability of data were different enough across phases to infer a difference in outcome between supervision formats, (3) if data patterns across phases demonstrated overlap, consistency, and immediacy of change, and (4) if there were at least three separate demonstrations of intervention effect across all participants in the multiple baseline design.

Visual analysis was supplemented with statistical analysis. An effect size was calculated for each participant-outcome using the Baseline Corrected Tau single-case statistic (Tarlow, 2017). Baseline Corrected Tau is an improved version of the widely used Tau-U statistic for

single-case data analysis (Parker et al., 2011). In the first step of a Baseline Corrected Tau analysis, baseline phase data are evaluated to determine if a statistically significant trend is present (trend patterns in the baseline phase suggest the targeted outcome is not stable, which may weaken any inferences of intervention effect, e.g., “the supervisory working alliance was already improving prior to implementing telesupervision”). If a statistically significant baseline trend is detected, data are corrected to adjust for the presence of baseline trend (similar to how covariates are controlled in a multiple regression analysis). An effect size is then calculated by comparing baseline phase and intervention phase data. Effect sizes are reported as Kendall’s Tau rank order correlation coefficients, which indicate the direction and strength of association between intervention and outcome. In this study, a positive, statistically significant Tau effect size would therefore suggest an improvement in outcome following the transition from in-person supervision to telesupervision; a nonsignificant Tau effect size would suggest equivalence between supervision formats. An online Baseline Corrected Tau calculator was used for all statistical analyses (Tarlow, 2016).

Qualitative Analysis

Phone interviews lasted between 17 and 34 minutes. Participants electronically signed a consent form prior to interviews and agreed to be audio recorded. Recordings were transcribed by the interviewer. The interviewer conducted a thematic analysis using an open coding scheme to identify emergent codes. This method of data analysis was selected because it is ideal for identifying themes that surface from the data to describe and explain the phenomena being researched (Fereday & Muir-Cochrane, 2006). During analysis, the interviewer identified codes and converged findings between interviews to find emergent themes.

Compliance with PCORI Standards

This study complied with relevant Patient-Centered Outcomes Research Institute (PCORI, 2019) methodology standards for clinical comparative effectiveness research (CER), including standards for formulating research questions (RQ1–RQ6), standards associated with patient-centeredness (PC1–PC4), and standards for causal inference methods (CI1–CI3).

Ethical Approval

This study was approved by an Institutional Review Board at Texas A&M University #IRB2018-0815D.

Results**Weekly Outcome Measures**

Supervision Satisfaction Questionnaire (SSQ) scores for each supervisee are presented in Figure 1, and Supervisory Working Alliance Inventory (SWAI) scores for each supervisee are presented in Figure 2. First, data were visually analyzed to determine if there were different outcomes across supervision format. In each time-series, the baseline phase data were stable and indicated high levels of satisfaction and working alliance during the period of in-person supervision. There were no visibly detectable changes in either outcome after supervisees transitioned to telesupervision, suggesting that the change to telesupervision did not cause a decrease in supervision satisfaction or supervisory working alliance, and that these outcomes were equivalent across conditions. There was total overlap between baseline and intervention phase data in all six time-series, suggesting no immediate or delayed effects of the switch to telesupervision.

INSERT FIGURE 1 AND FIGURE 2 HERE

Statistical analyses were consistent with visual inspection of time-series graphs.

Supervisee 1 had no statistically significant change in SSQ score ($\text{Tau} = .470, p = .152$) or SWAI score ($\text{Tau} = .511, p = .079$). Supervisee 2 also had no statistically significant change in SSQ score ($\text{Tau} = .272, p = .540$) or SWAI score ($\text{Tau} = -.478, p = .130$). Supervisee 3 had no statistically significant change in SSQ score ($\text{Tau} = .405, p = .144$); however, Supervisee 3's SWAI scores increased following the transition to telesupervision ($\text{Tau} = .537, p = .035$). That said, the magnitude of improvement in working alliance during telesupervision was small, with the average increase from baseline to intervention phase equal to 0.33 points on a 7-point Likert scale.

Interviews

All three supervisees agreed to participate in follow-up interviews. The main emergent themes revealed through qualitative analysis included: (a) differences between modalities, (b) characteristics of an effective supervisor, (c) the role of technology, and (d) personal preference.

Differences Between Modalities

All participants mentioned minor differences between in-person supervision and telesupervision. Two of the three participants stated that non-verbal cues were difficult to perceive when being supervised through telesupervision, though one stated that those cues are not necessary and they learned to adapt their communication style. One participant said:

“If anything our ability to work together got stronger with time. Because the distance supervision was later, the working alliance may have been stronger ... we were forced to get to know each other better and pick up on subtle cues.”

