ONE

History and Future Trends

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The field of Marriage and Family Therapy (MFT) is on the fast track to becoming a prominent and competitive mental health profession, based on an expected growth in MFT jobs (United States Department of Labor, 2012), as well as a growing body of clinical research (Sprenkle, 2010). The number of programs across the country, ranging from master's to doctoral programs, is continuously growing.

The Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE) develops accreditation standards for graduate and postgraduate Marriage and Family Therapy training programs to ensure that students are getting a strong educational foundation in MFT (see the COAMFTE *Accreditation Standards for Graduate & Post-Graduate Marriage and Family Therapy Training Programs*, Version 12.0 Draft). The COAMFTE has identified its function as fivefold:

> First, the COAMFTE establishes and maintains professional standards in the education and training of CMFTPs.
>
> Second, the COAMFTE is committed to establishing and maintaining professional standards that support diversity and inclusion within MFT programs, and ensuring through accreditation excellence in multi-culturally/internationally informed education.
>
> Third, the COAMFTE accredits and ensures excellence in educational programs that educate CMFTPs who are relationally/systemically, multi-culturally/internationally and ethically informed.
>
> Fourth, the COAMFTE provides leadership and advocates for change in the larger practice and regulatory communities in defining competent CMFTPs.

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> Finally, the COAMFTE promotes consistency of qualifications and competency of CMFTPs to the public (COAMFTE Accreditation Standards, 2014).

The COAMFTE focuses on the various aspects of MFT training, including the educational and practice (clinical training) regulatory requirements. Clinical training is an important aspect of training MFTs, which not only requires significant face-to-face contact with individuals, couples, families, and other systems, but also must include relationally oriented supervision. The focus should be on the developmental needs of master's and doctoral students, as the supervisor provides supervision in an ever-changing environment. Supervision for MFT students and postgraduates working toward licensure is generally provided by American Association for Marriage and Family Therapy (AAMFT) Approved Supervisors.

AAMFT Approved Supervisors are an integral part of training MFT students and postgraduates, focusing on clinical growth and development. Because AAMFT Approved Supervisors are so important in the growth and development of today's and future MFTs, it is important to understand the history of AAMFT supervision; this is a building block for today's standards and will be the foundation for future trends and directions. AAMFT Approved Supervision is now and has continuously been one of the most active and fastest-growing subsystems of the MFT field (Liddle, Breunlin, & Schwartz, 1988). Before looking at the history, present trends, and future direction, it is important to understand what an AAMFT Approved Supervisor is, as defined in the *Approved Supervisor Designation: Standards Handbook* (AAMFT, 2014a):

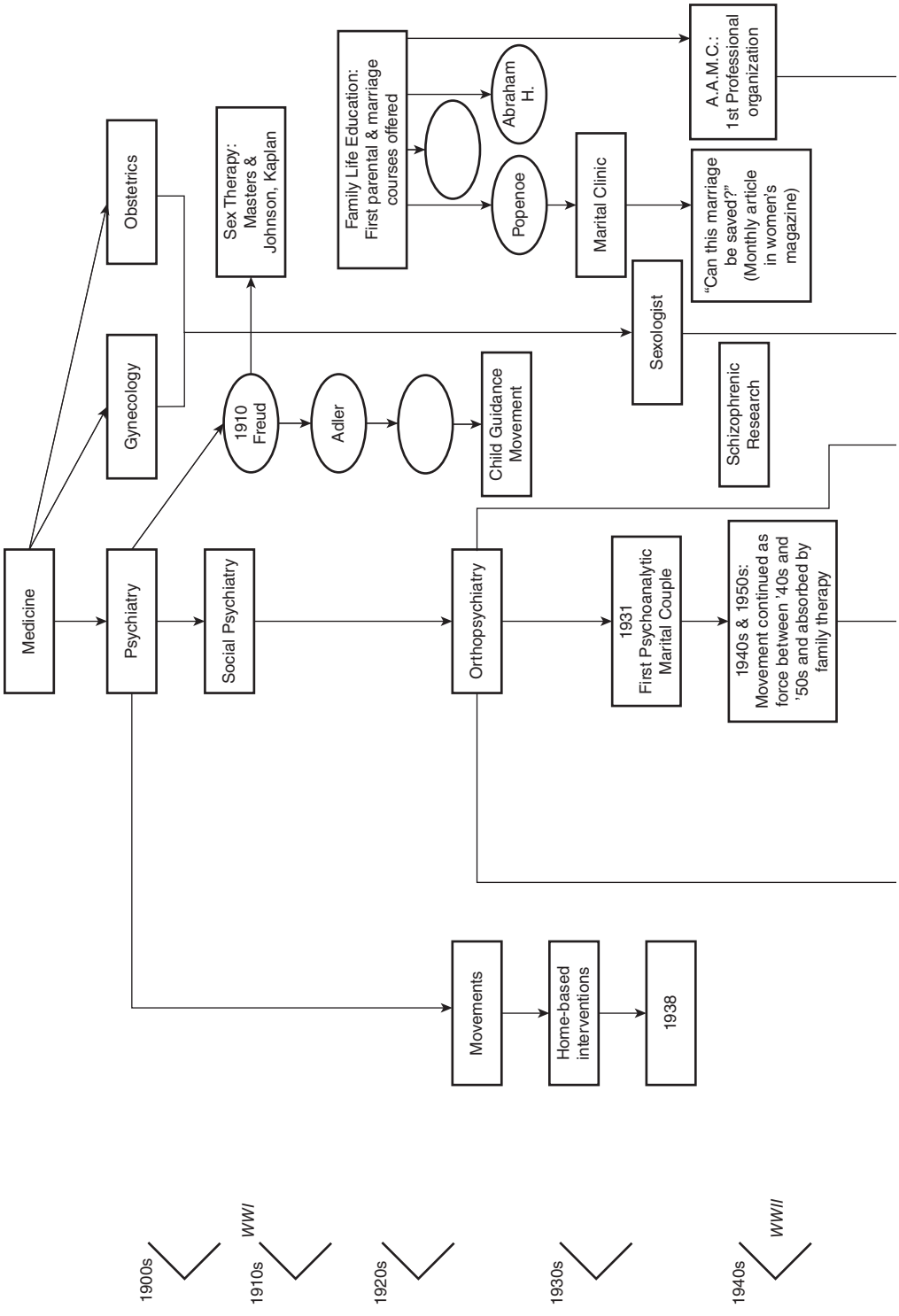
> AAMFT Approved Supervisor (AS) is a marriage and family therapist who has completed the supervisor candidate training requirements established by AAMFT as described below and who has applied for and been awarded the Approved Supervisor designation. The Approved Supervisor designation is not an advanced clinical credential but rather identifies, for the mental health community, those professionals who have met the AAMFT requirements to provide MFT supervision. Therefore, Approved Supervisors must also be Clinical Fellows of AAMFT. Approved Supervisors complete an AAMFT approved refresher course every five years to remain current on supervision standards, literature, and practices, and to renew their designation. (p. 5)

