Research Article

DOI: https://doi.org/10.18357/otessaj.2021.1.1.2
https://otessa.org
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Support to Rural, Remote, and Northern Counsellors: The Unique Features Inherent to Video-Conferencing Technology

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Abstract
This paper presents the qualitative findings from a mixed methods quantitative-qualitative explanatory sequential research project. It investigates unique features of video conferencing technology and how these can be helpful in supporting counsellors in rural, remote, and Northern contexts to mitigate compassion fatigue through video conferencing clinical supervision. Semi structured interviews with nine respondents were conducted and analyzed with thematic content analysis supported by *NVivo 10.* The results revealed eight higher order themes. Of note are the thematic results which described technology as a solution, the unique opportunities inherent in the medium of video conferencing, and some of its inherent challenges. These results are relevant to a variety of consultative contexts across healthcare and education because they assist in understanding how the technology impacts interpersonal connection and efficacy in supervision work.

Keywords: remote, rural, northern, clinical supervision, counsellors, video conferencing, e-supervision.

Introduction

This paper presents the qualitative results of a mixed methods research which looked at the role of video conferencing technology when integrated into clinical supervision to support counsellors working in rural, remote, and Northern communities. The quantitative results of this research are published elsewhere (Slipp, 2020).

Literature

Challenges of Rural, Remote, and Northern Work

Geographic Isolation

The literature suggests that those working as counsellors in Northern, rural, and remote communities are working in some of the most extreme and complex clinical environments (Malone, 2010, 2011, 2012; Malone & Dyck, 2011; O'Neill et al., 2016). By their nature these communities are geographically remote and difficult to access which likely contributes to the felt sense of isolation (O'Neill, 2010) experienced in these professional contexts. DuPlessis et al. (2001) defined *rural* as communities outside the commuting zone to a center of 10,000 or more, while the Ontario Ministry of Health and Long-term Care (2011) suggested that remote communities are those without year-round road access or those that rely on a third party (e.g., train, airplane, ferry) for transportation to access larger centers. Given the social and cultural complexity (Kassam, 2001) involved in identifying a singular definition of "Northern," respondents in this research were encouraged to self-identify if they thought that their context was accurately captured by this word.

Sociocultural Factors

Geographic isolation is compounded by complex sociocultural conditions related to poverty (Malone, 2012), lack of resources, perpetual staff turnover (O'Neill et al., 2016), and difficulty accessing primary, secondary, and tertiary health and mental health services given the extreme weather and large geographic distances that often span these sparsely populated and vast land masses (O'Neill et al., 2013). It should be noted that over half of the 1.4 million Indigenous peoples in Canada live in rural, remote, and Northern communities; overall, Indigenous communities in Canada show marked decrease in life expectancy which can differ by as much as 16 years when compared to non-Indigenous communities (Ministerial Advisory Council on Rural Health, 2002). These poor health outcomes and the disparity of available medical services undermines the values of a universal healthcare system that purports to offer essential healthcare services to all Canadians (Pong & Pitblado, 2005). This inequity of distribution supports the Truth and Reconciliation Commission of Canada's (2015) Call for proper tracking and reporting of these health indicators, along with the provision and availability of appropriate healthcare services.

Ethical Tensions

The unique tensions present in rural and rural Northern mental health which include deep ethical complexities inclusive of dual relationships, community pressure, (Halverson & Brownlee, 2010; Schank, 1992), and the "fish bowl" phenomenon that accompanies being a highly visible professional in a small community (O'Neill, et al., 2016, p. 134). Practitioners in rural settings often describe the need to have a generalist scope of practice which necessitates the stressful and ethically challenging reality that practitioners are often working "at the edge of competency" with professional codes of practice better suited for the realities of urban mental health work (O'Neill et al., 2016, p. 130).

Compassion Fatigue

The aforementioned ethical tensions put counsellors working in these contexts at risk for the development of secondary stress syndromes, which include burn out, compassion fatigue, and vicarious trauma. These syndromes are now recognized as occupational hazards emerging from cumulative exposure to their clients' suffering (Ben-Porat & Itzhaky, 2009; Cohen & Collens, 2013; Finklestein et al., 2015; Lerias & Byrne, 2003; Mailloux, 2014; Mathieu, 2014; Pearlman & Saakvitnee, 1995; Ringel & Brandell, 2011). Coined by Charles Figley, *compassion fatigue* is defined by Mathieu (2012) as

> a concept that refers to the emotional and physical exhaustion that can affect helping professionals and caregivers over time. It has been associated with a gradual desensitization to patient stories, a decrease in quality care for patients and clients (sometimes described as "poor bedside manners"), an increase in clinical errors, higher rates of depression and anxiety disorders among helpers, and rising rates of stress leave and degradation in workplace climate. Helping professionals have also found that their empathy and ability to connect with their loved ones and friends is impacted by compassion fatigue. In turn, this can lead to increased rates of stress in the household, divorce, and social isolation. The most insidious aspect of compassion fatigue is that it attacks the very core of what brings helpers into this work: their empathy and compassion for others. (p.136)