Characteristics of an Effective Supervisor

Through experience with in-person and telesupervision, supervisees were able to provide feedback on what makes for an effective supervisor and particular qualities or training they would need for successful telesupervision. All three supervisees mentioned openness, supportiveness, and communication skills were essential for an effective supervisor. One supervisee also wanted a supervisor who was empathetic. One supervisee said:

“I’m looking for a supervisor who can teach me something. At this time in my training I want the autonomy to do whatever I need to do and want. I am wanting a supervisor who will provide support as needed.”

Role of Technology

Two of the participants said an effective supervisor needed to possess familiarity with telesupervision technology because issues occurred frequently and could impact quality of time together. There were also occasional delays in video streaming and both individuals needed to become comfortable with the delay.

Personal Preference

All three participants preferred in-person supervision to telesupervision if they had to decide between the two modalities, though differences were minimal. All preferred video telesupervision to phone-based (audio only) telesupervision. One participant said there was more trust when they could see the supervisor’s face. However, all three expressed that it is not the medium that makes the largest difference and they liked both modalities for supervision delivery. One participant stated:

“The difference between in-person and telesupervision really comes down to the person itself [supervisor]. It would be really easy for a not so good supervisor to miss things in

telesupervision and just not be super in touch. The supervisor is the most important factor in the end though.”

Discussion

As an unprecedented number of mental health care providers adopt telesupervision in response to the COVID-19 pandemic, supervisors and supervisees alike are faced with a critical question: *How does telesupervision compare to traditional in-person supervision?* The purpose of this study was to compare the relative effectiveness of in-person supervision and telesupervision, and to determine if a transition from in-person supervision to telesupervision affected supervisee-reported outcomes. Both supervision outcomes—supervision satisfaction and supervisory working alliance—were assessed weekly for three supervisees using a multiple baseline single-case experimental design that spanned 12–16 weeks. All three supervisees had the same clinical supervisor and began the study utilizing in-person supervision, then one-by-one switched to telesupervision. Participant-reported supervision satisfaction and supervisory working alliance data were analyzed with a combination of visual and statistical analyses. Follow-up interviews were conducted with each supervisee and analyzed using thematic analysis.

We found that supervisees reported similar levels of supervision satisfaction and supervisory working alliance during in-person supervision and telesupervision. High levels of satisfaction and working alliance were established early in the in-person supervision phase of the study and remained at a high level following the transition to telesupervision. This was true for Supervisee 1 and Supervisee 2, who had previously worked with the supervisor, and also for Supervisee 3 who had not worked with the supervisor prior to the study (in fact, Supervisee 3’s ratings of working alliance slightly improved during telesupervision). These results are

consistent with previous studies that found the use of telesupervision was not associated with decreases in supervisee satisfaction or rapport, nor a compromised supervision experience (Conn et al., 2009; Gammon et al., 1998; Jordan & Shearer, 2019; Reese et al., 2009).

Qualitative feedback from supervisees suggested that telesupervision was in many ways similar to in-person supervision, and that differences between formats were minimal. Supervisees' emphasis of supervisor characteristics, including openness, supportiveness, and empathy, underscores the importance of the supervisory relationship regardless of supervision format. Supervisees also emphasized the importance of supervisors' competence with supervision technology.

As policymakers consider regulatory options for telesupervision, they should determine what additional standards are needed, if any, given the similarities between in-person supervision and telesupervision. We suggest that for some jurisdictions and organizations, adherence to existing supervision standards may be sufficient for the provision of telesupervision that is acceptable, effective, and ethical, though additional research comparing the effectiveness of supervision formats is recommended. While additional regulation of telesupervision may be intended to protect supervisees and clients, it may in practice offer limited safeguards beyond the protections provided by existing policies while also producing unintended consequences, including discouraging technological innovation, disadvantaging early career professionals seeking experience with telepractice, and limiting opportunities for supervisees working in historically underserved communities, including the rural and developing areas best supported through telepractice. As was the case in this study, telesupervision has the potential to facilitate flexible supervision opportunities for supervisees while increasing access to services for clients served by them. Policymakers weighing the benefits of telesupervision against its potential risks

must therefore balance the directive to “do no harm” (nonmaleficence) with the goals of promoting health (beneficence) and providing equitable access to care for all (justice) (Knapp & VandeCreek, 2017).

