ZERO TO THREE
JOURNAL

Measuring and Building Reflective Capacity

IN THIS ISSUE

ZERO TO THREE
Early connections last a lifetime

This Issue and Why it Matters

The concept of "reflective supervision and practice" has been a hallmark of ZERO TO THREE's work with practitioners in the infant-family field for several decades. Our first full Journal issue on the topic, *Supervision and Mentorship in Support of the Development of Infants, Toddlers, and Their Families* was published in 1991. By 1992, ZERO TO THREE published a groundbreaking book titled *Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers and Their Families: A Source Book* (Fenichel, 1992). In addition to numerous Journal articles, books, and trainings on the topic, we have devoted two additional entire Journal issues, each building on the prior knowledge base (*Reflective Supervison: What Is It and Why Do It?*, September 2007, and *Putting Reflective Supervision Into Practice*, November 2010).

In the 2010 issue, we noted the necessity to begin to construct a solid body of evidence for the effectiveness of reflective supervision and practice. The authors noted: "challenges for the future are to build on emerging interest in the topic of research about reflective supervision within the field and, simultaneously, to help convince (potential) funders to support the many-pronged set of inquiries necessary to adequately demonstrate its value. We hope that this article...will motivate some readers to find ways to pursue studies and help further many branches of the dearly needed process to build a research base for reflective supervision. In so doing, the field will teach itself more about how to improve and spread reflective supervision so that it has the greatest effect, economy, and clarity, increasing the quality and effectiveness of service delivery to babies and little children across systems" (Eggbeer, Shahmoon-Shanok, & Clark, pg. 44). This issue of the *ZERO TO THREE* Journal takes that next step toward strengthening the research base as we turn our attention to the progress of our colleagues in creating tools and processes to measure change and efficacy in reflective capacities. The articles in this issue feature efforts on the cutting-edge of this body of work, and we hope they will inspire others to contribute to this necessary next step in developing and maintaining a strong, competent workforce that values thoughtful reflection as a core value in effective practices with young children and their families.

Special thanks is due to Sherryl Scott Heller, a member of the Academy of ZERO TO THREE Fellows, for her work as Guest Editor for this issue of the Journal. As a ZERO TO THREE Fellow, her project focused on developing a measure to examine the impact of reflective supervision. Her knowledge and expertise were instrumental in the conceptualization, content development, and editing of this issue.

We also hope you will join us in ZERO TO THREE's exciting new membership program! We are thrilled that almost 1,000 members have joined since the launch of the program this summer. The *ZERO TO THREE* Journal is included as a benefit of membership, so I hope you will consider upgrading your subscription to membership if you haven't already. With membership you also gain access to Member Exclusive events, Bookstore and Annual Conference discounts, and additional content—free online virtual events, member-only resources, newsletters, and more. For more information, visit https://www.zerotothree.org/membership.

Stefanie Powers, Editor
spowers@zerotothree.org

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *ZERO TO THREE, 31*(2), 39–45.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book.* Washington, DC: ZERO TO THREE.

ZERO TO THREE JOURNAL

Measuring and Building Reflective Capacity

Contents

www.zerotothree.org/journal

Cover photo: Kiwi Street Studios

Measurement Development in Reflective Supervision

History, Methods, and Next Steps

Angela Tomlin
Indiana University School of Medicine

Sherryl Scott Heller
Tulane University School of Medicine

Abstract

This issue of the *ZERO TO THREE* journal provides a snapshot of the current state of measurement of reflective supervision within the infant-family field. In this article, the authors introduce the issue by providing a brief history of the development of reflective supervision in the field of infant mental health, with a specific focus on research regarding reflective supervision. They highlight why research on reflective supervision is vital to the field and provide an overview of current research methods. The emerging research methods and implications are discussed in more detail in the other articles in this issue.

Reflective supervision may be thought of as an outgrowth of clinical supervision in the mental health fields, both of which have been influenced over time by shifts in thinking and advances in the process of psychotherapy. Initial forms of clinical supervision were quite structured, controlled by the supervisor, and oriented toward teaching or guiding practice with little to no attention to the supervisee's experience or personal history (Tomlin, Weatherston, & Pavkov, 2014). As theory and practice in treatment evolved, so too did clinical supervision practices. Increasingly, it was seen as important for therapists to attend to their own experiences, sense of self, and professional development (Dewald, 1987; Kohut, 1971; Wallerstein, 1981). Examination of self and subsequent increases in self-awareness became understood as important parts of professional growth needed to improve practice (Ekstein & Wallerstein, 1972). In many cases, especially in self-psychology approaches, this was understood to happen most effectively through a supervision relationship (Sarnat, 1992; Yerushalmi, 1994).

As clinical supervision became more common and more studied, practitioners noted similar processes between treatment and supervision. For example, an early reference to what became known as the parallel process in supervision noted that activity in the patient-therapist and therapist-supervisor relationships had value and should be examined (Searles, 1955). By the 1980s, the parallel process was thought to be one of the most important phenomena that occurs in supervision and, as such, critical to understanding its functions (Loganbill, Hardy, & Delworth, 1982).

The changes in practices in treatment and expectations for clinical supervision occurred contemporaneously with the development of infant mental health as a field of practice and a research area. The Bowlby and Ainsworth attachment theories and research paradigms developed in the 1960s and 1970s set the stage for Fraiberg's (1980) articulation of infant mental health practice. Researchers recognized the importance of the parent's ability to attend to the experience of the young child, which would affect the child's current and future behavior and development; connected the parent's skills and deficits with their own early experiences; and developed methods to assess and to expand these capacities (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Sadler, Slade, & Mayes, 2006); these concepts were translated to practice in infant mental health work (Weatherston, 2000, 2001). Simultaneously in the education literature others, including Schön (1983), Bowman (1989), and Bertacchi & Coplon (1989), wrote about self-reflection as an essential component of work with infants and families. The importance of reflection on action, in action, and for action

(Killion & Todnem, 1991; Schön, 1983) became central components of reflective practice in the education field.

A Brief Overview of Reflective Supervision and Infant Mental Health

In 1990, ZERO TO THREE created an advisory board specifically to identify elements of training that were important across all the disciplines working with infants, toddlers, and families (Shahmoon-Shanook, 2009). This multidisciplinary advisory board recognized that clinical-like supervision allowed professionals to manage the interpersonal situations common in their work and to learn how to use their personal impact in a positive way (Fenichel, Eggbeer, & the TASK Advisory Board, 1990; Shahmoon-Shanok, 2009). The collaborative and reflective approach to supervision described in the publications released by this advisory board was "virtually unheard of in the experience of the nonmental-health professionals" provoked some concern about the ability of nonmental health professionals to provide this type of supervision to others within (or outside of) their own discipline (Eggbeer, Mann, & Seibel, 2007, p. 6).

In response to this concern, ZERO TO THREE created another multidisciplinary task force to study supervision as a relationship for learning (Fenichel, 1992). This task force led to the publication of a sourcebook describing reflective supervision and identifying three core components (reflection, collaboration, and regularity; Feinchel, 1992).

Despite this wide recognition of the value of reflective supervision, there is relatively little empirical evidence about its effect on professionals and practice.

As the field of infant mental health developed, its model of supervision began to be referred to as reflective supervision and differentiated itself from clinical supervision (see box Reflective What?: An Abridged Dictionary of Reflective Terms for definitions of the many similar terms that are used when discussing reflective practice). For example, the literature on clinical supervision included concerns about issues related to status; the supervisor may be seen as having power and authority over the supervisee, especially when evaluation is part of the relationship (Doehrman, 1976). Over time, some shifts were seen, beginning in the 1990s (Sarnat, 1992; Yerushalmi, 1994). Current descriptions of reflective supervision address these concerns by asserting that reflective supervision is collaborative and emphasizing the need to avoid supervisor behaviors that signal hierarchical arrangements (Fenichel, 1992; Shahmoon-Shanok, 2009). A goal of reflective supervision is for the supervisee to increase her own skills through supported "wondering" about the experience of the self and of her clients within an environment that feels safe. Although mindfulness, reflection, and sharpening insight have ancient roots, these practices were not routinely applied to therapy and clinical supervision until the 1990s, whereas they have always been an explicit part of reflective supervision (Dunne, 1994; Watkins, 1995).

It is perhaps not surprising then that leaders in infant-family field began to promote the use of reflection in practice and to emphasize participation in reflective supervision as necessary for high-quality work. Today, it is fair to say that supervision is considered to be "at the core of practice for service-based professionals" (Beddoe, 2010, p. 210). Reflective supervision is now frequently cited as a means for practitioners across the whole gamut of infant-family work to learn to apply knowledge and increase skills, leading to better practice (Gilkerson & Kopel, 2005; Virmani & Ontai, 2010; Watson, Neilsen Gatti, Cox, Harrison, & Hennes, 2014). Furthermore, the practice of reflective supervision has been reported to reduce burnout and to lower staff turnover (Gilkerson & Kopel, 2005).

Despite this wide recognition of the value of reflective supervision, there is relatively little empirical evidence about its effect on professionals and practice. In 2009, at ZERO TO THREE's National Training Institute, a symposium devoted to brainstorming strategies for researching the impact of reflective supervision was hosted by Rebecca Shahmoon-Shanook and Walter Gilliam (Eggbeer, Shahmoon-Shanook, & Clark, 2010). The response was overwhelming as the standing room only crowd participated in an animated discussion on how to build an empirical base regarding reflective supervision. (See Eggbeer et al., 2010, for a full description of this session.) Some of the essential areas of inquiry identified in this 2009 session and in following publications included identifying the core processes of reflective supervision, examining the impact of reflective supervision on the supervisee and client, and ascertaining aspects of reflective supervision sessions that differentiate it from other types of supervision (Beddoe, 2012; Falender, 2014; Tomlin et al., 2014). The articles in this issue of *ZERO TO THREE* will discuss why research on reflective supervision is vital, examine some emerging research methods, and provide suggestions for next steps.

Why Research Reflective Supervision?

Evidence to support the value of reflective supervision is needed for many reasons. These include increasing needs to demonstrate effectiveness in order to:

- access funding to support reflective practice in early intervention programs,

- develop a competent workforce to provide reflective supervision, and

- provide data on the impact of reflective supervision that informs policy regarding infant and family work.

Funding

A new "culture of competence" (Roberts, Borden, Christiansen, & Lopez, 2005, p. 356) describes an emphasis on implementation science, which involves the measurement of accountability and quality improvement across an expanding array of human

Reflective What?: An Abridged Dictionary of Reflective Terms

Many similar terms are used when discussing reflective practice, such as reflective supervision, reflective capacity, reflective consultation, and reflective process. The terms clearly overlap; however, there are also important differences. This sidebar was created to help clarify some of the similarities and differences, especially as they pertain to this issue of ZERO TO THREE.

Reflective practice refers to a provider's ability to use reflection actively when working with clients (Brandt, 2014). This approach to the work happens when the practitioner goes beyond applying professional knowledge (Schön, 1987); instead, "the practitioner continually uses internal knowledge and external knowledge to examine and advance practice" (Brandt, 2014 p. 294). External knowledge is learned or acquired from the external environment (e.g., research-based, best practice standards, observations, feedback from others) and internal knowledge (also referred to as self-awareness) is process-based knowledge constructed from sources such as the provider's ideas, thoughts, awareness, experience, and insight. Reflective practice uses reflective process to enhance reflective capacity. Reflective practice activities include, but are not limited to: reflective supervision, consultation or facilitation, reflective journaling, and mindfulness exercises.

Reflective process occurs when the practitioner uses both internal and external knowledge to examine and advance practice (Brandt, 2014). It has been called "a process of thinking about what you think and what you do" (Heller, 2012). Reflective process happens when the provider integrates a set of ideas or sensibilities within a particular body of professional knowledge to guide how he does his work (Pawl, St. John, & Perkarsky, 1999). Reflective supervision (or other reflective activities such as journaling) support reflective process to enhance the provider's reflective capacity or functioning.

Reflective capacity is the ability to imagine, think, and plan; to generate new awareness; to construct new understandings; and to use this process to transform practice (Brandt, 2014). Heffron and Murch (2010) described reflective capacity as similar to parental reflective functioning (Slade, Sadler, & Mayes, 2005). They summarized reflective function as the "parent's capacity to think and respond in a reflective manner rather than with projections, distortions, or premature conclusions" (p. 10). It is this reflective ability that reflective supervision (or other reflective activities) work to enhance, which in turn is believed to improve the supervisee's clinical work and outcomes for the individuals receiving services.

Reflective supervision has been described as a relationship for learning in which both the client's and the provider/supervisee's needs are being considered so that the effectiveness of the intervention is optimized. Reflective supervision "is where strengths are emphasized and vulnerabilities partnered" (Costa, 1999). It is a partnership in which the supervisee never feels alone; is not overwhelmed by fear or uncertainty; and feels safe to express fears, uncertainties, thoughts, feelings, and reactions. Through reflective supervision, the supervisee learns more about herself, the client, co-workers/colleagues, and the work (Costa, 2006; Shahmoon-Shanok, 2009). There is consensus among practitioners and researchers that regularity, collaboration, and use of reflection around the work and the professionals in the work are needed for supervision to be considered reflective (Fenichel, 1992). Reflective supervision can also be viewed from a parallel process lens in which the supervision relationship provides a model for relationship work and reflective practice that occurs between provider and client (Weatherston & Barron, 2009).

Brandt (2014) described reflective supervision and reflective facilitation as being synonymous, and some practitioners would also include reflective consultation within that group. The only difference between the three is that some reflective supervisor practitioners may serve a dual role as both an administrator and a reflective supervisor, whereas this would not typically be the case for a reflective consultant or facilitator, who are typically professionals from outside of the organization that is receiving reflective consultation or facilitation (see Bertacchi & Gilkerson, 2009, and Heffron & Murch, 2010) for discussions of a supervisor serving dual roles as both a mentor and monitor).