The AAMFT Approved Supervisor definition has evolved for more than 50 years and is continuously changing as the field of MFT grows and changes.

HISTORY

The history of AAMFT Approved Supervision goes back to David Mace in 1961. Mace was the Executive Director of the American Association for Marriage Counseling (AAMC), which changed its name to the American Association for Marriage and Family Therapy (AAMFT) when designated marriage counseling internship sites in one county could not be accessed, and a group of members were asked to serve as supervisors. However, the topic of supervision was something that the organization spent more than a decade discussing, even though Mace strongly advocated for supervision as a means of quality control and increasing membership. Others, however, feared that supervision would create an opposite effect, discouraging practitioners from seeking the credential in marriage counseling, and therefore negatively affecting membership (Benningfield, 1985). It was during this time that a consensus gradually evolved as to the definition of *supervision* and as to what supervisor qualifications should be, and in 1971 the Approved Supervisor designation was established after several years of naming individuals to supervise candidates for membership. Also during this time, a definition of *supervision* was adopted and 67 persons (20 females and 47 males) were grandfathered in and named Approved Supervisors. The number of Approved Supervisors grew quickly, rising to 200 in 1974. During this time, a Committee on Supervision (COS) was developed by the board. Fred Humphry was the chair of the newly formed COS and was charged with reviewing and approving applications for Approved Supervisor status. In 1975, the COS was also charged with setting standards for Approved Supervisors. The COS developed both supervision practices and procedures for Approved Supervisor designation. In 1976, there were 233 Approved Supervisors in the United States, constituting 14% of the AAMFT clinical members (Lee, Nichols, Nichols, & Odom, 2004). In support of Marriage and Family Therapy (MFT) being a unique profession, in 1977 the COS identified that those who sought the Approved Supervisor designation needed to demonstrate systemic conceptualization.

One of the salient components of MFT supervision is live supervision, which sets it apart from other disciplines (Montalvo, 1973). In this supervision medium, the MFT student and/or MFT postgraduate (or therapist) is observed through one-way glass and occasionally receives suggestions via a phone call (Montalvo, 1973) as well as videotapes and use of the "bug in the ear" (Birchler, 1975). This allows provision of immediate feedback to the MFT student or postgraduate. Live supervision goes back to the seminal research conducted by Bateson (1972) in collaboration with Haley, Weakland, and later Jackson, focusing on observation and teamwork. The Milan team, practicing from Milan, Italy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), utilized both a team behind the one-way glass and a co-therapy team