Paradoxically, it is understood that, while capacity for empathetic engagement with the client is essential to ensuring therapeutic effectiveness, it is precisely this factor that seems to put clinicians at risk for developing secondary stress reactions (Pearlman & Saakvitnee, 1995; Rassmussen, 2019). Miller and Sprang (2017) suggested that although reports of incidence vary across the literature, it is estimated that compassion fatigue may occur in 8%–16% of social workers. Molnar et al. (2017) saw compassion fatigue as a systemic public health issue. The literature suggests that compassion fatigue affects workplace productivity and increases both absenteeism and premature departure from the field (Figley, 1995a, 1995b; Harris, 1995; Middleton & Potter, 2015; Sommer; 2008). Perhaps mostly disturbingly, compassion fatigue creates the sheer loss of hope that often ensues in counselling professionals who are suffering in this way (Edey & Jevne, 2003; O'Hara, 2013).

Clinical Supervision

Inspired by clinical supervision's potential to facilitate post-traumatic growth (Abel et al., 2014; Cohen & Collens, 2013; Neswald-Potter & Tripanny-Simmons, 2016) and compassion satisfaction (Figley & Stamm 1996), this research explored the ways in which video conferencing clinical supervision can help to facilitate health and wellness, while supporting counsellors in rural, remote, and Northern contexts to mitigate compassion fatigue risk. Merriman (2015) suggested that clinical supervision is the best place to sensitize students to the risks of compassion fatigue, while several other authors (Abassary & Goodrich, 2014; Lester, 2010; Miller & Sprang, 2017; Molnar et al., 2017; Wheeler & Richards, 2007) see clinical supervision of both students and professionals as providing an ideal opportunity to prevent and mitigate the risk.

Clinical supervision is a signature pedagogy (Munchel, 2014) in the fields of counselling, psychotherapy, and psychology. This practice has traditionally been conducted with the supervisor and counsellor in person. A classic definition offered by Bernard and Goodyear (2014) describes *clinical supervision* as

> an intervention that is provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients she, he, or they see and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

Because this research focused exclusively on post-graduate professional, registered counsellors rather than student counsellors in training, the following definition is relevant:

> a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (Falender & Shafranske, 2004, p. 5)

Clinical supervision has consultative, educative, and counselling functions (Bernard, 1997). It offers a professional mentor-like relationship in which practitioners can access emotional support and find solutions to some of the ethical tensions noted above. It is an arena is which they may develop competencies and learn new skills that assist them in managing these challenging contexts. It is recommended by Canadian social worker and psychologist codes of ethics and practice that therapists continue to engage in clinical supervision throughout the lifetime of their career (Canadian Association of Social Workers [CASW], 2005; CCPA, 2007; Canadian Psychological Association [CPA], 2017).

Integrating Technological Innovation

Given logistics and geographic isolation, counsellors working in rural, remote, and Northern contexts are typically reliant on distance clinical supervision services, often mediated by technology (Mitchell & McDougall, 2016; Murphy & Mitchell, 2016; Rousmaniere, 2014; Rousmaniere et al, 2016). This differs from traditional models in which supervision is typically offered in person. Weather, mountainous roads, ice roads, and expense of travel all contribute to the sheer impossibility in accessing face-to-face clinical supervision from within geographically remote communities (Austen & McGrath, 2006; Perle & Nierenberg, 2013; Wood et al., 2005).

The rapid growth of e-health and tele-mental health technologies has created opportunity to harness the power of connectivity offered by video conferencing to reach professionals working in isolated communities. In a broad survey of e-mental health initiatives across the country, the Mental Health Commission of Canada (MHCC, 2014) identified the imperative to meet this challenge: “the demand for mental health care exceeds available Canadian mental health services and resources, and this gap is likely to increase…demand for services continues to outpace supply…” (p. 2). Additionally, the MHCC suggested that

> cost pressures require that more be done with less and providers therefore must find innovative ways to deliver services. Connected health innovations—i.e., e-mental health interventions—have the potential to offer flexible, more patient-centered services to meet the burgeoning needs. (p. 2)

As indicated, the opportunities afforded by technological development have the potential to transform healthcare for both the patient and the practitioner and between the practitioner and the supervisor. Rousmaniere (2014) identified the sharp growth in the demand for video conferencing supervision and acknowledged its many benefits, including its ability to support clinicians in remote areas.

Video-Conferencing Technology

An interesting feature noted in the video conferencing literature is the difficulty inherent in making true eye contact, given that a parallax typically results from the difference in angles between the space where the users' cameras are positioned and where the image of the partner is displayed on the screen (Bohannon et al., 2013; Jaklicet al., 2017). For the video conferencing systems typically used on most personal laptops or computers, the camera that captures the user's image is located at the top of the screen, whereas the image of the conversational partner tends to rest in the middle of the user's computer screen. In order for the camera to capture the direct eye gaze, both users would need to both be looking directly at the camera; yet, this would seem unnatural, because neither individual would be seeing the image of the other person while speaking to them. There is some research suggesting that this lack of direct eye contact can diminish trust between video conferencing conversational partners (Bailenson et al., 2001; Bohannon et al., 2013; Jaklic et al., 2017). However, research trials show that generally users continue to perceive eye contact with about a 15-degree range of variation. Given this leeway, Bohannon et al. (2013) suggested that if the software generated image of the user is placed just below the computer's camera, the resulting parallax will decrease to about five degrees, which is still within the range of what most users will perceive as eye contact. This is one proposed solution that resolves the concerns that arise from diminished eye gaze in video-conferencing formats.