Bertacchi, J., & Gilkerson, L. (2009). Can administrative and reflective supervision be combined? In S. S. Heller and L. Gilkerson (Eds.), *A practical guide to reflective supervision*, (pp. 121–134). Washington, DC: ZERO TO THREE.

Brandt, K. (2014). Transforming clinical practice through reflection work. In K. Brandt, B. D. Perry, S. Seligman, & E. Tronick (Eds.), *Infant and early childhood mental health: Core concepts and clinical practice* (pp. 293–308). Washington, DC: American Psychiatric Publishing.

Costa, G. (1999). *Practices in reflective supervision.* Unpublished handout, Youth Consultation Services Institute for Infant and Preschool Mental Health.

Costa, G. (2006). Mental health principles, practices, strategies, and dynamics pertinent to early intervention practitioners. In G.M. Foley & J.D. Hochan (Eds.), *Mental health in early intervention: Achieving unity in principles and practice* (pp. 113–138), Baltimore, MD: Brookes.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook.* Arlington, VA: ZERO TO THREE.

Heffron, M. C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs.* Washington, DC: ZERO TO THREE.

Heller, S. S. (2012) Reflective supervision. In S. J. Summers & R. Chazan-Cohen (Eds.), *Understanding early childhood mental health: A practical guide for professionals* (pp. 199–216). Baltimore, MD: Brookes.

Pawl, J., St. John, M., & Pekarsky, J. H. (1999). Training mental health and other professionals in infant mental health: Conversations with trainees. In J. Osofsky & H. Fitzgerald (Eds.), *WAIMH handbook in infant mental health: Vol 2. Early intervention evaluation and assessment* (pp. 379–402), New York, NY: Wiley.

Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions.* San Francisco, CA: Jossey-Bass.

Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision*, (pp. 7–20). Washington, DC: ZERO TO THREE.

Slade, A., Sadler, L., & Mayes, L. C. (2005). Maternal reflective functioning: Enhancing parental reflective functioning in a nursing/mental health home visiting program. In L. Berlin, Y. Ziv, L. Amaya-Jackson, & M. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 152–177). New York, NY: Guilford.

Weatherston, D., & Barron, C. (2009). What does a reflective supervisory relationship look like? In S. S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision*, (pp. 63–72). Washington, DC: ZERO TO THREE.

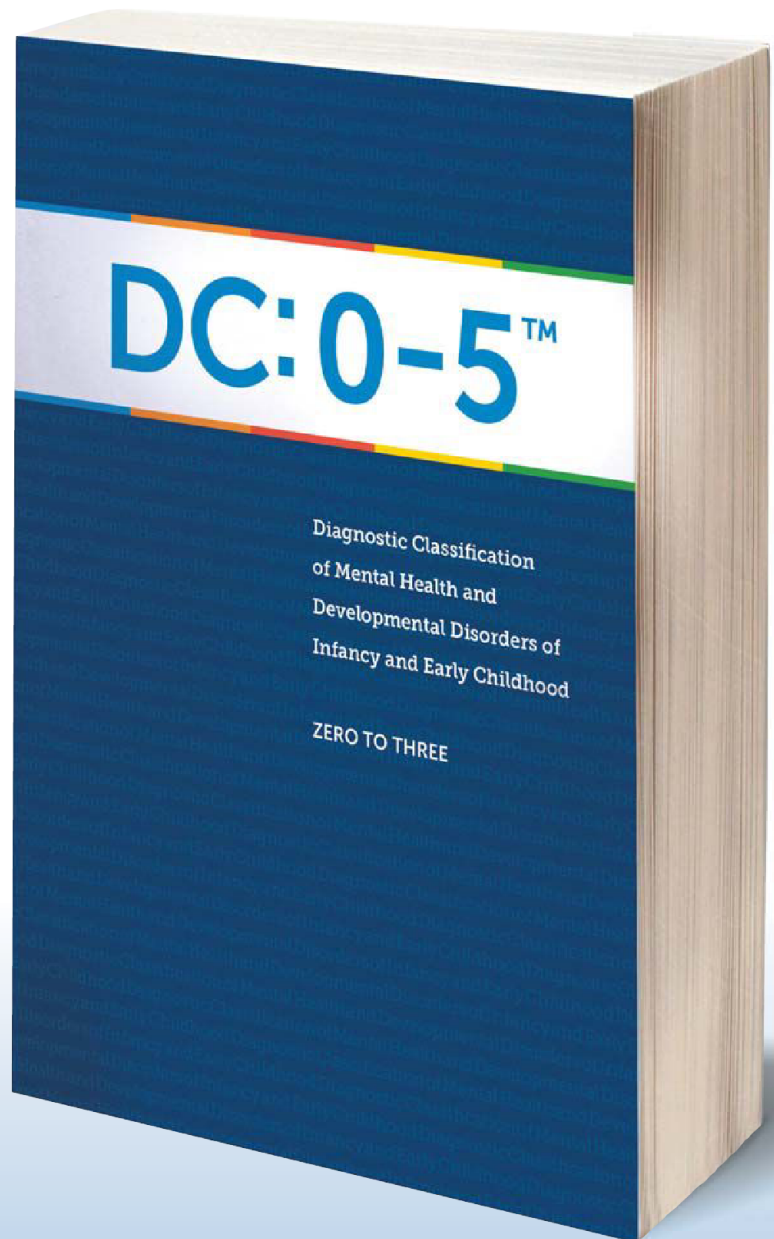service activities (Falender, 2014). Increasingly, funders and policymakers are expecting better evaluations of interventions and programs in order to demonstrate their effectiveness. For example, the emphasis on evidence-based or scientifically supported methods of treatment has now extended to home visiting approaches and preschool programming (Paulsell, Avellar, Sama Martin, Del Grosso, 2011; Yoshikawa et al., 2013). A demonstration of effectiveness by clearly connecting the intervention to meaningful outcomes is necessary for sustained funding of programs that rely on grant support or public funding. With regard to interventions, third-party payers may require the use of approaches that can be shown to be effective in fields including medicine, mental health, and education. Reflective supervision, as an approach that supports intervention effectiveness, must similarly be shown to have clear benefits in order to be supported as a fundable practice.

Workforce Capacity

Worker competence is critical to the effectiveness of any treatment approach. Most highly skilled workers require some combination of didactic and applied training, and this second piece must occur over time with support that may include reflective supervision, consultation, or mentoring (Knowles, 1980). Competencies in core knowledge and skills are available in most fields, including infant mental health (Michigan Association for Infant Mental Health, n.d., 2016). Measurement of skill attainment occurs through testing, assessment of client satisfaction, ratings from supervisors, and self-rating. However, there is little in the way of similar competencies or measurement methods that documents how to provide reflective supervision, how reflective supervision results in transfer of knowledge to practice (skill building), and how this change in practice affects family and child outcomes. Without these pieces of data, it is not only difficult to measure the effects of reflective supervision on supervisee development and family outcomes, but it is also difficult to develop programs to train new reflective supervisors. Furthermore, this lack of access to appropriate reflective supervisors will delay progress in training the overall workforce of infant and family providers, subsequently reducing access to services for families in need.

Policy

The previously mentioned reasons for obtaining empirical support for reflective supervision—accessing funding and expanding a competent workforce—point to a third reason: informing public policy. Interest in early childhood has increased in recent years, pushed by advocates armed with science that shows that these years form a foundation for later life. Broadly, this evidence includes increased awareness that young children have mental health needs, that adverse experiences can affect young children, that the effects of childhood experiences can linger, that relationships have the potential to help and harm, and that positive development is related to all of these factors (Fitzgerald, Weatherston, & Mann, 2011). Programs that span efforts to support young children and families from promotion to intervention have spread, supported by public dollars, and require a competent workforce for implementation. Clinicians, scientists, and program developers have argued that the work requires access to high-quality reflective supervision. Therefore, these programs are seeking ways to demonstrate to policymakers that reflective supervision is a necessary and effective program component. Measurement methods are needed, and these methods must be usable on a wide scale in practice settings and yield meaningful data.

Beyond grant-funded programs is the question of specialization and enhanced professionalization of the infant-family field, including mental health professionals, home visitors, child protection workers, early intervention therapists, and child care providers. In established human service fields, there are requirements that typically include documentation that one has obtained the training and experience needed for competent practice that lead to license or certification. This requirement protects the public by ensuring a well-trained workforce and by allowing for mechanisms for complaints and censure when needed. Requiring a credential that demonstrates specialization in early childhood would enhance the professional status of many of these workers while signaling their competence to consumers. For example, credentialing for the population of workers who serve very young children and families includes the Infant Mental Health Competencies and Endorsement, created by the Michigan Association for Infant Mental Health and currently administered by the Alliance for the Advancement of Infant Mental Health (Michigan Association for Infant Mental Health, 2016; Weatherston, Kaplan-Estrin, & Goldberg, 2009); the California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health Endorsement, administered by the California Center of Infant-Family Early Childhood Mental Health (California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup, 2012); and the Colorado Coaching Credential administered by the Colorado Coaching Consortium (Colorado Coaching Consortium, 2014). These credentials may require the holder to receive reflective supervision depending on the level of certification being sought. If members of the infant-family field are to continue to push for specialized training that leads to these types of credentials, they will need to provide evidence to state and federal decision makers that reflective supervision is an integral and effective part of professional training for the infant-family field.

> *Funders and policymakers are expecting better evaluations of interventions and programs in order to demonstrate their effectiveness.*

Overview of Current Measurement Approaches

Early efforts to understand the reflective process included efforts to determine the value that early childhood providers place on the use of reflection and their self-report of using these skills (Tomlin, Sturm, & Koch, 2009). There have also been efforts to obtain a consensus regarding the components of reflective supervision using survey approaches (Tomlin et al., 2014) with similar efforts for clinical supervision (Pack, 2009). These descriptions have provided a basis for identifying factors such as characteristics of supervisors and supervisees, behaviors of supervisors and supervisees, characteristics of the environment, and interactions between supervisors and supervisees (Tomlin et al., 2014; Weatherston, n.d.). Following these studies, research has turned to the development of tools and procedures to assess reflective supervision and consultation, along with similar efforts to evaluate clinical supervision, particularly in the fields of psychology and social work that have pertinence for this discussion (Beddoe, 2012).

Types of Measurement

Most existing measurement methods can be divided into three types: formal rating scales, direct observations (live, recorded), and reports of internal changes, usually in the form of written or spoken narratives.

Rating Scales

A number of published and unpublished pencil and paper rating scales have been created to evaluate aspects of clinical and reflective supervision. These include measures completed by the supervisor, the supervisee, or both. The measurement focus of these tools varies, but typically involves the use of Likert Scales to rate actions or behaviors that are part of reflective supervision interactions. Often, they primarily function as scales, assessing satisfaction with factors such as the supervision, the supervisor, or the supervisory alliance, or ratings of one's own performance as a clinician or practitioner (Falender, 2014).

The Reflective Supervision Rating Scale (RSRS; Ash, 2010) is completed by the supervisee and rates the degree to which the supervisor performs activities that are understood to be part of a reflective supervision interaction. This tool includes 17 items that are sorted into four factors: reflective process and skills, mentoring, supervision structure, and mentalization. More details about the development and use of the RSRS can be found in this issue (Gallen, Ash, Smith, Franco, & Willford, p. 30).

The Reflective Supervision Self-Efficacy Scale (Shea, Goldberg, & Weatherston, 2012) is an example of a self-rating tool that is completed independently by the supervisor and the supervisee. Each scale includes 17 items, and most of the items are not duplicated across scales, though they are related. In contrast to the RSRS, which asks the rater to report how often a behavior, action, or outcome has occurred, this scale instead asks raters to state their level of confidence that they can demonstrate a specific behavior or skill.

Photo: © Stephen Bobb

Requiring a credential that demonstrates specialization in early childhood would enhance the professional status of many of these workers while signaling their competence to consumers.

Observational Approaches

Pencil and paper measures have much utility, including simplicity and ease of use and scoring; however, some of the more complex aspects of reflective supervision are difficult to capture through a rating scale. There are also concerns that rating scales rely on memory and can be vulnerable to halo effects. Another issue is that supervisors may have had little training in evaluating supervisees, potentially compromising the utility of their reports (Falender, 2014). In recognition of the need to address these concerns and of the dynamic nature of the reflective supervision relationship and sessions, researchers have begun to examine the use of audio and video recordings of supervision sessions (Hill, Crowe, & Gonsalvez, 2016; Watson et al., 2014)

In a recent study of clinical supervision, researchers prompted reflective dialogue between supervisors and supervisees by asking each to independently select a segment of a session, to respond in writing to questions about the session, and then to review the selected video segments and written responses together (Hill et al., 2016). The authors suggested that the method can increase reflection in both supervisor and supervisee, bring to light material that might not otherwise be discussed, provide an opportunity for supervisors to model openness to feedback and other reflective practice skills, and result in changes in supervisory practices.

Review of reflective supervision sessions performed by infant mental health specialists is the focus of the Reflective Interactive Observation Scale (RIOS), currently under development by Christopher Watson and colleagues in Minnesota with support and input from members of the Michigan Association for Infant Mental Health-led Alliance for the Advancement of Infant Mental Health (Watson et al., 2014). The RIOS provides a framework for detailed observation and coding of interactions between a supervisor and supervisee engaged in reflective supervision.

The tool recognizes five Essential Elements of reflective supervision and allows an observer to identify their occurrence at different levels. More details about the development and details about the RIOS can be found in this issue (Watson, Harrison, Hennes, & Harris, p. 14). Mary Claire Heffron and colleagues in California have created a process checklist to code video tapes of reflective supervision sessions. The checklist consists of reflective supervisory competencies and can be used to support the development of reflective supervisors. Their article in this issue will describe this checklist and its development in more detail (Finello, Heffron, & Stroud, p. 39).