1900s
WWI
1910s
1920s
1930s
1940s
WWII
Medicine
Psychiatry
Social Psychiatry
Orthopsychiatry
1931
First Psychoanalytic
Marital Couple
1940s & 1950s:
Movement continued as
force between '40s and
'50s and absorbed by
family therapy
Obstetrics
Gynecology
Sex Therapy:
Masters &
Johnson, Kaplan
1910
Freud
Adler
Child Guidance
Movement
Family Life Education:
First parental & marriage
courses offered
Abraham
H.
Popenoe
Marital Clinic
A.A.M.C.:
1st Professional
organization
"Can this marriage
be saved?"
(Monthly article
in women's
magazine)
Sexologist
Schizophrenic
Research
Movements
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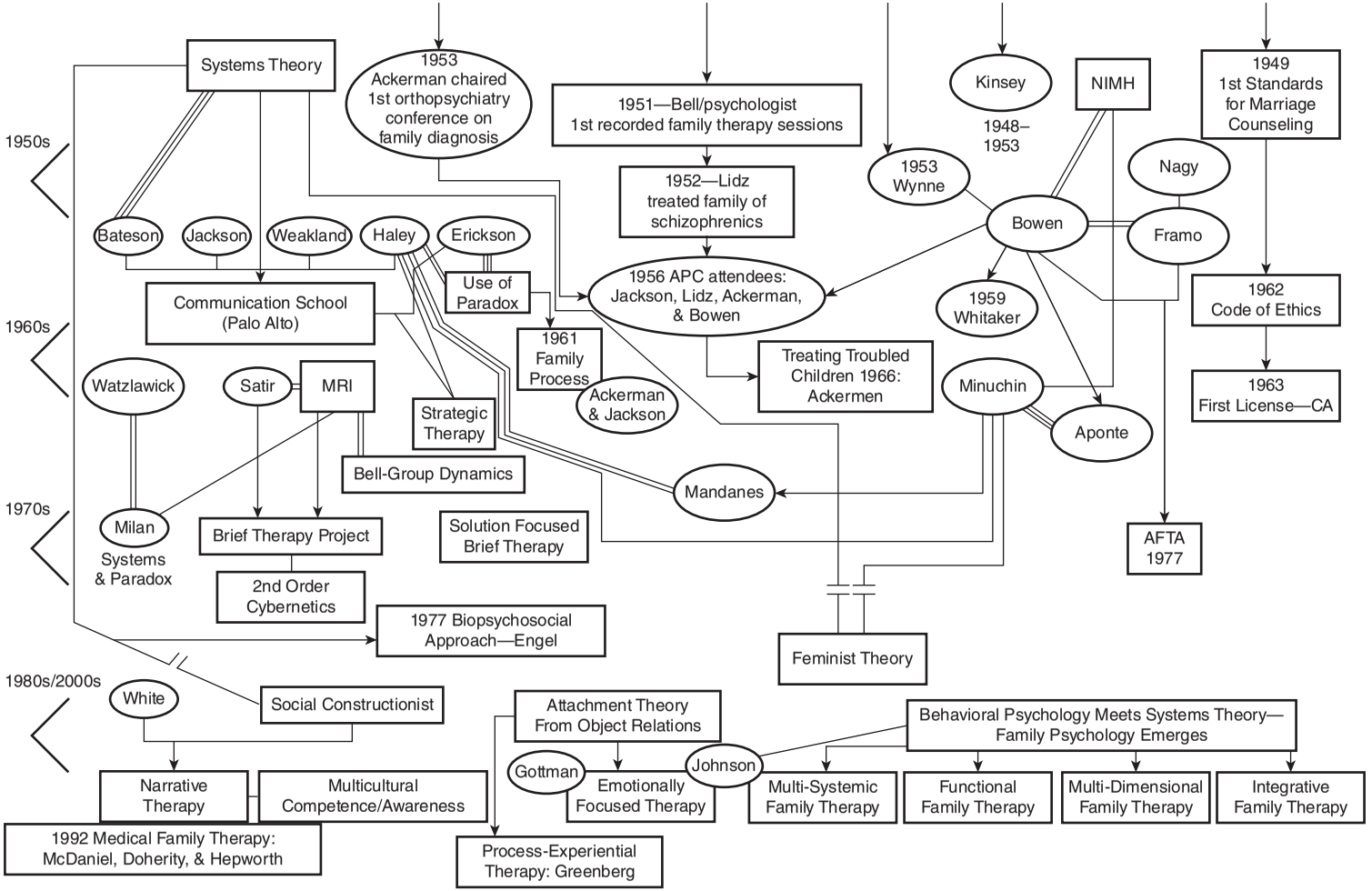

This historical supervision genogram has been included to better demonstrate the MFT supervision evolution.

Source: Parr, Boyle, Tejada, & Perosa (2008), revised by Boyle, Tejada, & McDowell-Burns (2015).

when working with seriously disturbed families. Their model included five stages: (1) pre-session, (2) session, (3) intersession, (4) intervention, and (5) post-session. During the intersession, the whole team (a team behind the one-way glass and a co-therapy team) discussed what they saw and devised a strategy that was delivered as a team message. Computer-assisted supervision was used to provide information to the supervisee (Smith, Mead, & Kinsella, 1981).