Research Method

This project was a case study (Yin, 2006, 2012, 2018) that encompassed an explanatory sequential mixed methods Quan-Qual research design (Creswell & Creswell, 2013). This paper focuses on the qualitative results of the study, particularly those most relevant to the video conferencing technology itself.

Sampling

Certified members of the Canadian Counselling and Psychotherapy Association (CCPA) were chosen as the population from which to draw the sample. This organization was chosen because it is a national organization which serves and supports counsellors and psychotherapists across the country. By its very nature, it is a heterogeneous organization with representation from all provincial jurisdictions and territories, with many clinical specializations and a range of educational levels represented.

Once ethics approval was obtained by Athabasca University's Research Ethics Board, purposeful sampling was used to identify participants best suited to provide insight regarding the research questions (Gerber et al., 2017). From February to August of 2019 respondents were contacted by email though the CCPA professional newsletter and invited to participate in an online survey. The survey isolated a specific sub-sample of counsellors who indicated having worked in rural and/or remote and/or Northern communities in Canada; these respondents indicated that they had accessed clinical supervision; additionally, they identified as having experienced compassion fatigue. Semi-structured interviews were conducted with an encrypted video counselling portal designed for tele-health service delivery. Given the sensitive nature of the information provided in the interviews, participants were given the option to review the transcript prior to analysis to check for accuracy and to review the information provided.

Data Collection

Nine respondents provided consent to participant in semi-structed interviewing which was supported by a list of guiding questions as outlined in Appendix 1. The questions were designed to give insight into how video conferencing-based clinical supervision sustained rural, remote, and Northern counsellors to mitigate compassion. The research sought to answer the following question: how can video conferencing-based clinical supervision support rural professional counsellors to enhance wellness and mitigate compassion fatigue?

Data Analysis

All interviews were recorded, then transcribed, and then all identifying information was removed. The transcript was sent to respondents for review prior to analysis. *NVivo 11 for Mac* was used to analyze the data through thematic content analysis (Braun & Clarke, 2006; Vaismoradi et al., 2011). I followed Braun and Clark's six coding steps, which included familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. As recommended by King (2004) and Saldaña (2013), I departed slightly from this method by beginning with a small series of provisional codes to work with the initial interview transcript. As I began coding the second transcript, new codes emerged from the data and were added to the coding framework; a process of sub-coding occurred and the development of child nodes emerged (Saldana, 2016). Green and Thorogood (2018) suggested that when little is known about a given phenomenon, explanatory projects should code the data with a focus on content and should include significant description in order to remain close to the participant's experience. As suggested by these authors, I moved between deductive and inductive modes of analysis. While the use of a set of provisional codes provided some deductive delineation, new codes were added inductively as the analysis progressed. The second and third passes through the transcripts allowed for all the data to be coded against the final code book which included clear, operationalized definitions of each code's inclusion criteria. I included exemplars in the code book to support the definitions. As noted above, analytic memos were written throughout the process to enhance research reflexivity. In addition to reviewing transcripts respondents were invited to review the completed codebook. Seven out of nine participants indicated that their experience was accurately reflected in this codebook.

Results and Limitations

The results generated eight higher order themes and sub-themes. The first five major themes were (a) contextual factors in rural, remote, and Northern practice; (b) problems associated with compassion fatigue; (c) the expressed need for praxis development in this area; (d) unresolved points of tension in the practice of clinical supervision; and (e) ways in which clinical supervision is helpful to maintaining wellness. These themes support what has been identified in the literature as noted above. Because this project aimed to understand how video conferencing specifically can alleviate some of the burdens and challenges identified thus far, the following three other main themes will be elaborated on in detail: (a) technology as a solution, (b) unique opportunities inherent to the medium of video-conferencing technology, and (c) unique challenges inherent to the medium of video-conferencing technology. These findings offer insight into how counsellors in Northern, rural, and remote contexts can be supported through the integration of technology and clinical supervision practice.