Narrative or Internal Approaches

A few authors have developed systems for examining samples of internal narratives, with the idea that changes in these narratives could be identified following participation in reflective supervision. This concept is potentially quite valuable, because much of reflective practice involves efforts to examine one's own inner dialogue (Senediak, 2014). Examination of narratives brings some of the advantages of rating scales, including being relatively inexpensive. Use of journal writing or a reflective diary is a simple method that is often implemented in clinical training. The journal can be used to monitor clinical progress independently or in review with a supervisor (Brandt, 2014; Senediak & Bowden, 2007). Reviewing changes in thinking that appear throughout the journal may be attributed to participation in reflective supervision.

Tomlin, Hines, & Sturm (in press) conducted a pilot study of nonmental health providers' responses to standardized vignettes about common challenging occurrences in home visiting. Participants were asked to respond to a series of questions about what they might say or do after witnessing the event. Follow-up questions asked participants to share what they might hope to accomplish with their interventions and to reflect on their own internal responses. Responses suggested that even though participants demonstrated some complex thinking about relationships, there was relatively little reflective processing. The authors suggested that this method could be used as a before and after assessment to identify changes in responses that reflect changes in thinking across time in a sample of participants who receive a reflective supervision experience.

The most formal and well-developed approach for examining reflective processes of practitioners through narratives is the Provider Reflective Process Assessment Scales, a measure created to assess changes in the reflective process of early childhood intervention providers after participating in reflective supervision. This measure involves participants responding to a small set of reflective prompts regarding a recent challenging case. The participants' responses are then coded on six scales each with two to three subscales and five-point anchored scales. More details about the development and use of this

scale can be found in this issue (Heller & Ash, p. 22). Gilkerson and Imberger (this issue, p. 46) describe infusing the FAN as a tool of reflective practice into a home visiting program in New Mexico. An outcome of this adaptation was change in the reflective capacity of staff and supervisors. The qualities identified in this qualitative research are very similar to the scales described in Heller and Ash (this issue, p.22).

Future Directions

As service fields continue to require an evidence base for their practice, proponents of reflective supervision must keep pace. However, many questions remain to be resolved. Several recent articles laid out the case for stepping up efforts to meaningfully evaluate clinical supervision, offered useful recommendations that apply to the need to develop measurement for reflective supervision, and pointed to questions that remain to be answered (Falender, 2014; Milne, 2014).

Falender stated that clinical supervision skills must be seen as a "distinct professional competency" (2014, p. 143). Given that reflective supervision is required for some programs, in many regards, this shift has already occurred in the infant-family field. However, this change has occurred ahead of achieving an agreement regarding what reflective supervision is, understanding what makes it work, and delineating specific competencies. This type of information is needed both for creating a curriculum to train supervisors and for developing evaluation methods and measures that will allow professionals to document that appropriate supervision is occurring.

Worker competence is critical to the effectiveness of any treatment approach.

A second issue in the evaluation of clinical supervision that is shared by reflective supervision is the determination of expected outcomes (Milne, 2014). In mental health fields, the "acid test" for efficacy is typically improved client outcomes (Ellis & Ladany, 1997, p. 485). However, relatively little data is available to demonstrate direct links between positive client outcomes and the receipt of clinical or reflective supervision (Hill et al., 2016). Infant mental health has a strong theoretical basis for the stance that receipt of reflective supervision will result in better practice and therefore better outcomes for young children and families. This stance includes data from attachment research, for example. However, direct evidence that the receipt of reflective supervision influences practice and that this change in practice results in better child and family outcomes is not available. Better, but still imperfect, data exists regarding the effects of supervision on the supervisee (Falender, 2014). There is at least some support for a range of outcomes of positive supervisory relationships including higher job satisfaction, less turnover, less burnout, increased comfort with disclosure, and less anxiety (Hill et al., 2016; Jones Harden, 2010; McAllister & Thomas, 2007; Watson & Neilsen Gatti, 2012).

 A third issue that research should eventually address can be thought of as fidelity (Milne, 2014). Once a consensus is

achieved regarding what constitutes reflective supervision, and tools that measure the process are widely available, then it will become more possible to develop protocols for training and rating supervisors. The work of both Watson (Watson et al., this issue, p. 14) & Heffron (Finello et al., this issue, p. 39) will be essential to allowing the field to develop fidelity measures.

This special issue provides a snapshot of the current state of measurement of reflective supervision within the infant-family field. Much has been accomplished, and much remains to be done. Some examples of future work include examining different forms of reflective supervision, such as groups or supervision conducted by distance means. It would be interesting to determine whether reflective supervision is more effective than other methods that address worker mindfulness or insightfulness in changing practice. Finally, documentation of the links between changes in practice of the provider to family/child outcomes is needed.

Angela M. Tomlin, PhD, is a clinical psychologist and associate professor at the Indiana University School of Medicine (IUSM). At IUSM, she directs the section of Child Development and Riley Child Development Center, Indiana's Leadership Education in Neurodevelopmental and Related Disabilities interdisciplinary training program. Dr. Tomlin provides clinical services to families with children with neurodevelopmental disabilities, supervises graduate trainees, provides reflective consultation in the community, and is a frequent presenter on topics including autism, behavior management, and infant mental health. She is the author or co-author of 20 publications and, with Stephan Viehweg, authored *Tackling the Tough Stuff: A Home Visitor's Guide to Supporting Families at Risk* in 2016.

Sherryl Scott Heller, PhD, is currently an associate professor in the Department of Psychiatry and Behavioral Medicine at Tulane University School of Medicine. Dr. Heller directs the Fussy Baby Network New Orleans and Gulf Coast Program and serves as a senior team member on Louisiana's Statewide Early Childhood Infant Mental Health Consultation to Child Care program (TIKES). In 2009, Dr. Heller co-edited a book with Dr. Linda Gilkerson, of the Erikson Institute in Chicago, on providing reflective supervision to professionals in the field of early childhood intervention. In October 2011, Dr. Heller was selected to be a fellow in ZERO TO THREE's Leadership Development Institute where her project focused on developing a measure to examine the impact of reflective supervision.

References

Ash, (2010). *Reflective Supervision Rating Scale*. Boulder, CO: Mental Health Partners.

Beddoe, L. (2010). Surveillance or reflection: Professional supervision in "the risk society". *British Journal of Social Work, 40*, 1279–1296.

Beddoe, L. (2012). External supervision in social work: Power, space, risk, and the search for safety. *Australian Social Work, 65*(2), 197–213.

Bertacchi, J., & Coplon, J. (1989). The professional use of self in prevention. *ZERO TO THREE, 9*(4), 1–7.

Bowman, B. (1989). Self-reflection as an element of professionalism. *Teachers College Record, 90*(3), 444–451.

Brandt, K. (2014). Transforming clinical practice through reflection work. In K. Brandt, B. D. Perry, S. Seligman, & E. Tronick (Eds.), *Infant and early childhood mental health: Core concepts and clinical practice* (pp. 293–308). Washington, DC: American Psychiatric Publishing.

California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup. (2012). *California training guidelines and personnel competencies for infant-family and early childhood mental health, revised.* Sacramento: California Center for Infant-Family and Early Childhood Mental Health.

Colorado Coaching Consortium. (2014). *Colorado competencies for early childhood coaches.* Retrieved from http://cocoaches.net/uploads/Colorado_Competencies_for_Early_Childhood_Coaches.pdf

Dewald, P. (1987). *Learning process in psychoanalytic supervision: Complexities and challenges.* Madison, CT: International Universities Press.

Doehrman, M. J. (1976). Parallel process in supervision and psychotherapy. *Bulletin of the Menninger Clinic, 40*, 9–104.

Dunne, R. V. (1994). The acquisition of professional activity in teaching. In G. Harvard & P. Hodkinson (Eds.), *Action and reflection in teacher education* (pp. 105–124). Norwood, NJ: Ablex.

Eggbeer, L., Mann, T. L., & Seibel, N. L. (2007). Reflective supervision: Past, present, and future. *ZERO TO THREE, 28*(2), 5–9.

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *ZERO TO THREE, 31*(2), 39–45.

Ekstein, R., & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). New York, NY: International Universities Press.

Ellis, M., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins (Ed.), *The handbook of psychotherapy supervision* (pp. 3–10). Chichester, UK: Wiley.

Falender, C. A. (2014). Supervision outcomes: Beginning a journey beyond the emperor's new clothes. *Training and Education in Professional Psychology, 8*(3), 143–148.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook*. Arlington, VA: ZERO TO THREE.

Fenichel, E., & Eggbeer, L. (1991). *Preparing practitioners to serve infants, toddlers, and families.* Arlington, VA: ZERO TO THREE

Fenichel, E. S., Eggbeer, L., & the TASK Advisory Board. (1990). *Preparing practitioners to work with infants, toddlers and their families: Issues and recommendations (four related documents for parents, the professions, policymakers and educators and trainers).* Arlington, VA: National Center for Clinical Infant Programs.

Finello, K. M., Heffron, M. C., & Stroud, B. (2016). Measuring process elements in reflective supervision: An instrument in the making. *ZERO TO THREE, 37*(2), 39–45.

Fitzgerald, H. E., Weatherston, D., & Mann, T. L. (2011). Infant mental health: An interdisciplinary framework for early social and emotional development. *Current Problems in Pediatric Adolescent Health Care, 41*, 178–182.

Fonagy, P., Steele, H., Moran, G., Steele, M., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal, 13*, 200–217.
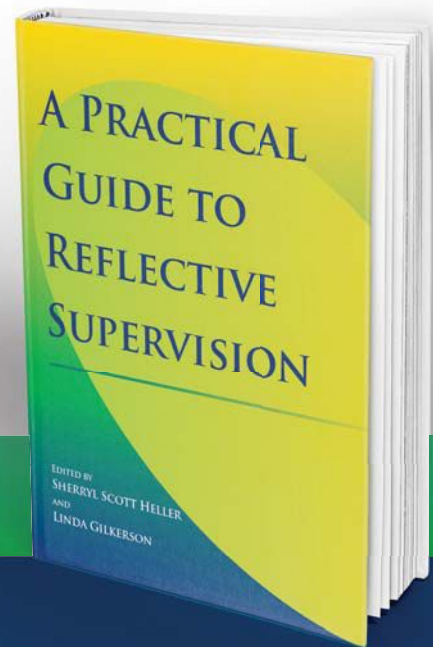
Fraiberg, S. (1980). *Clinical studies in infant mental health: The first year of life.* New York, NY: Basic Books.

Gallen, R. T., Ash J., Smith, C., Franco, A., & Willford, J. A. (2016). How do I know that my supervision is reflective?: Identifying factors and validity of the Reflective Supervision Rating Scale. *ZERO TO THREE, 37*(2), 30–37.

Gilkerson, L., & Imberger, J. (2016). Strengthening reflective capacity in skilled home visitors. *ZERO TO THREE, 37*(2), 46–53.

Gilkerson, L., & Kopel, C. C. (2005). Relationship-based systems change Illinois' model for promoting social-emotional development in Part C early intervention. *Infants & Young Children, 18*(4), 349–365.

Heller, S. S., & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *ZERO TO THREE, 37*(2), 22–28.

Hill, R. M. H., Crowe, T. P., & Gonsalvez, C. J. (2016). Reflective dialogue in clinical supervision: A pilot study involving collaborative review of supervision videos. *Psychotherapy Research, 26*(3), 263–278.

Jones Harden, B. (2010). Home visitation with psychologically vulnerable families: Developments in the profession and in the professional. *ZERO TO THREE, 30*(6), 44–51.

Killion, J. P., & Todnem, G. R. (1991). A process for personal theory building. *Educational Leadership, 48*(6), 14–16.

Knowles, M. S. (1980). *The modern practice of adult education. Andragogy versus pedagogy.* Englewood Cliffs, NJ: Prentice Hall/Cambridge.

Kohut, H. (1971). *The analysis of the self.* New York, NY: International Universities Press.

Loganbill, C. R., Hardy, E. V., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist, 10*(1), 3–42.

McAllister, C. L., & Thomas, T. (2007). Infant mental health and family support: Contributions of early head start to an integrated model for community-based early childhood programs. *Infant Mental Health Journal, 28*(2), 192–215.

Michigan Association for Infant Mental Health. (n.d.). *Best practice guidelines for reflective supervision/consultation.* Retrieved from http://mi-aimh.org/wp-content/uploads/2016/03/BPGRSC-20160428-NP-FE.pdf

Michigan Association for Infant Mental Health. (2016). *Competency guidelines: Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®.* (4th ed.). Southgate: Author.

Milne, D. (2014). Beyond the "acid test": A conceptual review and reformulation of outcome evaluation in clinical supervision. *American Journal of Psychotherapy, 68*(2), 213–229.

Pack, M. (2009). Clinical supervision: An interdisciplinary review of literature with implications for reflective practice in social work. *Reflective Practice, 10*(5), 657–668.

Paulsell, D., Avellar, S., Sama Martin, E., & Del Grosso, P. (2011). *Home Visiting Evidence of Effectiveness Review: Executive summary.* Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Roberts, M. C., Borden, K. A., Christiansen, M. D., & Lopez, S. J. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. *Professional Psychology: Research and Practice, 36*, 355–361.

Sadler, L. S., Slade, A., & Mayes, L. C. (2006). Minding the baby: A mentalization-based parenting program. In J. G. Allen & P. Fonagy (Eds.), *Handook of mentalization-based treatment* (pp. 271–288). New York, NY: Wiley.

Sarnat, J. E. (1992). Supervision in relationship: Resolving the teach-treat controversy in psychoanalytic supervision. *Psychoanalytic Psychology, 9*(3), 387–403.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action.* New York, NY: Basic Books.

Searles, H. F. (1955). The informational value of supervisor's emotional experiences. *Psychiatry, 18*, 135–146.