In 1983, the AAMFT Board changed the COS to a Commission, to function semi-autonomously. During the next decade, the number of Approved Supervisors kept increasing, and a course on supervision was added to the training of Approved Supervisors (with parts of the course being offered at the annual AAMFT conference, thus initiating the supervision track). Also during this time, the *Supervision Bulletin*, a newsletter for sharing information and supervision trends/issues, was started. The first editor of the *Supervision Bulletin* was Tony Heath. By 1986 the number of Approved Supervisors had grown to 1,286, constituting 14% of the AAMFT clinical members (Lee et al., 2004). According to Everett (1980), the population of AAMFT Approved Supervisors had changed since the 1970s: There were more women, a shift toward systemic theoretical orientation, a decline in the popularity of personal psychotherapy, an increased popularity of the use of video recording, and an increase in persons identifying themselves as MFTs.

A further development arrived in 1986, when Fred Piercy edited the book *Family Therapy Education and Supervision*. One of the chapters, written by Robert Beavers, was titled "Family Therapy Supervision: An Introduction and Consumer Guide." According to Beavers, "Supervision in marriage and family therapy is both a legitimate offspring of individual psychotherapy supervision and a mutant, representing qualitative differences from the parent" (p. 15). The conclusion of the chapter contributed by Piercy and Sprenkle (1986) states:

> The key figures of family therapy were revolutionaries. They took strong, often unpopular, theoretical stands that [ran] counter to the Zeitgeist of their time and paved the way for the theoretical models taught today. (p. 12)

In 1988, another supervision book was published, authored by Howard Liddle, Doug Breunlin, and Richard Schwartz and titled *Handbook of Family Therapy Training and Supervision*. This book focuses on thinking structurally and thinking strategically, using the concepts of cybernetics. It covers the various systemic models to choose from, interconnected relationships in isomorphic proportions, and various forms of supervision (live and video). Neither the Piercy book nor the Liddle et al. book focuses on what constitutes supervision; instead, they focus on systemic thinking as well as the training for and supervision of marriage and family systems work. The requirement from AAMFT was the notion that training in systemic thinking was a prerequisite

for supervising other MFTs (MFTs in training). In addition, AAMFT required that supervisees practice systemically.

One of the first recognitions of the importance of cultural influences in supervision was found in the Liddle et al. (1988) book, specifically the chapter written by Falicov, titled "Learning to Think Culturally" (Falicov, 1988). The COS recognized the importance of diversity and, more specifically, the diversity of Approved Supervisors and diversity sensitivity when doing supervision; its focus was on contextual variables such as gender, ethnicity, race, and so on. A minority stipend for supervisors-in-training was also set up, and the COS diversified by filling vacancies with diverse members to create a balanced member representation of minority and majority cultures. Later in 1991, the COS again became a committee. The field of MFT, as well as AAMFT, were out in front, recognizing the importance of cultural influences on couple and family systems. However, the movement from cultural competence to cultural equity and humility has fallen short in AAMFT supervision and will have to be given more attention.

More research in the area of training MFTs and supervision emerged in the 1990s, by researchers such as Avis and Sprenkle (1990), Frankel and Piercy (1990), and Liddle (1991), to list only a few. However, research in the area of supervision was sparse. Liddle (1991) wrote:

> Supervisors must be formally trained. . . . Being a skilled therapist is not enough. Clinical skill and knowledge are indispensable for, but no guarantee of, supervisory success. Without exaggeration, the success of the family therapy field depends on the next generation(s) of supervisors. Our field can progress no further than do those who define it and teach it to others. . . . It is they who carry the torch. (p. 688)

Although supervision research was occurring during the 1990s, there was a lack of research focusing on the effectiveness of AAMFT Approved Supervision for the MFT student and MFT postgraduate.

In 1995, the COS and AAMFT Membership Committee were combined into the Standards Committee. The charge for this new committee was twofold: (1) AAMFT membership procedures, and (2) procedures for Approved Supervisor designation. The Approved Supervisor designation has been developing continuously since that time.

In 2001, a national survey of AAMFT Approved Supervisors showed that major MFT theories were no longer dominated by allegiance to a single theory (Blow & Sprenkle, 2001). In the early 2000s, the focus in the MFT supervision literature was on the importance of common practice, sometimes called *best practices* in AAMFT Approved Supervision (Storm, Sprenkle, & Morgan, 2001). The latest COAMFTE (2002) standards require that accredited programs have a minimum of three faculty members; however, only two of them must be AAMFT Approved Supervisors—one can have

an "equivalence" (Lee et al., 2004). During this time, an equivilance could include being an independent licensed Marriage and Family Therapist (IMFT) who has 2 to 3 years experience as an IMFT and has some supervision training (Lee et al., 2004). The focus was on refining the standard of practice to define best practice for Approved Supervisors. Best practice was to provide AAMFT-approved supervision for the MFT after graduation and to include topics such as ethical responsibilities, the gatekeeping role, quality client care, and so on. In 2001, the number of Approved Supervisors had grown to 2,046, constituting 13% of the AAMFT clinical members (Lee et al., 2004).