This multiple baseline single-case study had several limitations. All three supervisees began the study period with in-person supervision, then switched to telesupervision. All three supervisees also established high levels of supervision satisfaction and supervisory working alliance prior to using telesupervision. It is therefore not possible to rule out the influence of order effects; for example, it is plausible that supervisees would not have established strong rapport or supervision satisfaction had they started in the telesupervision condition. It is also possible that supervisees with poor supervision satisfaction and/or supervisory working alliance during in-person supervision would experience a deterioration of these outcomes following a transition to telesupervision. Others have speculated that in-person supervision is important for establishing a supervisory relationship before initiating telesupervision (Martin et al., 2017), though there is little empirical data to support this claim, and at least one recent study indicated effective supervision can be established entirely through telesupervision (Jordan & Shearer, 2019). The results of this study could therefore be conservatively interpreted to conclude that telesupervision at a minimum did not damage the high levels of supervision satisfaction and working alliance established through in-person supervision. While supervisees expressed mild personal preference for in-person supervision, telesupervision yielded equivalent outcomes when compared to in-person supervision in this study, limitations notwithstanding. These results may be reassuring to supervisors and supervisees forced to abruptly transition to telesupervision because of COVID-19.

The first author of this study also served as supervisor to the study's participants, and was therefore not blind to the design and hypotheses of the study, though several steps were taken to protect the integrity of the data and analyses. Participants were informed that their weekly outcome questionnaires would not be examined by any members of the research team (including their supervisor) until the conclusion of the study period (i.e., after the participants completed their practicum training and terminated supervisory relationships), and follow-up interviews were conducted and analyzed by the third author, who had no prior contact with participants.

Given the strengths of single-case experimental designs (e.g., Heppner et al., 2016), we are confident that telesupervision did not cause a decrease in supervision satisfaction or supervisory working alliance for these participants; however, any generalization of these findings to other supervisees should be tentative. As the APA Presidential Task Force on Evidence-Based Practice (2006) stated, evidence-based practice involves “integrating multiple streams of research evidence—including but not limited to RCTs” (p. 273) and that “multiple research designs contribute to evidence-based practice” (p. 274). This study provides limited but encouraging evidence supporting the use of telesupervision, in what is an emerging field of research. Future studies using complementary research designs would further strengthen the evidence base for telesupervision. Future telesupervision studies should also evaluate additional supervision outcomes, such as supervisee competencies and client outcomes. Determining if/how effective supervisory relationships can be established via telesupervision, without any initial in-person contacts, should also be a priority for future telesupervision research.

Recommendations and Practical Considerations

The COVID-19 pandemic is an unprecedented challenge for mental health care professionals and for the public they serve. There is an urgent need to adapt practices to confront

this crisis; clinicians and regulatory bodies have so far acted with remarkable speed and flexibility. Our collective response to COVID-19 should include the appropriate use of telesupervision when it serves the needs of supervisees and their clients. The results of this study, though limited in scope and generalizability, support the use of telesupervision and suggest that telesupervision is a viable alternative to traditional in-person supervision. This study provides one additional data point to policymakers deciding whether to sanction the use of telesupervision in their agency or jurisdiction, both during and after the COVID-19 crisis.

Mental health care providers should ultimately defer to their respective licensing and accrediting organizations before utilizing telesupervision. Supervisors and supervisees should also consider other uses of technology besides video telesupervision, such as remote note review and remote direct observation of supervisees. They should seek additional training and/or continuing education to ensure competence with telepractice technologies as necessary. Mental health care providers adopting telesupervision should also seek out and consult with colleagues who are experienced with telepsychotherapy and telesupervision during this period of transition.

Finally, supervisors and supervisees should be mindful not to neglect their own health, wellbeing, and basic needs during these uncertain times. No degree of technological innovation will compensate for the therapist who is struggling as a result of the inevitable dislocation and trauma caused by the COVID-19 pandemic. Mental health workers have a vital role to play in the organized response to this unfolding crisis (see Galea et al., 2020). Yet the very technologies we use to maintain physical distance may in fact bring us intimately close to clients experiencing loss, terror, illness, and death. Supervisees may be particularly vulnerable to secondary trauma and professional burnout at this time, as their profound clinical responsibilities are paired with a relative lack of clinical experience. Their supervisors should remember that telesupervision

provides—perhaps most importantly—an opportunity to create supportive human relationships with their supervisees.