Senediak, C. (2014). Integrating reflective practice in family therapy supervision. *Family Therapy, 34*, 338–351.

Senediak, C., & Bowden, M. (2007). Clinical supervision in advanced training in child and adolescent psychiatry: A reflective practice model. *Australian Psychiatry, 15*, 276–280.

Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. S. Heller and L. Gilkerson (Eds.), *A practical guide to reflective supervision*, (pp. 7–20). Washington, DC: ZERO TO THREE.

Shea, S. Goldberg, S. & Weatherston, D. (2012). *Reflective Supervision Self-Efficacy Scale.* Unpublished manuscript.

Tomlin, A. M., Hines, E., & Sturm, L. (in press). Reflection in home visiting: The what, the why and a beginning step toward how. *Infant Mental Health Journal.*

Tomlin, A., Sturm, L., & Koch, S. (2009). Observe, listen, wonder, and respond: A preliminary exploration of reflective function skills in early care providers. *Infant Mental Health Journal, 30*(6), 634–647.

Tomlin, A., Weatherston, D., & Pavkov, T. (2014). Critical components of reflective supervision Responses from expert supervisors from the field. *Infant Mental Health Journal, 35*(1), 70–80.

Virmani, E. A., & Ontai, L. L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal, 31*(1), 16–32.

Wallerstein, R. (1981). *Becoming a psychoanalyst: A study of psychoanalytic supervision.* New York, NY: International Universities Press.

Watkins, C. E. (1995). Psychotherapy supervisor and supervisee: Developmental models and research nine years later. *Clinical Psychology Review, 15*, 647–680.

Watson, C., Harrison, M., Hennes, J. E., & Harris, M. (2016). Revealing "the space between": Creating an obervation scale to understand infant mental health reflective supervision. *ZERO TO THREE, 37*(2), 14–21.

Watson, C., & Neilsen Gatti, S. (2012). Professional development through reflective supervision in early intervention. *Infants & Young Children, 25*(2), 109–121.

Watson, C., Neilsen Gatti, S., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. *Advances in Early Childhood and Day Care, 18*(1), 1–26.

Weatherston, D. J. (2000). The infant mental health specialist. *ZERO TO THREE 21*(3), 3–10.

Weatherston, D. J. (2001). Infant mental health: A review of the relevant literature. *Psychoanalytic Social Work, 8*(1), 39–69.

Weatherston, D. J. (n.d.). Reflective supervision wheel. Retrieved from http://mi-aimh.org/reflective-supervision-wheel

Weatherston, D., Kaplan-Estrin, M., & Goldberg, S. (2009). Strengthening and recognizing knowledge, skills, and reflective practice: The Michigan Association for Infant Mental Health Competency Guidelines® and Endorsement® process. *Infant Mental Health Journal, 30*(6), 648–663.

Yoshikawa, H., Weiland, C., Brooks-Gunn, J., Burchinal, M. R., Espinosa, L. M., Gormley, W. T., ...Zaslow, M. J. (2013). Investing in our future: The evidence base on preschool education. *Society for Research in Child Development.* Retrieved from http://fcd-us.org/whats-new/evidence-base-preschool

Yerushalmi, H. (1994). A call for change in emphasis in psychoanalytic supervision. *Psychotherapy.*

Revealing "The Space Between"
Creating an Observation Scale to Understand Infant Mental Health Reflective Supervision

Christopher L. Watson
Mary E. Harrison
University of Minnesota

Jill E. Hennes
Minneapolis/St. Paul, Minnesota

Maren M. Harris
Aequus Consulting
Eagan, Minnesota

Abstract
The Reflective Interaction Observation Scale (RIOS) describes and operationalizes the nature of the interactions between a supervisor and supervisee(s) during reflective supervision. Developed in collaboration among researchers and clinicians from the University of Minnesota, the Minnesota Association for Infant and Early Childhood Mental Health, and the Alliance for the Advancement of Infant Mental Health, the RIOS is organized around five core Essential Elements that constitute the content of the discussion conducted between the supervisor and supervisee during a reflective session: Understanding the Family Story, Holding the Baby in Mind, Professional Use of Self, Parallel Process, and Reflective Alliance. Interactions between supervisor and supervisee(s) are identified as Collaborative Tasks: Describing, Responding, Exploring, Linking, and Integrating. The RIOS coding process captures the nature of interactions during a supervision session and can demonstrate the progression of the relationship over time.

It's not coaching or technical assistance, and it isn't mental health case consultation or therapy. So what is infant mental health reflective supervision or reflective consultation for professionals working with infants, young children, and families? In spite of its widening circle of participants in multiple infant and early childhood disciplines and programs, there is no single, commonly held definition of reflective supervision. It is not a manualized process, and, in fact, reflective supervision is intentionally not constrained by a strict protocol. Although it has been eloquently described (Heffron & Murch, 2010; Heller & Gilkerson, 2009; Schafer, 2007; Shahmoon-Shanok, 2009; Weatherston & Barron, 2009; Weatherston, Weigand, & Weigand, 2010), there is no empirically established definition. As a result, it has appeared to be somewhat mysterious and may even appear arbitrary to those who are unfamiliar with the purpose and goals of the practice. In addition, as programs and funding organizations focus more keenly on evidence-based practice, there is continual pressure to confirm the efficacy of

work with children and families. Currently there is no empirical evidence to substantiate the effectiveness of reflective supervision (Korfmacher, 2014).

This particular form of supervision is based in developmental and attachment theories and is informed by the rapidly growing body of research exploring interpersonal neuroscience (Schore, 1994; Siegel, 2012; Siegel & Shahmoon-Shanok, 2010). Many professionals in the field believe that reflective supervision serves a dual purpose. The first is to assist professionals in understanding the many facets of their work with families, in particular the varied relational dynamics involved in meeting the needs of babies, young children, and their families and the professionals' responses to those dynamics (Schafer, 2007). As a result of having a deeper understanding of their work, professionals can more effectively engage families and implement home visiting models, developmental interventions, or child care curricula. The second purpose is to support those

professionals when they struggle with the many challenges in their work, which can include families living in poverty and/or unsafe communities, parents with mental health issues, or other challenging circumstances (Lipsky, 2009). In the face of emotionally evocative work performed in sometimes chaotic settings, professionals can struggle to maintain focus and equilibrium (Lane, 2011). Reflective supervision addresses the impact on the professionals of these contextual factors so that she can better focus on her particular role with families.

How does reflective supervision achieve these two goals? Since 2010, members of the research committee of the Alliance for the Advancement of Infant Mental Health (formerly called the League of States), have been engaged in a collaborative project to create a measurement tool, the Reflective Interaction Observation Scale (RIOS), to answer this question. The tool defines and operationalizes the process of reflective supervision by identifying and demonstrating the unique components which differentiate it from other forms of relationship-based professional development. The RIOS assesses the nature of the interactions between the supervisor and supervisee in a given time period using digitally recorded reflective sessions. The focus is not specifically on characteristics or behaviors of the supervisor or supervisee individually, but rather on how the dyad works together to attend to specific aspects of the work. We refer to this as "the space between the two." It is not about judging either participant but on understanding what is occurring in their work together.

There are a number of efforts now under way to address the lack of consensus on a definition of reflective supervision, identify its "active ingredients," and clearly articulate the process that occurs during this complex ongoing professional development relationship (Tomlin, Weatherston, & Pavkov, 2014; see, Gallen, Ash, Smith, Franco, & Willford, this issue, p. 30; Heller & Ash, this issue, p. 22; Shea & Goldberg, this issue, p. 54).

Tool Development

From the start, our research committee focused on developing a tool to make direct observations of the supervisory relationship. We envisioned developing an observational measure to make reflective supervision "testable" (For an in-depth discussion see Watson, Gatti, Cox, Harrison, & Hennes, 2014). At the 2010 annual Alliance Retreat, we collected initial data from five focus groups with approximately 10 participants each including people with years of reflective supervision experience, clinical infant mental health practice, and research expertise. Each group viewed a different videotaped recording of a reflective supervision session and identified concrete examples of the characteristics of the dyad that they believed defined reflective supervision. Subsequently, we conducted a thematic analysis of the data to begin to hone in on essential elements of the reflective supervision process, and, as a result of this phase, we determined there were 16 elements. We then verified the face and construct validity of these elements through an extensive literature review and via a survey sent to a broad national group of experts through a modified Delphi process, which is

In the process of working with a family, attention cycles back to the baby and the baby's experience and well-being.

a structured communication process that allows a group to establish consensus without meeting face-to-face (Linstone & Turoff, 1975). We developed a preliminary concept map from the survey data results. Other research occurring simultaneously (Tomlin et al., 2014) confirmed some elements. In addition, we held monthly calls with members of the research committee that detailed progress on the creation of the tool and sought input to support the research process.

As a result of this phase, we identified two dimensions that comprise the focus and process of reflective supervision. First, we identified five *Essential Elements* that constitute the content of the discussion between the supervisor and supervisee and the alliance established between them during a reflective session. These Essential Elements are: (1) Understanding the Family Story, (2) Holding the Baby in Mind, (3) Professional Use of Self, (4) Parallel Process, and (5) Reflective Alliance.

Second, we defined the critical relational and dialogue processes that occur during reflective supervision, which we called *Collaborative Tasks*. The tasks include: (1) Describing, (2) Responding, (3) Exploring, (4) Linking, and (5) Integrating. The Tasks track the developmental level of the supervision interaction. Together the Essential Elements and Collaborative Tasks form the framework of the RIOS.

The research group went on to identify observable "Indicators" for each of the Collaborative Tasks associated with the Essential Elements. The *Indicators* are defined as examples of "topics of

conversation, observable behaviors and ways of interacting" (Watson, Harrison, Hennes, & Harris, 2016).

The following section provides excerpts from the RIOS coding manual with detailed descriptions of the five Essential Elements and Collaborative Tasks as well as brief summaries of the content (Watson et al., 2016). See Figure 1 for a visual representation of the Essential Elements and Collaborative Tasks.

The Essential Elements of Reflective Supervision

The RIOS is organized around five core Essential Elements that constitute the content of the discussion conducted between the supervisor and supervisee during a reflective session. These components embody the distinctive nature of this form of reflective supervision grounded in infant mental health theory and practice.

Understanding the Family Story

"…'There is no such thing as a baby'—meaning that if you set out to describe a baby you will find you are describing a *baby and someone*. A baby cannot exist alone but is essentially part of a relationship" (Winnicott, 1964, p. 88, italics in original). Understanding the family story includes what is currently known about the baby's environment, focusing on the people who provide the relational context for the baby's social and emotional development. Topics of conversation might include what was seen and heard and other relevant facts and information. The attention of both reflective partners is on gaining an understanding, to the best of their ability, of the realities of the family's experience. Events, interactions, and details are considered from the perspective of family members and caregivers.

Holding the Baby in Mind

"Growing infants are held in their caregiver's symbolic world before they form one of their own" (Lichtenberg, 2003, pp. 498–499). Holding the baby in mind refers to a central tenant of reflective practice within infant mental health work: that in the process of working with a family, attention cycles back to the baby and the baby's experience and well-being, as well as the impact of the presence of this baby on the others in the story. The supervisor and supervisee may consider imagining how it might feel to be a baby in this particular family.

Professional Use of Self

"How you are is as important as what you do" (Pawl & St. John, 1998). Professional use of self has also been referred to as "the conscious use of self" (Heller & Gilkerson, 2009, p. 16). It involves the careful attention to one's subjective experiences, thoughts, beliefs, and emotional responses, which become important information and lend greater understanding and clarity to the work with families. The deliberate use of one's own reactions and perceptions in order to promote progress through a helping relationship depends upon a high degree of self-awareness. In reflection with a trusted supervisor, and through experience and expression of authentic responses to the work, this continually evolving awareness allows the supervisee to make conscious, moment-by-moment decisions about if, when, and how personal responses might be "used" to promote growth and change in a family. Concurrently, the supervisor engages in the process of self-awareness and use of self to help guide decisions regarding when and how to promote the continued learning of the supervisee.

Figure 1. Essential Elements and Collaborative Tasks

Parallel Process

"Do unto others as you would have others do unto others" (Pawl & St. John, 1998, p. 21). Parallel process "describes the interlocking network of relationships between supervisors, supervisees, families and children" (Heffron & Murch, 2010, p. 9). The supervisor and supervisee seek to understand how the lived experience of one relationship might be impacting the other relationships. Awareness of the dynamics of how one relational experience might echo another relationship allows the supervisee to understand the work from a new perspective.

Reflective Alliance

Reflective supervision is "a collaborative relationship for professional growth that improves program quality and practice by cherishing strengths and partnering around vulnerabilities to generate growth" (Shahmoon-Shanok, 2009, p. 8). An effective and supportive professional relationship is at the heart of reflective supervision. As a relationship-based approach to professional development, *how* the supervision happens and the quality of the relationship developing between supervisee and supervisor are of utmost importance. With some individuals, this relationship will require time to develop, but a successful alliance can also develop quickly between two individuals with no previous relationship. As conceptualized in the RIOS, the Reflective Alliance is the "vessel" which holds the work of the supervisor and supervisee.

The Reflective Alliance between supervisor and supervisee facilitates the supervisee's understanding, reflective capacity, and professional judgment. It is a mutually created relationship of trust and requires a commitment to maintaining ethical standards and the safety of the participants. The pair may either begin with, or come to know, a mutually understood purpose of their interaction. They come together to learn about, clarify, and refine both the supervisee's case and the work in general. Their focus is on forming a partnership to explore the experience of the supervisee and to ensure that the work is firmly grounded in infant mental health principles and theory.