In 2004, Lee and Everett wrote a book titled *The Integrative Family Therapy Supervisor: A Primer,* in which they identified 12 principles of supervision:

1. Supervision must be respectful.
2. Supervision, like therapy, must be a safe place.
3. A working alliance must be developed.
4. A supervisor does not offer therapy to the clinical family.
5. A supervisor does not offer therapy to the therapist-in-training.
6. The dynamic of supervision includes hierarchy and power.
7. Supervision develops through predictable stages.
8. Supervision interventions are driven by theory.
9. Supervision should be competency based.
10. The supervisor has simultaneous responsibilities to the therapist, the clinical setting/institution, and the self.
11. The supervisor, like the therapist, follows clear ethical principles of conduct and practice.
12. Supervision is unique within each training system. (p. 4)

More specifically, their book referenced the integration of the various systemic concepts and theories (such as Structural Theory and Bowen Theory). It was written using postmodern thinking, attempting to "identify, and appreciate the unique qualities, resources, and constructions of reality of the many therapists and their clients" (p. 4).

In 2007, the AAMFT developed its own book on training AAMFT Approved Supervisors, titled *Approved Supervisor Designation and Standards Handbook*. The book provides information about training requirements, guidelines, application forms, and other tools. It was developed to help AAMFT Approved Supervisors-in-Training gain knowledge about the training and requirements for becoming an AAMFT Approved Supervisor. The book focuses on three steps: (1) prepare to train, (2) complete training, and (3) submit application.

In 2012, Carlson and Lambie presented a systemic developmental approach called *Systemic Developmental Supervision.* This model was developed specifically to govern supervision for MFT students and postgraduates, focusing on the developmental path these students go through as they learn more about functioning as an MFT, integrate skills, and become familiar with the

various systemic models that will cumulate in the emergence of the MFT identity. More specifically, this developmental model incorporates aspects of the integrated developmental model (Stoltenberg, 1981; Stoltenberg & McNeill, 2010) and the life-span developmental model (Ronnestad & Skovholt, 1993, 2003).

TODAY'S TRENDS

Today, in a complex and ever-changing world in which communication and education have become easier than ever, technology is rapidly expanding the possibilities for supervision and supervisors. For example, AAMFT Approved Supervisors looking for a refresher workshop can, as they have in the past, sign up for the refresher course offered at the AAMFT annual conference, and/or (at the state level) attend a 5-hour in-person workshop. As of 2014, however, AAMFT Approved Supervisors can also sign up for an online refresher course. This has created convenience and flexibility for AAMFT Approved Supervisors. In addition, the AAMFT has also put its 30-hour fundamentals of supervision course for clinical fellows and preclinical fellows online. This fundamental training is comprised of a 15-hour didactic course, a 15-hour interactive portion, and a personal paper on one's philosophy of supervision. After all three parts have been completed for the fundamentals of supervision, a certificate of completion is awarded. There is also an option to take only one part, either the didactic or interactive portion, of the training online, in addition to the ability to take both portions online.

Today's fast-growing technology is affecting both Marriage and Family Therapy and supervision. Today, there is no AAMFT Approved Supervision Code of Ethics; rather, ethical guidelines for AAMFT Approved Supervisors are addressed in the AAMFT Code of Ethics (2012):

> Principle IV: Responsibility to students and supervisees. Various aspects of supervision are addressed in the literature, however complex client and student issues dealing with technology are non-existent, despite tech's impact and seeming omnipresence—e.g., social media (Facebook, Twitter, etc.), e-mail, texting, web conferencing, etc. It is important to recognize that technology presents opportunities and challenges for supervision that must be addressed in the AAMFT Code of Ethics.

In an era in which technology use is rapidly growing, with clients as well as students and supervisees employing many and various forms of technology in their daily lives, there is an expectation that technology will also be used in the process of marriage and family therapy. This can range from such formal measures as online therapy and supervision to the use of smartphones, Twitter, Skype, and the like. Unfortunately, the Code of Ethics, especially in the area of AAMFT Approved Supervision, has not kept up with the rapid growth in technology.