Technology as a Solution

A clear and emergent theme centered around the ways in which technology can act as a solution to the complex and extreme nature of rural, remote, and Northern clinical conditions. Respondents spoke about technology being useful in clinical supervision but also in order to

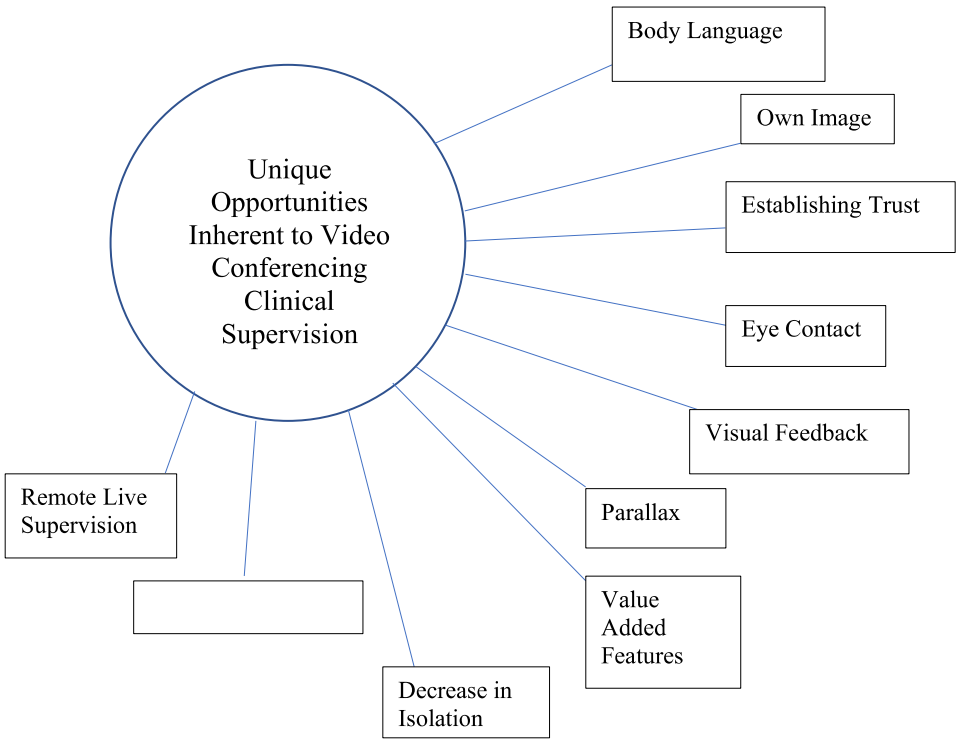
access clinical training opportunities, peer consultation, and their own personal therapy support. Technology was discussed in broad and general terms as a practical way to mitigate geographic distance and as a solution in such challenging circumstances. One respondent works with visually impaired individuals and noted that “distance technology is good so it just depends on the person. Yeah, and what kind of technology you're using so far. A lot of people who have visual impairments they can use an iPad.” They discussed how both clients and supervisees in rural or distant community can make use of technology to connect and access necessary services.

Unique Opportunities Inherent to the Medium of Video Conferencing Technology

Another more complex theme emerged from the data set pertaining specifically to the unique opportunities inherent to the video conferencing technology. This differed from the technology as a solution theme, since data coded in this theme was specific to the properties of video conferencing and exclusively included reference to its application to the practice of clinical supervision. The sub-themes and exemplars in this section provide insight related to how the medium itself provides unique features that may lend themselves to innovative and effective supervision practice; they are represented below in Figure 1.

Figure 1

Unique Opportunities Inherent to the Medium of Video-conferencing Technology



contact, making conscious use of parallax, visual feedback, seeing one's own image, replacing two-way mirror supervision, value added functionality and practice recommendations. Each sub-theme will be expanded upon with exemplars in the sections below.

Body Language

Several respondents identified the importance of and value of being able to view body language through video conferencing technology, which differs radically from doing clinical supervision by telephone. One respondent stated

> I need to have the visual of people so the comfort of actually being able to see if something I said, has made people make a face, [or] where I need to clarify it or if I'm like that was perhaps inappropriate say. I need to have those visual feedbacks.

Visual Feedback

The body language sub-theme is quite strongly related to the visual feedback sub-theme. There is likely some overlap between these two, as it seems that being able to witness the body language of the other person helps to create a strong and useful conversational feedback loop. Video supervision offers more information than the telephone because one can view facial expressions and some body language. It is also possible to ask about the body language that may not be viewable on the screen. Another participant noted the following:

> I very much need to have like a visual feedback when I'm being supervised. I can provide counselling to people over the phone and be fine but when it's my own I want to see the reactions of my supervisor. So initially we had discussed like just doing telephone conferencing and I was like "no, no," I actually want to see your face as I explain things to you. So, like the technology to have video is huge for me because of just the way that I process.

This respondent indicates the importance to being able to see their supervisor's facial reactions in order to be able to gauge their reactions to the material being shared. Related to this, another respondent expressed the following:

> Well just seeing someone listen to you is nice. And you know what? Actually, like in person when I am talking to my supervisor, you know he's like scribbling stuff down or like looking at his notes or whatever. When you're on video I just feel like people are almost very attentive. And you would think that it wouldn't be because you could get something under the table or whatever. But I don't feel that, I really feel people are watching are watching and looking and listening. And my clinical supervisor even just gives me encouragers when I'm talking.

This respondent noted the felt-sense of being better heard and better accompanied when witnessed by video as compared to in-person supervision. It appears that she experiences a quality of attention that is more satisfying through the technology.