An alliance for the purpose of reflection requires a respectful collaborative stance and process, an attention to emotional content and co-regulation, and an agreement to establish a working relationship that is safe. Both parties have responsibilities in the creation of this relationship. The supervisee takes responsibility for co-creating the agenda, sharing honestly and openly, including personal reactions, being willing to consider various perspectives, and generating possible solutions when appropriate. The supervisor has responsibility for creating a safe and predictable environment, attending to and holding the concerns of the supervisee, attempting to understand deeply the supervisee's experience, sharing in vulnerability and self-reflection, and considering new ways of thinking about a situation. An effective Reflective Alliance allows for joint exploration and learning with regard to expectations and assumptions of boundaries related to both the supervisee's work and also to the supervisee-supervisor relationship. Emotional reaction to the content of the work requires mindful attention. Together

The supervisor and supervisee seek to understand how the lived experience of one relationship might be impacting the other relationships.

the pair learns to fully experience the joys and the sorrows of the work, and maintains or regains a regulated state. As the pair interact, it becomes clear that there is a shared vision of their work: they come together in a relationship that engenders curiosity, creativity, and learning in order to co-create a clearer formulation of the work at hand. There is a sense that together they can pursue a line of inquiry even as they address difficult issues.

The Collaborative Tasks of Reflective Supervision

As conceptualized in the RIOS, the reflective process at work during the interaction between the supervisor and supervisee encompasses a cumulative, and therefore overlapping, progression of Collaborative Tasks. Although these Tasks are distinctive, they may coexist within the session.

Describing addresses the question, "What do we know?" It may include discussion of factual information, what has transpired, and clarifying and organizing details of what was seen and heard.

Responding addresses the question, "How do we and others think and feel about this?" Discussion may focus on the emotional experience of the baby, parents, or the supervisee, as well as thoughts and feelings related to the baby, parents, and the issue at hand.

Exploring addresses the question, "What might this mean?" It may be focused on gaining insight into the emotional experience of self and others, including the baby. It may involve attempting to acknowledge and address difficult issues and concerns.

Linking addresses the question, "Why does this matter?" This involves creating connections between the baby's and parents' experience and relevant infant mental health theory, research, and best practice. Linking includes considering the supervisee's role, boundaries, and the purpose of the work.

An effective and supportive professional relationship is at the heart of reflective supervision.

....

Integrating addresses the question, "What have we learned?" It can include developing a summary of what has been discovered and exploring the implications for the work going forward.

Coding Interactions Using the RIOS

The RIOS is based on the hypothesis that reflective supervision contains common processes that occur between the supervisor and supervisee that can be ordered and measured within and between sessions. It is hypothesized that the Essential Elements and Collaborative Tasks may be present to different degrees depending on how long and at what depth the issue has been discussed, as well as the extent to which the supervisory relationship has developed. It was anticipated that some Collaborative Tasks and Essential Elements may be present in greater quantity early on in the relationship while others may emerge more frequently as the relationship evolves over time.

The RIOS includes a coding manual with detailed descriptions of the Essential Elements and Collaborative Tasks along with indicators for each (Watson et al., 2016). The coding process involves viewing a digitally recorded reflective supervision session in 15-minute segments and using a coding matrix to assess the specific Collaborative Tasks the pair are using to discuss each Essential Element. Coders listen for the Essential Element being discussed and then look at the nature of the Collaborative Task in which the pair are engaged. For example, when hearing the pair discuss the baby, coders assess whether what they hear indicates Describing, Responding, Exploring, Linking, or Integrating on the basis of specific indicators which distinguish one task from the others. The researchers "code" this Collaborative Task using its assigned numerical code with a focus on noting the "highest" number, or most complex Collaborative Task, occurring.

As the RIOS was being refined, it became clear that the fifth Essential Element, Reflective Alliance, required a different approach to account for its presence. The Reflective Alliance between supervisor and supervisee(s) permeates every aspect of the professional relationship. In addition to verbal indicators,

the Reflective Alliance encompasses important non-verbal ways of communicating between the collaborators. In the RIOS, the Reflective Alliance is coded using a checklist of observable behaviors indicating the extent to which those engaged in the process are interacting in a manner consistent with a collaborative, reflective stance such as "sharing power" and "contingent mirroring each other's affect."

The RIOS does not focus solely on either the supervisor or supervisee to code or "rate" the "performance" of either participant. Rather, it serves to document the nature of the interaction between the two parties during a particular session. It is anticipated that by coding multiple sessions over an extended period of time, an observer can discover whether and in what ways the nature of the conversation and collaborative supervision relationship and process change as a supervisory relationship unfolds over time. By looking at the codes, we anticipate that patterns will be revealed which will further illuminate how the process evolves. The codes function as a sort of "shorthand" in order to look at and think about the kinds of patterns that occur in this form of relationship-based professional development. We hope that the data that make up this shorthand will illuminate a broader story about the phenomenon of reflective supervision across sectors and disciplines.

Issues Encountered in Development of the Tool

Creating the RIOS involved working through a number of stages of development and entailed many unanticipated challenges. The first great challenge was distilling the data we had gathered regarding the components of reflective supervision into discrete Essential Elements. Each Essential Element had to contain distinctive characteristics of reflective supervision used in conjunction with infant mental health work—characteristics that set it apart from coaching, mentoring, and other forms of relationship-based professional development. In addition, each had to stand alone as an independent topic, such as "Holding the Baby in Mind," or concept, such as "Parallel Process." As we began coding digital recordings, it became apparent that clarifying the ways the Essential Elements may overlap would take careful observation. For instance, Professional Use of Self and Parallel Process are closely aligned. Careful scrutiny of exactly what was heard and observed was required to determine which of the Essential Elements was at play during a given segment of reflective conversation.

The second large challenge was deciding how many Collaborative Tasks constituted a complete developmental, reflective process and ensuring that the Tasks were described in such a way as to focus on the reflective nature of the interaction while using an infant mental health lens. After settling on the five Collaborative Tasks, we realized how they were related but still retained their distinctive nature.

Defining the components of a Reflective Alliance and how to code them was a third challenge. We began with a long list of verbal and nonverbal behaviors that fit into establishing and

maintaining an alliance. Then we attempted to "fit" the list into the format of the five Collaborative Tasks we had identified. Eventually Reflective Alliance was converted to a checklist format, which allows observers to more accurately account for the wide variety of ways this important aspect of interaction is revealed.

We did not want to cast the RIOS as an evaluation tool in its initial research form. The RIOS is meant to "record dyadic process—what is seen and heard;" to make visible the developmental process of a supervisory session (Watson et al., 2016). The emphasis is not on "getting a high code or score." For example, the first Collaborative Task of Describing—producing a rich description— is a critical foundation of

reflection and not a "lesser" task. Even so, over time, the supervisor and supervisee are increasingly familiar with a case and would likely spend more time Responding, Exploring, and, eventually, Linking and Integrating as they more deeply understand the evolving story of a particular child and family. The RIOS provides a way to delineate the relational process and organize the fluid, organic, and subjective experience of reflective supervision in order to better understand this phenomenon. In the manual, each Essential Element has its own description of the Collaborative Tasks and indicators associated with it. The box Holding the Baby in Mind presents an abbreviated example of how one of the Essential Elements is described in the RIOS Manual (Watson et al., 2016).

Holding the Baby in Mind

Describing: "What do we know about the baby? The supervisor and supervisee focus on the facts of the baby's experience including what was seen and heard. This Collaborative Task may also include clarifying and organizing what is known about the baby. The distinguishing characteristic is that the pair is primarily attempting to gather rich facts and detail.

Indicators of the Collaborative Task—Describing:
- Discussing factual information and what has transpired
- Discussing observations of the baby, highlighting baby's interaction with others
- Clarifying and organizing what is known about the baby's experience

Responding: "How might the baby think and feel?" The pair openly consider their thoughts and feelings about the baby's emotional experience as well as the baby's effect on the supervisee, parents, and caregivers related to the baby. The distinguishing characteristic is that thoughts and feelings of participants in the story, including those of the supervisee and supervisor, are expressed.

Indicators of the Collaborative Task—Responding:
- Considering the baby's emotional experience
- Expressing thoughts and feelings related to the baby

Exploring: "What might this mean? The distinguishing characteristic is a deep exploration of the lived experience of the baby, with a deliberate and thoughtful discussion of what is known about the baby or what the baby's experience with the caregiver(s) might mean.

 The supervisor and supervisee acknowledge the complexity of the unfolding story, naming perceptions, motivations, values, biases, impacts of history, and cultural context for the purpose of organizing the baby's experience. They seek to articulate impressions, patterns, and themes, with particular attention to what these might mean for the baby's developing sense of security, self-worth, and understanding of how relationships work.

Indicators of the Collaborative Task—Exploring:
- Seeking insight into the baby's experience
- Attempting to acknowledge difficult issues and concerns for the baby
- Searching for meaning in impressions, themes, and patterns in the baby's experience

Linking: "Why might it matter?" The distinguishing characteristic of this Task is that conversation seeks connection between the baby's experience and fundamental theoretical principles that might clarify and organize understanding of the work. They consider theoretical frameworks such as attachment, trauma, and child development that inform their hypotheses and anticipate future implications in light of these frameworks. The reflective partners approach the application of theory with curiosity, resisting rigidity and avoiding absolutes while maintaining an openness to other possibilities.

Indicator of the Collaborative Task—Linking:
- Identifying connections between this baby's experience and relevant theory and principles

Integrating: "What have we learned?" The supervisor and supervisee use their understanding about what they have learned together to form a summary of the baby's experience and the baby's impact on developing relationships. The distinguishing characteristic is that they use the central focus on the baby to formulate an understanding of the supervisee's role in promoting growth and change in the family relationships.

Indicators of the Collaborative Task—Integrating:
- Developing a summary of what has been discovered about this baby
- Anticipating the impact of this baby's development on relationships
- Exploring the implications of the work going forward given the baby's current and anticipated developmental needs

Source: Watson, Harrison, Hennes, & Harris, 2016, p. 10–16

Next steps

We are continuing to receive valuable input from the research committee and others as we complete the development of the RIOS. In August 2016, the RIOS was used as one lens with which to view "fishbowl" reflective supervision sessions at the first annual Reflective Supervision Symposium sponsored by the Alliance and the Michigan Association for Infant Mental Health. We have identified video exemplars of the Collaborative Tasks used to explore each Essential Element that we will use in reliability training. Negotiations are underway with partner organizations in several states who want to join with us in using the RIOS in pilot studies and who are interested in receiving training in reflective supervision using the RIOS as a framework for understanding the supervision process. We feel the RIOS has potential as a tool for conducting empirical investigation about the content and process of reflective supervision, which, up until this point, has been under-researched. It is our hope that eventually this line of research will lead to an understanding of the impact of reflective supervision on child, family, and provider outcomes.

Christopher L. Watson, PhD, IMH-E® (IV), is a research associate at the Center for Early Education and Development (CEED) in the College of Education and Human Development at the University of Minnesota–Twin Cities. His research focuses on professional development, particularly reflective supervision, to support practitioners working with young children and their families. One of his recent large-scale projects was an evaluation of a system-wide reflective practice capacity-building initiative conducted for the Minnesota Department of Health.

Mary E. Harrison, PhD, LICSW, is a research associate at the Center for Early Education and Development (CEED) in the College of Education and Human Development at the University of Minnesota–Twin Cities. Her research focuses on reflective supervision with an emphasis on the ways practitioners and their work with families are impacted by participation. She also does training and professional development for practitioners in the child welfare system on infant mental health principles and best practice. Prior to this work, Mary was an infant and early childhood mental health therapist.

Jill E. Hennes, MSW, LICSW, IMH-E® (C), is an independent consultant and trainer specializing in infant mental health and reflective consultation, Jill serves to build capacity among those serving families with very young children through the creation of reflective spaces that support growth and change. Previously, at the Minnesota Department of Health, Jill was able to learn about building a statewide system of support for reflective practice while training and mentoring Public Health supervisors, home visitors, and infant mental health consultants.

Maren M. Harris, MA, LMFT, IMH-E® Infant Mental Health Mentor, reflective practice consultant, and clinical supervisor, of Aequus Consulting, LLC, provides reflective consultation and clinical supervision to early childhood practitioners and home visitors. She has trained on infant mental health and reflective practice, and is currently co-chair for the Minnesota Association for Infant and Early Childhood Mental Health.

Learn More

Release, Reframe, Refocus, and Respond: A Transformation Process in a Reflective Consultation Program
M. Harrison (in press)
Infant Mental Health Journal

Starting Where the Program Is: Three Infant Mental Health Consultants Discuss Reflective Practice
S. S. Heller, F. Jozefowicz, R. Reams, & J. Weinstock (2004)
ZERO TO THREE, 24(6), 10–19

Reflective Supervision in Practice: Stories From the Field
R. Parlakian (Ed.) (2002)
Washington, DC: ZERO TO THREE

Reflective Interaction Observation Scale (RIOS)
C. Watson, M. Harrison, J. Hennes, & M. Harris, (2016)
Unpublished measure

Providing Reflective Consultation for an Urban Early Intervention Education Team: Bridging Education and Mental Health
C. Watson & S. N. Neilsen Gatti (2012)
Infants & Young Children, 25(2), 109–112

References

Gallen, R. T., Ash, J., Smith, C., Franco, A., & Willford, J. A. (2016). How do I know that my supervision is reflective? Identifying factors and validity of the Reflective Supervision Rating Scale. *ZERO TO THREE, 37*(2), 30–37.

Heffron, M. C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs.* Washington, DC: ZERO TO THREE.

Heller, S. S., & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *ZERO TO THREE, 37*(2), 22–28.

Heller, S. S., & Gilkerson, L. (Eds.). (2009). *A practical guide to reflective supervision*. Washington DC: ZERO TO THREE.