Today, the field of AAMFT supervision has expanded from theory-specific AAMFT approved supervision to include (and focus on) population-specific supervision. Special attention has turned to such areas as medical family therapy and trauma therapy supervision. The field of medical family therapy (MedFT), which goes back to the 1990s, is the application of systems theory in the form of a bio-psycho-social systems approach to conducting systemic therapy with patients and their families who experience physical health problems, including illness and disability, among other things. MedFT supervision is rooted in systems theory, bio-psycho-social thinking, and collaborative (community agencies, hospitals, etc.) thinking (Doherty, McDaniel, & Baird, 1996; Pratt & Lamson, 2012). Supervision in the field of Trauma Informed Marriage and Family Therapy (T-IMFT) has been addressed in the past by such researchers as Jordan (2003, 2005) and often focused on those working with survivors of abuse. At first, it was realized that marriage and family therapists working with survivors of abuse may experience vicarious traumatization (Jordan, 2010): The theory was that vicarious traumatization is the cumulative effect of the caring marriage and family therapist repeatedly hearing stories of abuse while working with abuse survivors. It is also believed that vicarious traumatization is a job hazard for those working with clients affected by other types of trauma (e.g., veterans, disaster survivors, accident survivors). Even though much research today has focused on working with abuse survivors, the cumulative effect of hearing trauma stories can affect marriage and family therapists on a professional and personal level of functioning as they work with other trauma-affected clients.

Multiculturalism in a globalized society is important for marriage and family therapy students and supervisees as well as AAMFT Approved Supervisors (see "Standard II: Commitment to Diversity and Inclusion," in *COAMFTE Accreditation Standards: Graduate & Post-Graduate Marriage and Family Therapy Training Programs* [Version 12.0, p. 16]).

Supervisors must address the issues of multiculturalism, diversity, marginalization, and globalization with students and supervisees. These issues have to be brought into both the therapy process and the supervision process, providing an opportunity for open dialogue and exploration of values, beliefs, and perception. More specifically, marriage and family therapy students and supervisees can benefit from doing a cultural self-reflection, not to evaluate other cultures, but to recognize and evaluate their own prejudices, racism, stereotypes, and personal reactions. The cultural self-assessment will promote the student's/supervisee's awareness of his or her internalized culture. Marriage and family therapy students and supervisees should be knowledgeable about the integrative systemic multicultural approach, as this will help them (a) to understand the individual/couple/family's internal reality and context, as well as (b) to develop an inclusive and effective treatment plan. Multiculturalism and diversity are important in a globalized world; however, of equal importance is the acculturation process of international marriage and family therapy students and supervisees, as they go through adjustments in their

personal and professional beliefs and values. The AAMFT Approved Supervisor will need to understand each student's/supervisee's cultural background by being curious and interested. In addition, language can be challenging; both supervisors and supervisees must learn to understand colloquial terms, slang, phrases, stories, and metaphors. Cultural concepts and phenomena can also impact the marriage and family therapy student and supervisee. AAMFT Approved Supervisors are challenged with helping international students and supervisees conceptualize client issues and discuss possible treatment plans and also with helping them prepare to return to their native countries. This kind of AAMFT Approved Supervision can be both challenging (e.g., cultural differences, language differences, etc.) and rewarding for the supervisors, as they expand their own worldviews and gain more cultural knowledge.

The field of AAMFT Approved Supervision appears to be growing parallel to the field of marriage and family therapy. Today there is more focus on the use of technology, population-specific treatment and supervision, and ethics, as well as multiculturalism and globalization. The process of supervision is becoming more effective in an era of changing technology, meeting the demands of today's marriage and family therapy students and supervisees, as well as their clients.

FUTURE DIRECTION: THE USE OF TECHNOLOGY

COAMFTE has charged programs to: "Ensure [that] your program has exposure to the newest innovations and strategies for educating marriage and family therapy students" (COAMFTE Accreditation Standards, Version 11, p. 5, 2005). Technology, which has become an integral component in today's education system, is also used to deliver supervision to mental health clinicians (Lux & Sivakumaran, 2010). Various mental health professionals use technology to provide supervision in clinical settings and training programs when supervising students and postgraduates; however, these uses have raised a question as to whether supervisors and supervisees must meet face-to-face for the entire required number of hours. Other similar questions were raised when technological advances were first implemented in the sphere of mental health services (such as, "Are clinicians able to receive an adequate amount of supervision?"). One of the obstacles for delivering mental health services is the physical distance between clients and clinicians (Layne & Hohenshil, 2005); research is still determining whether technology-enabled services are appropriate and equivalent to in-person contact.