Eye Contact

Both body language and visual feedback are connected firmly to the eye-contact sub-theme. One participant felt strongly that the eye contact offered via video-conferencing technology facilitates communication of "empathy through the screen"; they noted that "I would intentionally look at the camera so that I was offering my eyes." Another participant commented on the

unusual nature of eye contact through video conferencing and noted that given the parallax it can seem as though the other party is making eye contact even though they may not be: "they're really looking at a screen which I can tell they're looking at the screen. And even if I wouldn't even know if they're looking at a document it looks like they're looking at me."

Yet another respondent expressed, "I think you are making mind contact. Eye contact may not be very good. But mind contact is." This same respondent identified this as a possible benefit:

> take a client where culturally they are not used to looking in the eye. It could be normal to them and go unnoticed. It depends, I have First Nations clients and they look at me in the eye. I have First Nations clients that preferred to look to a point on the floor, somewhere to the side.

Another respondent who also works with Indigenous clients echoed this sentiment and noted that the option to avoid or vary eye contact in video conferencing could enhance or meet the need for cultural sensitivity and competency. Direct eye contact is not necessarily appropriate in all culture contexts (Bailenson et al., 2001; Bohannon et al., 2013; Hall, 1959; Jaklic et al., 2017; Nixon & West, 1995). In several Indigenous cultures, holding a direct gaze could be considered to be quite offensive (Caron, 2006). This merits particular attention as the importance of cultural competence is highlighted in several clinical supervision competency profiles (CCPA, 2016). As in face-to-face communication, variance in eye contact is possible which supports cross-cultural communication. Some may feel obliged to look at the screen, but it is also possible to give permission to look away; this may not only be important cross-culturally but also in cases where brain injury is present and extensive screen viewing may exacerbate symptoms.

One's Own Image

Deeply associated to the eye-contact sub-theme was the sub-theme into which responses were coded pertaining to the fact that video-conferencing software often includes a window showing one's own image, in addition to the image of the conversation partner. When speaking about the nature of eye contact in video conferencing one respondent noted:

> Yeah, I think that generally the eye contact seems to be more with my own. Which sounds weird… being able to move my little bubble to a different part of the screen is helpful too.

This respondent went on to talk about how viewing one's own image in clinical supervision, and the self-monitoring potential it provides, can be helpful:

> So, it's always strange when people are like 'you are a good counsellor' and I'm like 'you never seen me work'…. the video thing is painful but has been helpful and I think is a piece that I enjoy in my supervision with my face in a window also.

In this exemplar, the respondent discusses how the visual feedback loop happens not only with supervisor but also with oneself. The respondent likens this to clinical supervision via recorded sessions, in which the counsellor is able to observe their own facial reactions and body language. Watching one's own body language through the video-conference screen, while discussing clients in clinical supervision, may provide the supervisee with some insight into what the client sees when they are in session. The video conferencing technology may act as a sort of parallel processing mirror or feedback loop in which the supervisee is able to gain insight into their own non-verbal behaviour as one might do when watching recording sessions. This may add a layer of self-supervision within the video-conferencing clinical supervision session. This

feature is built into the technology by virtue of the fact that many video conferencing software programs enable one to see the image that one is projecting to their conversation partner.

Making Conscious Use of the Parallax

Closely related to the eye contact sub-theme was the parallax-sub theme, where respondents directly addressed how the parallax affected their experience of eye contact in video conferences. As noted in an earlier section, for the typically used video conferencing systems, the camera that captures the user's image is located at the top of the screen, whereas the image of the conversational partner tends to rest in the middle of the user's computer screen. True eye contact is somewhat impossible as it would necessitate both partners to look directly into the camera, which would be unnatural as this would prevent them from seeing each other's image. As noted above, some respondents thought that having the ability to vary eye contact could be a strong advantage, especially in instances of inter-cultural communication. One respondent actually identified making conscious use of the parallax to create humour or levity in the conversation: "I'd like look straight into the camera and like almost to like this weird like creepy but I go close and kind of funny." The respondent exploits the parallax to vary the emotional tone of the conversation and may indicate a certain degree of comfort and ease with this technology.

Remote Live Supervision

One respondent identified a compelling use of video-conferencing technology to facilitate a technologically enhanced live two-way mirror supervision:

> One of the ways that we're using it that I like though is not distance is just distance across the clinic. So, we don't have the ability to see and but I don't have to a mirror or anything in our clinic. So, what we do is we have Skype for business set up so we set up a phone call and then I tape the session.

The respondent explains how the supervisor can watch the session live, which can also be recorded for later viewing. This is similar to a practice described by Rousmaniere and Frederickson (2016) who termed this practice Remote Live Supervision. This method also allows the supervisor to input text messages into the text box if the supervisee appears to be needing prompts or suggestions. This provides a less intrusive way of providing live-real time feedback to supervisees without disrupting the session by interrupting or phoning in. This respondent thought that it was also less intrusive and provided more autonomy to the supervisee than session co-facilitation. This innovative use of technology could provide this supervisor with a less invasive means by which to offer live observation

Several other respondents identified that the chat box feature as being a value-added feature inherent to the technology. Most video-conferencing applications include a chat box which enables the supervisor to provide links to resources such as research articles or client worksheets, in real time as they are being discussed.