Korfmacher, J. (2014). *Infant, toddler, and early childhood mental health competencies: A comparison of systems.* Washington DC: ZERO TO THREE. Retrieved from https://www.zerotothree.org/resources/121-infants-toddlers-and-early-childhood-mental-health-competencies-a-comparison-of-systems

Lane, V. (2011). The emotional labor of Early Head Start home visiting. *ZERO TO THREE, 32*(1), 30–36.

Lichtenberg, J. D. (2003). Communication in infancy. *Psychoanalytic Inquiry, 23*(3), 498–520.

Linstone, H. A., & Turoff, M. (Eds.). (1975). *The Delphi method.* Reading, MA: Addison-Wesley.

Lipsky, L. D. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others.* San Francisco, CA: Berrett-Koehler.

Pawl, J. H., & St. John, M. (1998). *How you are is as important as what you do… in making a positive difference for infants, toddlers and their families.* Washington, DC: ZERO TO THREE.

Schafer, W. M. (2007). Models and domains of supervision and their relationship to professional development. *ZERO TO THREE, 28*(2), 10–16.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Mahwah, NJ: Erlbaum.

Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. Scott Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 7–23). Washington, DC: ZERO TO THREE.

Shea, S. E., & Goldberg, S. (2016). Training in reflective supervision: Building relationships between supervisors and infant mental health specialists. *ZERO TO THREE, 37*(2), 54–62.

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: Guilford Press.

Siegel, D. J., & Shahmoon-Shanok, R. (2010). Reflective communication: Cultivating mindsight through nurturing relationships. *ZERO TO THREE, 31*(2), 6–14.

Tomlin, A., Weatherston, D. J., & Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant Mental Health Journal, 35*(1), 70–80.

Watson, C., Gatti, S. N., Cox, M., Harrison, M., Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. In E. Nwokah & J. A. Sutterby (Eds.) *Early childhood special education* (*Advances in Early Education and Day Care, Volume 18*, pp. 1–26). Bingley, UK: Emerald Group Publishing.

Watson, C., Harrison, M., Hennes, J. E., & Harris, M. (2016). *Reflective Interaction Observation Scale (RIOS) manual.* Unpublished manuscript.

Weatherston, D. J., & Barron, C. (2009). What does a reflective supervisory relationship look like? In S. Scott Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 63–82). Washington, DC: ZERO TO THREE.

Weatherston, D., Weigand, R. F., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *ZERO TO THREE, 31*(2), 22–30.

Winnicott, D. W. (1964). Further thoughts on babies as persons. In *The child, the family, and the outside world* (pp. 85–92). Harmondsworth, England: Penguin Books.

The Provider Reflective Process Assessment Scales (PRPAS)

Taking a Deep Look Into Growing Reflective Capacity in Early Childhood Providers

Sherryl Scott Heller
Tulane University

Jordana Ash
Colorado Department of Human Services
Denver, Colorado

Abstract

The need to build an evidence base for reflective supervision (RS) is threefold: (1) to determine the elements of a supervision session that make it reflective, (2) to demonstrate that change occurs within the supervisee, and (3) to demonstrate that having staff members participate in RS enhances positive program (or client) outcomes. This article introduces a new measure, the Provider Reflective Process Assessment Scale, created to assess change in reflective capacity in early childhood providers and practitioners after participating in RS or training. The authors discuss the creation of the measure, the coding system, the administration, and how it is currently being used.

Over the past decade, interest in reflective supervision (RS) as a means to support and enhance the skills of early childhood providers[1] has increased significantly. RS is a recommended practice for Early Head Start/Head Start (Early Head Start National Resource Center, 2010; Head Start, 2015), home visiting programs (e.g., Nurse Family Partnership [Beam, O'Brien, & Neal, 2010; Dawley, Loch, & Bindrich, 2007], and Fussy Baby Network, trauma-informed care [Osofsky, 2009; van Berckelaer, 2011], early childhood mental health consultation [Duran et al., 2009; Heller, Steier, Phillips, & Eckley, 2013]) and other programs serving families with young children. RS builds a relationship between a supervisor and service provider that aims to create a climate in which both the client's and the helper's (conventionally referred to as the supervisee, e.g., a home visitor or early intervention provider) needs are being considered so that the effectiveness of the intervention is optimized. It is a partnership in which the supervisee never feels alone; is not overwhelmed by fear or uncertainty; and feels safe to express fears, uncertainties, thoughts, feelings,

and reactions. Through RS, the supervisee learns more about himself, the client, co-workers/colleagues, and the work. This form of supervision requires the commitment of program resources (e.g., time for staff, funding, training) and an openness to welcome this type of support as part of the overall program culture. Research findings that demonstrate the effectiveness of RS would move the practice toward becoming an evidence-based practice, enable early childhood programs to assure funders of the importance of allocating funds for the practice, and influence early childhood policy to support RS as an important component of best practice standards.

Interest in building an evidence base for reflective supervision has increased over the past decade (see Tomlin & Heller, this issue, p. 4). In the past 5 years, numerous sessions at ZERO TO THREE's National Training Institute have focused on reflective practice, RS, and research on RS. The need to build an evidence base for RS is threefold: (1) to determine the elements of a supervision session that make it reflective

---

[1]   In this article, *provider* will be used to refer to individuals providing preventive, intervention, or treatment services to young children and their families.

(reflective process), (2) to demonstrate that change occurs within the supervisee (provider growth), and (3) to demonstrate that having staff members participate in RS enhances positive program outcome (client outcome). Figure 1 depicts these three research needs and some of the measurement tools that currently exist to assess those needs.
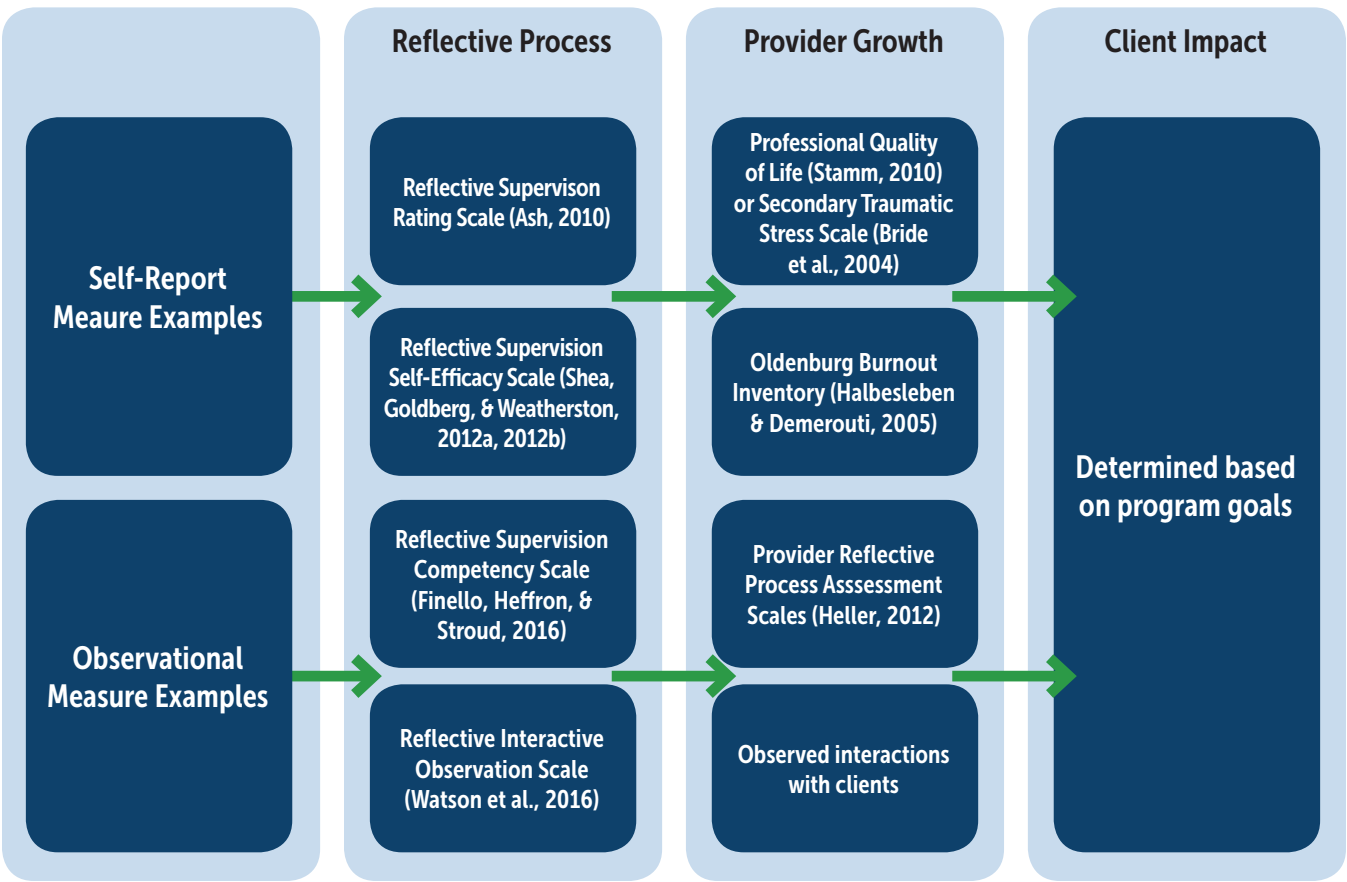
Research Background

Until recently, the majority of research publications related to RS have been qualitative in nature. These findings have indicated that RS enhances practice in early intervention fields (Gilkerson & Kopel, 2005), decreases the effects of burn-out and compassion fatigue (Osofsky, 2009), and supports the development of reflective skills that are essential to work with young children and families (Tomlin, Sturm, & Koch, 2009).

When creating the Provider Reflective Process Assessment Scales (PRPAS) tool, we drew from three bodies of knowledge beyond the literature defining RS and how to provide it. The research literature that focused on reflective abilities in providers was limited, however the research literature on parental reflective capacity and child outcomes was more robust (Benbassat, & Priel 2015; Fonagy & Target, 2005; Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Pally & Popek, 2012; Slade 2005). The second area was

the mindfulness literature which had a growing research base on the impact of mindfulness on patient outcome (Gotink et al., 2015; Sharma & Rush, 2014) and on parents (Cachia, Anderson, & Moore, 2015). And finally, although there was a very limited research base, the literature on mindsight was helpful in operationalizing (the process of defining the phenomenon that is not directly measurable), some of the important components of RS (Siegel, 2009; Siegel & Shahmoon-Shanok, 2010).

In the parenting literature, reflective terms are specific to the parent's ability to understand their child's internal world. *Insightfulness*, a term used by Oppenheim and Koren-Karie (2002), is defined as the "capacity to see things from the child's point of view, based on insight into the child's motives, a complex view of the child, and openness to new information about the child" (p. 593). Similarly, the term *reflective functioning* is defined as a parent's "capacity to understand the nature and function of her own as well as her child's mental states" (Slade, 2005, p. 275). The Insightfulness Interview (Koren-Karie et al., 2002; Oppenheim & Koren-Karie, 2013) is used to assess insightfulness in parents, similarly the Parent Development Interview (PDI; Slade, Belsky, Aber, & Phelps, 1999) has been used to assess parental reflective functioning. High scores on both measures have been related to positive parent-child relationships (i.e., more sensitive

Figure 1.

	Reflective Process	Provider Growth	Client Impact
Self-Report Meaure Examples	Reflective Supervison Rating Scale (Ash, 2010)	Professional Quality of Life (Stamm, 2010) or Secondary Traumatic Stress Scale (Bride et al., 2004)	
	Reflective Supervision Self-Efficacy Scale (Shea, Goldberg, & Weatherston, 2012a, 2012b)	Oldenburg Burnout Inventory (Halbesleben & Demerouti, 2005)	**Determined based on program goals**
Observational Measure Examples	Reflective Supervision Competency Scale (Finello, Heffron, & Stroud, 2016)	Provider Reflective Process Asssessment Scales (Heller, 2012)	
	Reflective Interactive Observation Scale (Watson et al., 2016)	Observed interactions with clients	

Reflective supervision is a partnership in which the supervisee never feels alone; is not overwhelmed by fear or uncertainty; and feels safe to express fears, uncertainties, thoughts, feelings, and reactions.

and responsive parenting) and positive child outcomes (i.e., positive sense of self, learn more easily, more empathic, and better peer interactions). It is interesting that both of these tools have been adapted and used to assess insightfulness and reflective functioning in preschool teachers. Stacks and colleagues (2013) found that teachers who scored high on reflective functioning were able to list significantly more examples of teaching behaviors that fostered social emotional skills in children. Virmani & Ontai (2010) found an increase in

the continuous scales used to assess insightfulness in teachers who received reflective supervision over a 3-month period of time. Unfortunately, the PDI and Insightfulness Interview are not readily adaptable for use more broadly in program settings as they focus principally on an individual child and involve videotaping interactions. However, some of the elements assessed by the PDI and Insightfulness scales fit descriptions of important elements of RS such as openness, acceptance, perspective taking, and insight.

Another body of research that was applicable to the descriptions of reflective skills used by practitioners was the mindfulness literature. In the RS literature, reflection has been referred to as "the mindful consideration of one's actions" (Gilkerson & Shahmoon-Shanok, 2000). Kabat-Zinn (2005) defined mindfulness as "an open-hearted, moment to moment, non-judgmental awareness" (p. 24). Similarly, Sharpiro and Carlson (2009) described mindfulness as "the awareness that arises though attending in an open, caring and non-judgmental way" (p. 4). The majority of the research on mindfulness has focused on the impact of patient or client mindfulness, rather than provider mindfulness, on patient or client outcome (Nyklíček, Hoogwegt, & Westgeest, 2015; O'Doherty et al., 2015; Valls-Serrano, Caracuel, & Verdejo-Garcia, 2016). Regardless, essential components of mindfulness (Kabat-Zinn 2005; Shaprio & Carlson, 2009) also align with descriptions of important elements of RS: openness, acceptance, curiosity.