AAMFT Approved Supervisors, similar to supervisors of other mental health professionals, are dealing with the use of technology to provide supervision for MFT students and postgraduates. Today there are approximately 2,000 AAMFT Approved Supervisors in the United States, 200 in Canada, and 40 in other countries (AAMFT, 2014b), while the number of MFT clinicians exceeds 29,000 in the United States alone (Bureau of Labor Statistics, 2013). As

described earlier, MFT programs are charged with "innovation" in the delivery of training programs, fulfilling another COAMFTE tenet of accredited MFT programs (COAMFTE Accreditation Standards, Version 11, p. 5, 2005). As the number of MFT student trainees working toward the MFT license grows, the need for access to supervisors grows as well. Furthermore, internship opportunities may also become more varied (Watson, 2003). The use of technology may facilitate the delivery of AAMFT Approved Supervision to MFT students and postgraduates who are not able to meet face-to-face with supervisors (Kanz, 2001) in their licensure jurisdiction, or in cases where licensure jurisdiction of the supervisor varies from that of the student. Also, when technology is used, the cost of AAMFT Approved Supervision may be lower, the convenience and scheduling of supervision meetings may increase, and the supervision process may become more accommodating to all parties (Vaccaro & Lambie, 2007). For example, for an MFT student or postgraduate needing urgent consultation, the AAMFT Approved Supervisor might be more accessible via technological means than by a face-to-face meeting (McAdams & Wyatt, 2010), thus giving both the AAMFT Approved Supervisor and the MFT student/postgraduate peace of mind, as supervision via technological means can be more immediately available in emergency situations. It is also a way to lower potential liability issues, as urgent issues can be quickly addressed. Furthermore, easier access to supervision may lead to higher job satisfaction and lower rates of clinician burnout (Kanz, 2001).

Types of Technologies Used

Technology has been transforming the field of mental health since the 1930s, when computers were first used to assist in the scoring of a vocational assessment, the Strong Vocational Interest Blank. The influx of personal computers into the business and public domains continues to improve the delivery of mental health assessments. By 1990, a variety of technology-assisted methods had been developed and used to connect supervisors, clinicians, and clients. Researchers reported these methods to be electronic mail, teleconferencing (Harvey & Carlson, 2003), chat-rooms (Vaccaro & Lambie, 2007), and videoconferencing (Watson, 2003).

In recent years, telehealth—the use of communication technology to provide mental health and consultation services—has become widespread (Himle et al., 2012). Although e-mail correspondence has improved the efficiency of communication, it has also been shown to decrease communication clarity, as body language and other subtle communication cues are missing (Watson, 2003). Due to the need for live observation, videoconferencing has become central in connecting individuals in the mental health industry. Videoconferencing has been the subject of recent studies and has shown to be effective in delivering successful therapeutic services to clients suffering from Tic Disorder (Himle et al., 2012), Obsessive Compulsive Disorder (Vogel

et al., 2012), substance abuse (King, Brooner, Peirce, Kolodner, & Kidorf, 2014), and anxiety and depression (Dunstan & Tooth, 2012).

Clinical supervisors have also been utilizing videoconferencing technology successfully. A literature review of studies conducted on the efficacy of using videoconferencing in supervision revealed that supervision provided via technology does not differ greatly from face-to-face supervision (Abbass et al., 2011). In fact, one study revealed that some clinicians were not able to meet the hourly requirement for meeting with a supervisor, and videoconferencing was the only means for them to receive supervision (Xavier, Shepherd, & Goldstein, 2007). Videoconferencing can be delivered via a variety of methods, including proprietary platforms such as eGetgoing, offered by the CRC Health Group, Inc. (King et al., 2014), and Skype (Armfield, Gray, & Smith, 2012; Krampe & Musterman, 2013); more recently, Blackboard (Elluminate) Web conferencing has been used to connect Internet users at different locations (Blackboard.com, n.d.). This becomes increasingly important in a global society, as international students come to the United States to be trained in the field of MFT. Supervision for these students can be done via Skype or the use of other technology. For example:

> A Sri Lankan student in a COAMFTE-approved program returned to his home country after the tsunami in 2004, wanting to assist with the aftermath of that disaster. For 1 year he was busy helping out, but after the year ended he contacted his MFT program in the United States and indicated that he wanted to finish his internship experience. He found an AAMFT Approved Supervisor who was able to provide the supervision in Sri Lanka, but needed to get university group supervision. Skype became the technology of choice and the student Skyped in each class meeting and was part of the group supervision provided by the university. He contributed to the class discussions and also presented his clinical cases and received both peer and AAMFT-approved faculty supervision. His supervision by the AAMFT Approved Supervisor in Sri Lanka was helpful, as some of his clients spoke Tamil, although the majority of them spoke English. There were also some cultural aspects that the in-country AAMFT Approved Supervisor seemed to be better equipped to address, as he was very familiar with the local cultural values and customs, having been born and raised in Sri Lanka. These issues were also addressed within the context of group supervision and became a valuable learning opportunity for all of the MFT students in the group supervision class.

This case example shows that technology can be a valuable tool for dealing with AAMFT Approved Supervision needs, at national and international levels, which will become increasingly important in an increasingly globalized society. In addition, most university training programs, including MFT

programs, are charged with providing "Global Preparedness" for students. In the preceding case example, not only did the student from Sri Lanka benefit from the use of technology, but so did the students in his internship class who were part of the AAMFT Approved Group Supervision, as issues of cultural diversity were addressed.