Decrease in Isolation

A perceived decrease in isolation emerged as another sub-theme. As one participant explained, "I find it really interesting now that we're talking about it like how I feel less isolated with people online versus my in-person counselor, or in person clinical supervisor." Some respondents also commented on the cost effectiveness of this technology:

> I personally believe that decisions are very easy to justify to the employer because what the clinicians do, they take days off. They get saturated they get to a point, the compassion fatigue, they're close to burnout, they're going to "blow a fuse" they tell you "any day" and then they take days off. If you… add those days lost, I bet you it's much cheaper to contract some remote counselling or remote supervision.

Finding ways of making supervision affordable is key; as noted in the quantitative results section of this study, cost emerged as a statistically significant barrier to accessing supervision (Slipp, 2020).

Privacy and Confidentiality

In terms of client privacy, one respondent identified that accessing through video conferencing allows her to secure her client's confidentiality, which is particularly crucial and difficult to do in small community: "that's why my supervisor is out of territory so that I could offload all my things and not have it circle back. Not that it ever would. But sometimes does."
This respondent actively chooses to access supervision by distance, because accessing a clinical supervisor in community might inadvertently result in an accidental breach of confidentiality and anonymity. Even if details are disguised, it is possible that the supervisor may figure out the identity of the client whose case the counsellor is seeking to consult about. This would not be unlikely in a community with a population of 3,000 people, for example, in which the supervisor and counsellor may both have interactions with the client as community members in non-clinical contexts.

Several respondents discussed the importance of developing competency in using the technology, particularly if using it for clinical supervision. One respondent asked, "how do we do connection differently when using technology?" This respondent discussed the experience as being impacted by, "the mixture of the technology itself and maybe the individual's competency level within that technology and with using that technology."

Finally, some respondents offered some recommendations for using video conferencing for clinical supervision. One respondent noted

> If I could make a recommendation what I would suggest is to meet first face-to-face. What I would do is if I would know that in a place there is there are three counselors are going to population of a thousand people or whatever. I would go there introduce myself in person and have a group more opportunity to interact and then meet with the three counsellors one-on-one individually and following that, the remote contact such as the one you and I are having now would suffice without any doubt. The other way of doing it. Doing it only remotely do it do it. Skipping the face to face might work too but I think that is much more effective when they had an opportunity to see you first in person because of a question of trust and rapport that can be established and that opportunity which is more difficult to establish remotely.

Unique Challenges Inherent to Video-conferencing Technology

The final higher order theme to emerge from the data included a focus on the unique challenges inherent to video conferencing technology, particularly when it is used for clinical supervision. This theme included the following sub-themes: a focus on a bias against technology, newness of video conferencing, poor connectivity, time zones, and trust in the technology's ability to maintain privacy.

Bias Against Technology

Some respondents commented on having a bias against technology and one noted that if given the choice between video conferencing and "in person and both were the same prices same person you're going to get I would choose in-person over doing it online." Technological bias may come from the fact that most counsellors are training and professionally socialized through in-person teaching and learning environments. Related to this bias was a sub-theme which clustered around the newness of technology and the difficulty of acclimatizing to this novelty. "Like it's new. Anything new is hard and difficult but not that it's bad. So, I think there's this newness and I haven't determined whether I'm still working through it."

It is possible that both the bias and ambivalence about technology's newness can be understood by considering Davis' (1989) technology acceptance model (TAM). As noted in an earlier section of this paper, professional caregiver perception plays a strong role in the acceptance and integration of technology within mental healthcare (Austen & McGrath, 2006; Perle & Nierenberg, 2013). As Davis (1989) suggested, it is likely both perceived usefulness and perceived ease of use that contribute to the doubt expressed by some respondents (Monthuy-Blanc et al., 2013).

Privacy and Confidentiality

The literature also showed that clinicians experience considerable reservation about technology's ability to maintain privacy and confidentiality (Austen &McGrath, 2006; Perle & Nierenberg, 2013). This bore out in the sub-theme that included respondents concerns about trust in the technology itself and whether or not it can maintain the users' privacy. One respondent noted

> If I was doing real clinical supervision where I wanted to have a heart to heart with an individual or with a group that you know, things were really a mess the last or this client… I would want that to be very private you know, to have the assurance of private and I would sort of like… the Patriot Act is in the US and the boundaries and so on…I would want us to find Canadian technology.

The concern expressed by this respondent is supported by the fact that codes of practice and ethics place a high degree importance on the maintenance of client confidentiality (CASW, 2005; CCPA, 2020; CPA, 2017).

Poor Connectivity

Several respondents commented on the nature of poor connectivity and how this impacts relational connection within clinical supervision via video-conferencing technology

> So, I find like right now there's feedback on the on the system and that's distracting. There's a bit of a lag and that's distracting. And so, it breaks up my train of thought. So, whether I'm the supervisee or the supervisor I don't get the same connection with the person I'm talking to because it's because of these distractions… distractions were major and again it didn't feel like we could go into as much depth. Like there wasn't the support there. I didn't feel held right. I didn't feel held. I didn't feel safe in unwrapping things beyond sort of the level that she engaged at. Whereas normally I would make an observation that would bring us deeper even though it's my supervision right. But I would take us deeper or she would. But in this case, it didn't go there so it didn't. I didn't feel held and it didn't feel safe.