Similar to mindfulness, mindsight is another mental activity that has been described as an important element of RS (Siegel & Shahmoon-Shanok, 2010). It is defined as the ability to represent mental activities (e.g., thoughts, feeling, intentions, and memories) of self and other, to have insight and empathy for the mental experience of self and other, and to sense shared patterns of communications within relationships (Seigel, 2009; Siegel & Shahmoon-Shanok, 2010). This ability allows one to step out of automatic reactions and untethered emotions. The capacity to pause and reflect, to be self-aware, and to be cognizant of the emotional climate are all mental activities that have been described as important elements of RS.

Creating the PRPAS

The next step in the measurement development process was to compare the reflective elements identified in the research literature review above with key elements or processes of reflective supervision identified in the practice and implementation literature. That is, the mental capacities that were held as being important abilities to have as a reflective practitioner and were believed to be enhanced by participation in RS. Concepts that demonstrated consistency across the research literature, the RS practice literature, and the first author's personal RS experience such as: openness, acceptance, insight, perspective taking, self-awareness, pausing, and curiosity were retained. Six reflective processes were distilled from this process and were developed into six scales that were created to assess change in reflective processing ability.

Validity is an important component of scale development. At this point, *face-validity* (the extent to which the measure appears to assess what it is designed to measure) was assessed by allowing a group of 12 experts in the field of early childhood mental health consultation who were experienced providers of RS to review the scales and provide feedback. All 12 agreed that the six scales represented important core reflective processes that should be impacted by participation in RS. They provided feedback on scale and subscale descriptions. In addition, 15 experienced early childhood mental health consultants, from two different state-wide programs, completed the measure, which included written responses to reflective prompts regarding a specific consultation experience. These transcripts were coded, and examples from the responses were used to enrich the anchor point descriptors in the scoring system. Each subscale is scored on a 5-point anchored system.

Before describing the PRPAS scoring system we will describe the measurement tool. The first author created and tested several different versions of the PRPAS. Initial versions involved using pictures to generate responses from those completing the measure. A later version used different reflective prompts, written responses, or both. Finally, the first authoer found that recording and transcribing a 5-minute speech sample in which the individual being interviewed responded to a small set of

Photo: Kiwi Street Studios

Many early childhood programs are searching for tools to measure the impact of their work, including the support these programs provide to staff through reflective supervision.

verbal and written prompts produced the most code-able responses and seemed to be the most versatile to be used across disciplines and program settings. In brief, the interviewer asks the provider to "think about a challenging family you worked with in the past year. Please tell us about your work with this family/child; why you considered the family/child challenging; how you went about addressing those challenges and working the child/family; and what, if anything, you learned about yourself in your work with this family." The interviewer also gives the provider a sheet of paper with the prompts listed as a reference. A trained coder codes the transcribed interview. Because the interviews are 5 minutes long, the transcription is typically one to one and half pages. This limited length allows nonprofessional transcribers to transcribe the interviews. To date we have had graduate students, administrative staff, and researchers successfully transcribe the interviews. The individual who codes or scores the interviews needs to be trained to reliability by the first author.

Each subscale is scored on a 5-point descriptive anchored system. The subscales can be added together to form six scale scores. We are currently collecting data that will allow us to determine whether using subscale scores, scale scores, or a

summed score leads to better validity and reliability. The six scales are described in the next section.

PRPAS Coding Scales

The first scale, **Self-Knowledge**, consists of two subscales: Self-Awareness and Seeks Growth. *Self-Awareness* examines the extent to which the provider considers the impact of her own internal world, especially her own values, beliefs, and assumptions, and considers how these may influence her words, actions, and thoughts. *Seeks Growth* has to do with the extent the provider seeks to learn more about herself, sees herself as a continual learner, and/or integrates information learned from RS and applies it to practice.

The second scale, **Self-Regulation**, consists of three subscales: The ability to create Emotional Breathing Space, to Hold Uncomfortable Emotions, and Awareness of the Emotional Climate. *Emotional Breathing Space* involves consciously taking time to pause and reflect before acting by saying something or responding to the content that was shared, especially in emotionally charged situations. *Holding Uncomfortable Emotions* entails the provider not rushing to dismiss or repair negative emotions but to remain in the moment with the client. *Awareness of Emotional Climate* involves recognizing the emotional climate and supporting others without adopting others' emotions.

The third scale, **Collaboration**, consists of three subscales: Inquiry and Exploration, Resists Pressure to Fix, and Impact of Words and Actions. *Inquiry and Exploration* assesses the degree to which the provider approaches concerns from the perspective of inquiry (not inquisition) and together with the client explores potential solutions. A provider who scores high on *Resists Pressure to Fix* does not respond to his client out

of an urge or pressure to fix but rather slows down, develops a full understanding, and supports the client in exploring potential solutions. A provider who is aware of the *Impact of Words and Actions* is attuned to the potential impact his words or actions may have on the client and takes time to contemplate how he will approach a client in especially tenuous situations, as in those times when the client may have overlooked or underestimated risk, caused a relationship disruption, or displayed little self-awareness.

The fourth scale, **Process**, consists of two subscales: Relationships Influence Change and Attends to Process. A provider who scores high on *Relationships Influence Change* recognizes that much of learning is experiential and occurs through relationships. The *Attends to Process* subscale assesses the level to which an individual appreciates the complexity and richness of the client's story and allows it to unfold; it includes the provider seeing part of her role as being the witness of change and the holder of history and using that perspective to support the client.

The fifth scale, **Authentic Attitude**, consists of three subscales, *Openness*, *Acceptance*, and *Curiosity*. The *Openness* subscale assesses the degree to which the provider is open to what happens with his client and how the client's story is revealed. The provider does not try to push his own agenda but rather focuses on understanding the client's perspective of her needs. The *Curiosity* subscale assesses the level to which the provider approaches the situation with kind-hearted inquisitiveness; as the story plays out and various strategies are tried, the provider displays a sense of curiosity as to what will happen. A provider who scores high on *Acceptance* maintains a nonjudgmental approach to clients and the situation and supports client-directed change.

The sixth scale, **Multiple Perspectives**, consists of a single scale. This scale assesses the level to which the provider exhibits the ability to consider the personal history, experiences, and culture of all the individuals involved, including her own.

Current Use in the Field

Currently, a handful of programs are administering the PRPAS in their statewide home visiting programs. The evaluation goal of these programs is to assess change in the providers' reflective processing abilities over the course of receiving RS. Program researchers are being trained to reliability on the PRPAS coding system. Pre-test data has been collected. The home visitors will participate in reflective practice trainings and RS. After 6 months, post-test data will be collected.

In addition to the PRPAS, these programs are administering self-report measures of mindfulness, curiosity, and therapeutic alliance to examine their association with the PRPAS. A moderate to high positive correlation would provide convergent validity to the PRPAS. *Convergent validity* is a type of construct validity, and it refers to the degree which two measures that assess the same underlying structure are

Learn More

Reaching Toward an Evidence Base for Reflective Supervision
L. Eggbeer, R. Shahmoon-Shanok, & R. Clark (2010)
ZERO TO THREE, 31(2), 39–45

Critical Components of Reflective Supervision: Responses From Expert Supervisors in the Field
A. M. Tomlin, D. J. Weatherston, & T. Pavkov (2014)
Infant Mental Health Journal, 35(1), 70–80

Professional Development Through Reflective Supervision in Early Intervention
C. Watson, & S. Nielsen Gatti (2012)
Infants & Young Children, 25(2), 109–121

Reflective Supervision and its Impact on Early Childhood Intervention
C. Watson, S. Neilsen Gatti, M. Cox, M. Harrison, & J. Hennes (2014)
Advances in Early Childhood and Day Care, 18(1), 1–26

a correlation. So for example, we would want to see that the PRPAS curiosity subscale correlates with the Curiosity and Exploration Inventory (Kashdan et al., 2009).

Next Steps

Many early childhood programs are searching for tools to measure the impact of their work, including the support these programs provide to staff through RS. To date, tools that are quantitative in nature have been limited in this field. The utility of the PRPAS to take a deep look into a provider's growing reflective processing is clear. Its focus on the change over time in the individual who is receiving RS will assist programs in validating investments and make the case for additional resources being dedicated to this activity.

In the future, assessing the relationship between this measure and the others presented in this issue (Finello, Heffron, & Stroud, this issue, p. 39; Gallen, Ash, Smith, Franco, & Willford, this issue, p. 30; Shea & Goldberg, this issue, p. 54; Watson, Harrison, Hennes, & Harris this issue, p. 14) will serve to enhance the understanding of RS and its impact, while also building the research base for RS.

Sherryl Scott Heller, PhD, is an associate professor in the Department of Psychiatry and Behavioral Medicine at Tulane University School of Medicine. Dr. Heller directs the Fussy Baby Network New Orleans and Gulf Coast Program and serves as a senior team member on Louisiana's Statewide Early Childhood Infant Mental Health Consultation to Child Care program. In 2009, Dr. Heller co-edited a book with Dr. Linda Gilkerson, of the Erikson Institute in Chicago, on providing reflective supervision to professionals in the field of early childhood intervention. In October 2011, Dr. Heller was selected to be a fellow in ZERO TO THREE's Leadership Development Institute, for which her project focused on developing a measure to examine the impact of reflective supervision.

Jordana Ash, LCSW, IMH-E® (IV), is director of early childhood mental health in the Colorado Office of Early Childhood, Department of Human Services. She is the first to hold this position, which represents public-private partnership and state-level commitment to the role. Ms. Ash previously held the position of senior program manager of early childhood services at Mental Health Partners in Boulder, Colorado. She developed the award-winning, nationally recognized Kid Connects: Integrated Health and Mental Health model of early childhood mental health consultation. She is the author of the *Kid Connects Implementation Manual*, a three-volume resource for communities replicating the Kid Connects model. She is an Irving Harris Graduate in Child Development and Infant Mental Health at the University of Colorado Denver and is an instructor with the Harris Program. She achieved Endorsement for Culturally-Sensitive, Relationship Focused Practice Promoting Infant Mental Health® as an Infant Mental Health Mentor-Clinical in 2010.

References

Ash, J. (2010). *Reflective Supervision Rating Scale.* Unpublished assessment tool.

Beam, R., O'Brien, R., & Neal, M. (2010). Reflective practice enhances public health nurse implementation of nurse-family partnership. *Public Health Nursing, 27*(2), 131–139.

Benbassat, N., & Priel, B. (2015). Why is fathers' reflective function important? *Psychoanalytic Psychology, 32*(1), 1–22.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*(1), 27–35.

Cachia, R. L., Anderson, A., & Moore, D. W. (2015). Mindfulness, stress and well-being in parents of children with autism spectrum disorder: A systematic review. *Journal of Child and Family Studies, 25*(1), 1–14.

Dawley, K., Loch, J., & Bindrich, I. (2007). The nurse-family partnership. *American Journal of Nursing, 107*(11), 60–67.

Duran, F., Hepburn, K., Irvine, M., Kaufman, R., Anthony, B., Horen, N., & Perry, D. (2009). *What works? A study of effective early childhood mental health consultation programs.* Washington, DC: Georgetown University Center of Child and Human Development.

Early Head Start National Resource Center. (2010). *Technical assistance paper No. 13: Reflective supervision: A tool for relationship-based EHS services.* Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/docs/reflective_super_TAPaper_13.pdf

Finello, K. M., Heffron, M. C., & Stroud, B. (2016). Measuring process elements in reflective supervision: An instrument in the making. *ZERO TO THREE, 37*(2), 39–45.

Fonagy, P., & Target, M. (2005). Mentalization and the changing aims of child psychoanalysis. In L. Aron, & A. Harris (Eds.), *Relational psychoanalysis: Innovation and expansion, Vol. 2* (pp. 253–278). Mahwah, NJ: Analytic Press.

Gallen, R. T., Ash, J., Smith, C., Franco, A., & Willford, J. A. (2016). How do I know that my supervision is reflective?: Identifying factors and validity of the Reflective Supervision Rating Scale. *ZERO TO THREE, 37*(2), 30–37.

Gilkerson, L., & Kopel, C. C. (2005). Relationship-based systems change Illinois' model for promoting social-emotional development in Part C early intervention. *Infants & Young Children, 18*(4), 349–365.

Gilkerson, L., & Shahmoon-Shanok, R. (2000). Relationships for growth: Cultivating reflective practice in infant, toddler and preschool programs. In J. Osofsky & H. Fitzgerald. *WAIMH handbook of infant mental health: vol 2. Early intervention evaluation and assessment,* (pp. 33–79). Hoboken, NJ: Wiley.

Gotink, R. A., Chu, P., Busschbach, J. V., Benson, H., Fricchione, G. L., & Hunink, M. M. (2015). Standardised mindfulness-based interventions in healthcare: An overview of systematic reviews and meta-analyses of RCTs. *Plos ONE, 10*(4).

Halbesleben, J. R, B., & Demerouti, E. (2005). The construct validity of an alternative measure of burnout: Investigating the English translation of the Oldenburg Burnout Inventory. *Work Stress, 19*, 208–220.

Head Start. (2015). *What is reflective supervision?* Retrieved from https://eclkc. ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/comp/reflective-supervision

Heller, S. S. (2012, December). *Reflective supervision and reflective functioning: Assessing change in reflective functioning in early childhood mental health consultants.* Poster presented at ZERO TO THREE 27th National Training Institute, Los Angeles, CA.

Heller, S. S., Steier, A., Phillips, R., & Eckley, L. (2013). The building blocks for implementing reflective supervision in an early childhood mental health consultation program. *ZERO TO THREE, 33*(5), 52–59.

Kabat-Zinn, J. (2005). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. 15th anniversary edition.* New York, NY: Delta /Bantam Dell.