Ethical Concerns

Technology in the field of mental health, specifically in MFT, has become more widespread, and therefore defining the ethical standards for services rendered thereby takes on a more prominent role (Mallen, Vogel, & Rochlen, 2005). When one looks at the various mental health professions and how the use of technology in supervision is addressed, it becomes obvious that very little guidance is provided. The use of technology in mental health, and specifically supervision, is growing very rapidly, making it difficult for the various professional codes of ethics to remain up to date. Because the AAMFT Code of Ethics serves as a guideline for what AAMFT Approved Supervisors, MFT students, and postgraduates can do, it leaves them with little guidance as to how to behave prudently and do no harm. The use of technology, because it is constantly changing, is basically uncharted; any uses should be looked at with a critical eye and chosen carefully to ensure safety and protection for the AAMFT Approved Supervisor, the MFT student/or postgraduate, and—most importantly—the clients.

The MFT profession entails an added dimension, as MFT students and postgraduates deal not only with individual clients, but also with couples and families. Providing MFT Approved Supervision tends to be more complex than other kinds of supervision, as the client modality can involve more than one client in the therapy session. Due to the complex process of connecting several family members via technological tools, issues of confidentiality, information disclosure, identity protection, and clinicians' abilities all become major concerns that must be addressed (Baltimore, 2000). For example, an Internet tool might be monitored, or content might be recorded by the provider (Wilson, 1995). This could be a concern not only for the MFT student or postgraduate who is conducting the session, but also for the AAMFT Approved Supervisor who is using technology to conduct supervision.

The use of technology by AAMFT Approved Supervisors raises a variety of ethical questions:

- How can client confidentiality be maintained when using technology such as Skype or Elluminate?
- How can confidentiality be ensured when dealing with transmission and recordkeeping on Internet-based platforms?
- How safe is it to e-mail client and/or supervision documentation? What measures are taken so that these documents do not end up in the wrong hands?

- Who is the owner of electronic transmissions received?
- To what degree does state law influence some of these questions and answers? For example, in the state of Ohio, the records belong to the entity that owns the equipment. So, if it is the agency's computer, then all the e-mail and document correspondence belongs to the agency. What implications might this have for AAMFT Approved Supervisors and MFT students and/or postgraduates? Is there a conflict between state law and the AAMFT Code of Ethics?

These and other questions must be raised by COAMFTE and the AAMFT, so that guidance and standards are available for AAMFT Approved Supervisors, MFT students, and postgraduates, to assure the provision of ethical services and ensure that clients are well served and—at the least—not harmed.

Diversity and Technology Use

Although the use of technology in the MFT field is growing, it is important to identify population sectors that either do not have access to it, or for whom technology is currently cost-prohibitive. A gap exists among those who are able to use information technology (e.g., Internet and social networking, cell phones, e-mail, etc.) and those who are not. Underrepresented populations include Native Americans, African Americans, Hispanics, and others, as well as individuals with disabilities (Taylor, 2010). Likewise, the elderly population may not be well equipped to effectively use new and innovative technology tools (Soares, Jacobs, Callari, Ciairano, & Re, 2012). Although using such technologies is an important part of integrating into the modern society, the elderly may not be able to do so without extensive training (González, Ramírez, & Viadel, 2012). AAMFT Approved Supervisors who depend on the use of technology for supervision meetings with MFT students and postgraduates may encounter barriers with and from these populations. Thus, it is important to assess the use of technology by MFT students and postgraduates, assessing their level of comfort with technology, as well as their skill/proficiency in technology and commitment and desire to grow and learn in this area.

CONCLUSION

MFT is still a young profession, but despite that, recognition of the importance of providing clinical training through relationally oriented supervision arose very early in its history. As seen in this chapter, the process of supervision in the MFT field evolved almost parallel to the growth of MFT theory development. Today there are unique challenges for AAMFT Approved Supervisors, who need to keep abreast of ever-changing technology and seek new ways to become part of a technology-based behavioral health care delivery system in which telehealth creates accessibility and new opportunities

for service delivery. It also creates new challenges in training future MFTs to become technologically equipped, knowing when it is and when it is not appropriate. Given the limited guidance in the AAMFT Code of Ethics, supervisory guidance has to be sought out and provided through consultation.

Other areas with which AAMFT Approved Supervisors need to become acquainted and knowledgeable are the various specializations, such as MedFt and T-IMFT. These create new opportunities for MFTs to collaborate and work as part of a team in often complex systems. However, as noted in this chapter, as we become an increasingly global society, it becomes imperative for AAMFT Approved Supervisors to be well versed in working with international students who seek out MFT training. As the field of MFT is continuously growing and maturing, the AAMFT Approved Supervisor needs to grow in a parallel process, which means that AAMFT Approved Supervisor training (initial and refresher courses) must be updated regularly to reflect the changes that are occurring in the profession, mental health field, and global society.

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