This respondent's comment speaks both to the importance of supervisory competency but also highlights how disruptive poor bandwidth can be, for example, constant interruptions dropped calls may lead to frustration or to difficulty discussing complex topic areas. Although this situation is changing as an increasing number of communities are able to access better service, inequity in broadband access continues, particularly in rural, remote, and Northern regions (MHCC, 2014).

Limitations

Given the small sample size, the results of this research cannot be generalized to the larger population of counsellors across Canada. It is also worth noting that this research was conducted prior to the onset of the COVID-19 pandemic. It is likely that many more counsellors now have experience using video conferencing technology due to the public health mandates requiring social distancing. Although there is likely still some hesitation with respect to technology use, it could be that this aspect has dissipated somewhat throughout the COVID-19 pandemic. Counsellor ambivalence towards technology could be explained in part by the technology acceptance model (Davis, 1989; Monthuy-Blanc et al., 2013). It is also likely that this ambivalence might be healthy and natural, as the technology is still relatively new and there is much that is yet unknown both about the modality for supervision but also about the nature of privacy and data security of internet communication technology (Austen & McGrath, 2006; Perle & Nierenberg, 2013). Many would suggest that an assurance of absolute privacy and security in internet communication should be held with skepticism (Snowdon, 2019) and that much more work needs to be done in the development of cyber ethics (Pardo & Siemens, 2014; Richards & King, 2014; Slade & Prinsloo, 2013; Zwitter, 2014). For strategies to mitigate this risk, the reader should consult Rousmaniere (2014), Rousmaniere et. al (2016), and Schell (2018). This uncertainty alone is likely to bring up strong reactions in both supervisors and supervisees that may have an important impact on the work. Communication through technology, as opposed to face to face, in person communication, has implications in terms of unintentional breach of confidentiality which may limit what and how the supervisee shares within this modality.

Clinical Supervision Versus Clinical Consultation

It should be noted that since this research was conducted, the Canadian Counselling & Psychological Association (2020a) has done significant work to define and discern the practices of clinical supervision and professional consultation. This research was done in 2019 and at that time, the same understanding and definition of clinical supervision applied both to students in training and to certified professionals working in the field with several years of experience. This research was conducted solely with professionals who had graduated from training and had anywhere from zero to twenty-five years of professional experience. As such, the current definition of "consultation" offered by CCPA (2020a), would be more appropriate than clinical supervision:

> Consultation is an arrangement between professionals in which the consultant provides a service, such as sharing of skills, providing opinion on a case, problem solving, and brainstorming but the professional receiving the consultation has the right to accept or reject the opinion of the consultant. A consultant does not take on the legal responsibility or liability for decisions made by the therapist. Consultation also may be undertaken as a formal arrangement with fee requirements. (p.33)

The current definition of clinical supervision is likely a better fit for students who are in training. None of the participants in this study were students and all of them chose voluntarily to engage in consultation as part of their professional roles. The practice of counselling therapy is going

through significant change with the establishment of statutory regulation (CCPA, 2020b); therefore, the practices of supervision and consultation are also in significant transformation as the profession attempts to delineate these subspecialties within the scope of a newly regulated profession.

Discussion

The results of this research apply beyond the scope of counselling and supervision but may offer guidance for supportive use of video conferencing technology broadly across educational or consultative settings in general. Far from being a detractor in communication, video conferencing can facilitate and enhance the relational experience. As noted above, one participant identified her preference for communicating in this modality as she noted a quality of presence in which she felt she was more deeply heard, understood, and supported than in some face-to-face, in person exchanges. Perhaps not only the convenience and ease of communicating through this technology but also the intensity of focus and attention paid to the screen can create a relationally intimate and satisfying experience for users.

In order for a fluent dialogue to function through video-conferencing technology, it is quite likely, as noted by one participant, that competency and familiarity with the technology itself is crucial. It is expected that the ease in of interpersonal exchange and the felt sense of support is aligned with comfort in use of the technology itself. Fortunately, this can be achieved; it is this author's anecdotal impression that during the pandemic that educators, counsellors, and supervisors have developed more skill and familiarity with video conferencing, if only out of necessity. At times supportive coaching and encouragement along with some practical tips is what is needed to instill some initial confidence in those who are most resistant or hesitant.

Eye-contact plays a significant role in terms of the opportunity and felt sense of connection that is experienced through video conferencing. Not only does it potentially enhance intercultural communication but, as noted by one participant, the parallax can be used to enhance the communication in a way that is humorous or intentionally emphasizes or exaggerates the speaker's intention. This light-hearted approach seems to humanize the technology and offers playful and spontaneous opportunity for engagement. This may be a delightful way to project one's personality and presence into the virtual space. The intentional use of eye contact and the parallax may also be an important way in which we can go about offering "empathy through the screen" as described by one participant who emphasizes awareness of how they "offered my eyes."