References

- Abbass, A., Arthey, S., Elliott, J., Fedak, T., Nowoweiski, D., Markovski, J., & Nowoweiski, S. (2011). Web-conference supervision for advanced psychotherapy training: A practical guide. *Psychotherapy*, 48(2), 109-118. <https://doi.org/10.1037/a0022427>
- American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271-285. <https://doi.org/10.1037/0003-066X.61.4.271>
- Barlow, D. H., & Nock, M. K. (2009). Why can't we be more idiographic in our research? *Perspectives on Psychological Science*, 4(1), 19-21. <https://doi.org/10.1111/j.1745-6924.2009.01088.x>
- Brown, N. (2020, March 20). As coronavirus takes emotional toll, mental health professionals brace for spike in demand. *Reuters*. <https://www.reuters.com/article/us-health-coronavirus-mentalhealth/as-coronavirus-takes-emotional-toll-mental-health-professionals-brace-for-spike-in-demand-idUSKBN2171HJ>
- Conn, S. R., Roberts, R. L., & Powell, B. M. (2009). Attitudes and satisfaction with a hybrid model of counseling supervision. *Educational Technology and Society*, 12(2), 298–306.
- Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, 37(3), 322-329. <https://doi.org/10.1037/0022-0167.37.3.322>
- Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. *JAMA Internal Medicine*. Advance online publication. <https://doi.org/10.1001/jamainternmed.2020.1562>

- Gammon, D., Sorlie, T., Bergvik, S., & Hoifodt, T. (1998). Psychotherapy supervision conducted by videoconferencing: A qualitative study of users' experiences. *Journal of Telemedicine and Telecare*, 4(1), 33–35. <https://doi.org/10.1258/1357633981931353>
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80–92. <https://doi.org/10.1177/160940690600500107>
- Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4th ed.). Cengage Learning.
- Knapp, S. J., & VandeCreek, L. D. (2017). *Practical ethics for psychologists: A positive approach* (3rd ed.). American Psychological Association.
- Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013). Guidelines for the practice of telepsychology. *American Psychologist*, 68(9), 791-800. <https://doi.org/10.1037/a0035001>
- 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>
- Kratochwill, T. R., Hitchcock, J., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M., & Shadish, W. R. (2010). *Single-case design technical documentation*. What Works Clearinghouse. https://ies.ed.gov/ncee/wwc/Docs/ReferenceResources/wwc_scd.pdf
- Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology*, 43(1), 10-24. <https://doi.org/10.1037/0022-0167.43.1.10>

- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, 2(3), 197-207. [https://doi.org/10.1016/0149-7189\(79\)90094-6](https://doi.org/10.1016/0149-7189(79)90094-6)
- Lundervold, D. A., & Belwood, M. F. (2000). The best kept secret in counseling: Single-case ($N = 1$) experimental designs. *Journal of Counseling & Development*, 78(1), 92-102. <https://doi.org/10.1002/j.1556-6676.2000.tb02565.x>
- Martin, P., Lizarondo, L., & Kumar, S. (2018). A systematic review of the factors that influence the quality and effectiveness of telesupervision for health professionals. *Journal of Telemedicine and Telecare*, 24(4), 271-281. <https://doi.org/10.1177%2F1357633X17698868>
- Nguyen, T. D., Attkisson, C. C., & Stegner, B. L. (1983). Assessment of patient satisfaction: Development and refinement of service evaluation questionnaire. *Evaluation and Program Planning*, 6(3-4), 299-314. [https://doi.org/10.1016/0149-7189\(83\)90010-1](https://doi.org/10.1016/0149-7189(83)90010-1)
- Parker, R. I., Vannest, K. J., & Davis, J. L. (2011). Effect size in single-case research: A review of nine nonoverlap techniques. *Behavior Modification*, 35(4), 303-322. <https://doi.org/10.1177/0145445511399147>
- Patient-Centered Outcomes Research Institute (2019). *PCORI methodology report: January 2019*. <https://www.pcori.org/sites/default/files/PCORI-Methodology-Report.pdf>
- Reese, R. J., Aldarondo, F., Anderson, C. R., Lee, S., 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>
- Tarlow, K. R. (2016). *Baseline Corrected Tau Calculator*. <http://ktarlow.com/stats/tau>

Tarlow, K. R. (2017). An improved rank correlation effect size statistic for single-case designs:

Baseline Corrected Tau. *Behavior Modification*, 41(4), 427-467.

<https://doi.org/10.1177/0145445516676750>

Wood, J. A., Miller, T. W., & Hargrove, D. S. (2005). Clinical supervision in rural settings: A telehealth model. *Professional Psychology: Research and Practice*, 36(2), 173-179.

<https://doi.org/10.1037/0735-7028.36.2.173>

World Health Organization (2018). *mhGAP operations manual: mental health Gap Action Programme (mhGAP)*.

<https://apps.who.int/iris/bitstream/handle/10665/275386/9789241514811-eng.pdf>

Figure 1

Equivalent Supervision Satisfaction for In-Person Supervision and Telesupervision

Figure 2

Equivalent Supervisory Alliance for In-Person Supervision and Telesupervision