Related to the role of eye contact is the importance of visual feedback between conversation partners. Interestingly, as noted by one participant, video conferencing software often involves both feedback with another person but also a feedback loop with oneself if the feature allowing the speakers to see their own image is enabled. One participant noted using this to her advantage as she observed her own reactions when discussing certain topics. This element of self-supervision or self-surveillance is a feature that differentiates video conferencing from telephone or in-person exchanges because there is not any other mode of communication that reflects a real time image of oneself into one's visual field. As much as viewing one's own image could be useful, it could also be a feature that enhances self-consciousness and creates distraction. The particulars of this aspect and how it effects interpersonal communication in video conferencing would be an interesting avenue for future research.

Of note is respondents' feedback about low bandwidth and poor internet connectivity. Reliable internet is crucial in being able to access consistent video conferencing support. It is imperative that rural, remote, and Northern communities have equitable access to strong, reliable, and affordable internet access. The digital divide and inequitable access to broadband is a human rights issue (United Nations News, 2017) that needs to be remedied at a systemic level. This is a broader issue that impacts this populations access to economic development opportunities, education, and access to eHealth services. In order for communities to access video conferencing services, whether for business, education, or health, they must have the broadband and equipment to support it. The fact that over half of the 1.4 million Indigenous peoples in Canada live in rural, remote, and Northern communities (Ministerial Advisory Council on Rural Health, 2002) means that a large number of Indigenous individuals are at a systemic disadvantage in terms of accessing opportunities offered by reliable internet technology. In the spirit of the TRC's (2015) *Calls to Action*, this omission in equitable access requires immediate remedy.

Finally, a number of respondents mentioned finances as barrier to accessing services. This result emerged in the quantitative aspects of this research (Slipp, 2020). Further research is needed to understand the costs involved in service delivery and to find ways of easing this burden for counsellors. Because clinical supervision supports health and wellness, it would be imperative for employers and workers compensation boards to consider how financially supporting the integration of this service can contribute to longevity and vitality to the mental health workforce.

Conclusion

The qualitative results from this mixed methods study showed how awareness of eye-contact and the parallax can be facilitate connection and enhance communication in video conferencing platforms. It also discussed how the integration of video conferencing facilitates live remote supervision. Respondents described how video-conferencing technology and its unique features provide a possible solution to the experience of isolation and the expression of compassion fatigue symptoms that often accompany work in these challenging contexts. The insights provided by respondents extend beyond the field of counselling and have implications for how to best use video conferencing to support communication and relational connection at large. Respondents feedback about the use of eye contact can be applied across disciplines and could be useful particularly in educational settings that employ this technology. The pandemic has brought an influx in the use of video conferencing to support education and as the world adapts to a new normal, awareness of these particular features is crucial to enhancing the benefits of video-conferencing technology.

Author's Contributions

Micheala Slipp completed all of the data collection, analysis, and writing in this piece of original research under guidance of a dissertation supervisory committee.

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Ethics Statement

Ethics approval was obtained through Athabasca University's Research Ethics Review Board.

Conflict of Interest

The author does not declare any conflict of interest.

Data Availability Statement

Codebook is available for download through the Zenodo repository:
https://zenodo.org/record/5148520

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Appendix

Semi-Structured Interview Schedule

Rural and/remote and/or northern respondents who have experienced compassion fatigue.

1. What are some of the benefits of working in a rural, remote, or northern community?
2. Please describe some of the challenges you have experienced as a certified counsellor working in a rural, remote, or Northern context.
3. Tell me about your experiences in receiving clinical supervision while working in a rural, remote, or Northern community.
4. Sometimes also referred to as “vicarious traumatization” or secondary traumatization, Figley (1995a) suggests that compassion fatigue occurs as the consequence of emotional residue or strain of exposure to working with those suffering from consequences or traumatic events. It differs from burn-out but can co-exist. Compassion fatigue can occur due to exposure to a single case, or it can be due to a “cumulative” level of trauma exposure. Please describe any experiences you have had with compassion fatigue while working in a rural context.
5. What strategies have you found to be effective in preventing or minimizing compassion fatigue? Please describe.
6. Clinical supervision is significantly associated with greater feelings of competence and successful achievement at work (Hayden et el., 2015; Lenz & Smith, 2010) and as a way to address compassion fatigue. Those counsellors living in rural, remote, or northern communities often lack access to clinical supervision. What could you foresee as being among the possible benefits and/or challenges of video-conferencing clinical supervision for rural counsellors in Canada?
7. Reflective exercises such as arts-based exercises, journaling, creative writing have been used in clinical supervision to enhance wellness. Please describe any such exercises you have used in clinical supervision.
8. Video-conferencing technology, like the technology we are using right now, has been used to support counsellors in rural, northern and remote communities. Please describe your experiences using this method of clinical supervision.
9. If you have not used video-conferencing for supervision, please imagine how you could see it being helpful to your practise, specifically, in mitigating compassion fatigue.