Kashdan, T. B., Gallagher, M. W., Silvia, P. J., Winterstein, P. B ., Breen, W. E., Terhar, D., & Steger, M. F. (2009). The Curiosity and Exploration Inventory-II: Development, factor structure, and psychometrics. *Journal of Research in Personality, 43*, 987–998.

Koren-Karie, N., Oppenheim, D., Dolev, S., Sher, E., & Etzion-Carasso, A. (2002). Mothers' insightfulness regarding their infants' internal experience: Relations with maternal sensitivity and infant attachment. *Developmental Psychology, 38*(4), 534–542.

Nyklíček, I., Hoogwegt, F., & Westgeest, T. (2015). Psychological distress across twelve months in patients with rheumatoid arthritis: The role of disease activity, disability, and mindfulness. *Journal of Psychosomatic Research, 78*(2), 162–167.

O'Doherty, V., Carr, A., McGrann, A., O'Neill, J. O., Dinan, S., Graham, I., & Maher, V. (2015). A controlled evaluation of mindfulness-based cognitive therapy for patients with coronary heart disease and depression. *Mindfulness, 6*(3), 405–416.

Oppenheim, D., & Koren-Karie, N. (2002). Mothers' insightfulness regarding their children's internal worlds: The capacity underlying secure child-mother relationships. *Infant Mental Health Journal, 23*(6), 593–605.

Oppenheim, D., & Koren-Karie, N. (2013). The insightfulness assessment: Measuring the internal processes underlying maternal sensitivity. *Attachment & Human Development, 15*(5–6), 545–561.

Osofsky, J. (2009). Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal, 30*(6), 673–677.

Pally, R., & Popek, P. (2012). Reflective parenting and the origins of the Center for Reflective Parenting. In M. H. Etezady, M. Davis, M. H. Etezady, & M. Davis (Eds.), *Clinical perspectives on reflective parenting: Keeping the child's mind in mind* (pp. 5–19). Lanham, MD: Jason Aronson.

Shapiro, S. L., & Carlson, L. E. (2009). What is mindfulness? In S. L. Shapiro & L. E. Carlson (Eds.), *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions* (pp. 3–14). Washington, DC: American Psychological Association.

Sharma, M., & Rush, S. E. (2014). Mindfulness-based stress reduction as a stress management intervention for healthy individuals: A systematic review. *Journal of Evidence-Based Complementary & Alternative Medicine, 19*(4), 271–286.

Shea, S. E., & Goldberg, S. (2016). Training in reflective supervision: Building relationships between supervisors and infant mental health specialists. *ZERO TO THREE, 37*(2), 54–62.

Shea, S., Goldberg, S., & Weatherston, D. (2012a). *Reflective Supervision Self-Efficacy Scale for Supervisees.* Unpublished measure.

Shea, S., Goldberg, S., & Weatherston, D. (2012b). *Reflective Supervision Self-Efficacy Scale for Supervisors.* Unpublished measure.

Siegel, D. J. (2009). Mindful awareness, mindsight, and neural integration. *The Humanistic Psychologist, 37*(2), 137–158.

Siegel, D. J., & Shahmoon-Shanok, R. (2010). Reflective communication: Cultivating mindsight through nurturing relationships. *ZERO TO THREE, 31*(2), 6–14.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development, 7*(3), 269–281.

Slade, A., Belsky, J., Aber, J. L., & Phelps, J. (1999). Maternal representations of their relationship with their toddlers: Links to adult attachment and observed mothering. *Developmental Psychology, 35*, 611–619.

Stacks, A. M., Wong, K., & Dykehouse, T. (2013). Teacher reflective functioning: A preliminary study of measurement and self-reported teaching behavior. *Reflective Practice, 14*(4), 487–505.

Stamm, B. H. (2010). *The Concise ProQOL Manual* (2nd ed). Pocatello, ID: ProQOL.org.

Tomlin, A., & Heller, S. S. (2016). Measurement development in reflective supervision: History, methods, and next steps. *ZERO TO THREE, 37*(2), 4–12.

Tomlin, A. M., Sturm, L., & Koch, S. M. (2009). Observe, listen, wonder, and respond: A preliminary exploration if reflective function skills in early care providers. *Infant Mental Health Journal,30*(6), 634–647.

Valls-Serrano, C., Caracuel, A., & Verdejo-Garcia, A. (2016). Goal management training and mindfulness meditation improve executive functions and transfer to ecological tasks of daily life in polysubstance users enrolled in therapeutic community treatment. *Drug And Alcohol Dependence, 165*[Q:, 9–14

Van Berckelaer, A. (2011). *Using reflective supervision to support trauma-informed systems for children: A white paper*. Retrieved from www.multiplyingconnections.org/become-trauma-informed/using-reflective-supervision-support-trauma-informed-systems-children

Virmani, E. A. & Ontai, L. L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal, 31*(1), 16–32.

Watson, C., Harrison, M., Hennes, J. E., & Harris, M. (2016). *Reflective Interaction Observation Scale (RIOS) manual*. Unpublished manuscript.

Watson, C. L., Harrison, M. E., Hennes, J. E., & Harris, M. M. (2016). Revealing "The space between": Creating an observation scale to understand infant mental health reflective supervision. *ZERO TO THREE, 37*(2), 14–21.
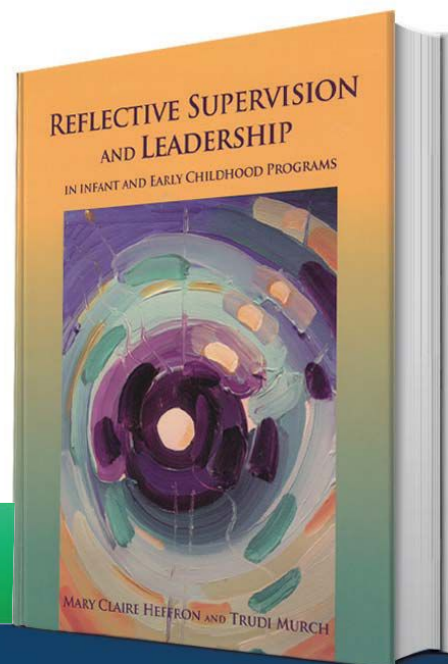
Your Guide to Blending Reflective and Administrative Supervision

Reflective Supervision and Leadership in Infant and Early Childhood Programs
Mary Claire Heffron and Trudy Murch

Reflective supervision is hard, and it's an even greater challenge when the same supervisor must provide both reflective and administrative supervision. *Reflective Supervision and Leadership* includes a unique focus on this blended model of supervision.

Other highlights of the book include: a discussion of the roles of the reflective supervisor, knowledge and skills needed for reflective supervision, tips for providing group reflective supervision, and vignettes outlining common supervisory dilemmas.

TO ORDER: call 800-899-4301 or visit www.zerotothree.org/bookstore

ZERO TO THREE Members
SAVE 20% on *Reflective Leadership and Supervision*

ZERO TO THREE's new membership program features opportunities for members to connect, as well as exciting benefits— including savings on tools and books from the ZERO TO THREE Bookstore, a subscription to the *ZERO TO THREE Journal*, discounts on registration to the ZERO TO THREE Annual Conference (formerly NTI), Member Exclusive online resources and events, and much more.

Find out more at www.zerotothree.org/membership

ZERO TO THREE is your one-stop shop for reflective supervision tools and training. Find out more at www.zerotothree.org/reflectivesupervision

About ZERO TO THREE
ZERO TO THREE works to ensure all babies and toddlers benefit from the family and community connections critical to their well-being and development. Since 1977, we have advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools, and responsive policies for millions of parents, professionals, and policymakers.

ZERO TO THREE
Early connections last a lifetime

How Do I Know That My Supervision Is Reflective?

Identifying Factors and Validity of the Reflective Supervision Rating Scale

Robert T. Gallen
University of Pittsburgh

Jordana Ash
Colorado Department of Human Services
Denver, Colorado

Conner Smith
Allison Franco
Jennifer A. Willford
Slippery Rock University

Abstract
Reflective supervision and consultation (RS/C) is often defined as a "relationship for learning"(Fenichel, 1992, p.9). As such, measurement tools should include the perspective of each participant in the supervisory relationship when assessing RS/C fidelity, delivery quality, and the supervisee's experience. The Reflective Supervision Rating Scale (RSRS) was developed for clinical use using a theory-driven item construction approach. The instrument assesses supervisor fidelity and delivery quality via supervisee ratings, and it can guide supervisees' expectations of the supervision experience. The RSRS was used to assess supervision quality and outcomes based on supervisee report in the Pennsylvania Early Intervention Reflective Supervision project. Data from this project provide early evidence for the utility of the RSRS as a tool sensitive to training in RS/C and associated with important RS/C variables.

One hallmark of support for providers of a variety of services in the early childhood field, whether they are child care providers, home visitors, integrated behavioral health specialists, nurses, or mental health consultants, is the provision of reflective supervision/consultation (RS/C; Tomlin, Weatherston, & Pavkov, 2014). RS/C has been described as a "relationship for learning" (Fenichel, 1992, p.9) and through regularity, collaboration, and reflection (Gilkerson, 2004; ZERO TO THREE, 2016), an early childhood professional is able to participate in a supportive, engaged experience to explore one's own reaction to work with families and thereby gain emotional stability, clarity of thinking, and broad case understanding. Reflective experiences are provided with the intent to produce better intervention outcomes by increasing curiosity about the family and the professional's experience, wondering about the meaning of events and

interactions for the infant or young child, noticing reactions of all involved, and coming to one's own answers to the difficult questions that arise in the work. During RS/C interactions, the professional learns to regulate emotions, integrate theory into practice, explore judgment toward the family and toward oneself, and use the feelings from one's own early experiences to better understand and support family relationships.

The effectiveness of RS/C has been described qualitatively (Heffron &Murch, 2010), and the approach has attained best-practice status in the early childhood helping fields (Watson & Neilsen Gatti, 2012). Investigations documenting the effectiveness of RS/C with empirical evidence, however, are limited (Siegel & Shahmoon-Shanok, 2010) and are described as "primarily conceptual and practical" rather than "data-driven"

(Watkins, 2015). RS/C studies have gathered expert consensus (Tomlin et al., 2014) to define the unique components of RS/C, have measured changes in supervisee mentalization such as insightfulness or reflective function (Eggbeer, Shahmoon-Shanok, & Clark, 2010; Tomlin, Sturm, & Kock, 2009; Virmani & Ontai, 2010), or have examined self-report experiences and reactions to RS/C from the early childhood workforce (Watson & Neilsen Gatti, 2012). More studies are needed to investigate not only what RS/C "is," but also its effectiveness and outcomes. Presently, RS/C remains a process-oriented intervention whose components are still being defined, and there is not yet a clear understanding of what to measure and how to measure it. To this point, Eggbeer et al. (2010) listed 25 questions produced at the 2009 ZERO TO THREE National Training Institute from a discussion group brainstorming next steps to develop the RS/C evidence-base.

The road map toward this goal may be found within implementation science (Sanetti & Kratochwill, 2014). Defined as "the scientific study of methods to promote the systemic uptake of research findings and other evidence-based practices into routine practice" (Eccles & Mittman, 2006, p. 1), implementation science guides decision making in regard to what questions need to be addressed to establish RS/C's evidence base. Accordingly, a key next step will include the ability to measure both RS/C fidelity and quality of delivery (Domitrovich et al., 2008). *Fidelity* refers to the extent to which RS/C is conducted as planned and adheres to an established intervention model. For example, is the supervisor "doing" those things that an RS/C supervisor is supposed to do? *Quality of delivery* includes effective implementation of RS/C's core components within supervision meetings. One might ask—does the RS/C supervisor "do" those RS/C things well? It may in fact be the case that "doing" RS/C is not the same as "being" an RS/C supervisor; there may be more to the "art" of RS/C than engaging in RS/C behaviors alone.

In order to measure RS/C fidelity and quality, there is a need for psychometrically sound and cost-effective assessment tools (Bellg et al., 2004; King & Bosworth, 2014). Measurement tools, such as questionnaires or rating scales, that are psychometrically "sound" meet a host of criteria, including but not limited to reliability (e.g., consistency), validity (e.g., measure what they are supposed to measure), and predictive validity (e.g., ability to predict important outcomes such as improved job performance or better child and family outcomes). Assessment of evidence-based practices generally includes the use of multiple types of assessment methods (e.g., supervisor and supervisee ratings, coding of recorded sessions, live observation) across multiple-informants (e.g., supervisor, supervisee, trained raters), thus requiring the development of several types of tools for several types of measurement.

The time is now to develop these tools so that the early childhood field can move forward in establishing RS/C as evidence-based practice. This article will describe efforts to measure the supervisee's experience in RS/C through self-report ratings using the Reflective Supervision Rating Scale (RSRS: Ash, 2010), including evaluation of the RSRS's

Photo: © istock/MIHAI ANDRITOIU

The Pennsylvania Early Intervention Reflective Supervision project created a unique opportunity to design, implement, and measure the impact of reflective supervision and consultation training on early intervention supervisors.

psychometric properties to establish its use as an effective tool for measuring RS/C fidelity and quality of delivery.

How Do I Know That My Supervision Is Reflective?

Much attention has been given to developing skilled and competent supervisors (Heffron & Murch, 2010). Local and national training opportunities abound, and there has been a recent proliferation of books, articles, and resources published to assist supervisors in advancing their knowledge and expertise in providing RS/C. But what about the supervisee? If there is to be a "relationship for learning" (Fenichel, 1992, p. 9), then RS/C, by its very definition, involves at least two individuals who are coming together in a very particular, specialized, kind of interaction. While there is an understanding that the supervisor, presumably the guide and initiator of this relationship, needs to be knowledgeable, trained, and experienced about core concepts of RS/C, there are analogous needs for the supervisee to be equally knowledgeable about core concepts, trained in the role of how to be a supervisee, and experienced enough to understand the types of interactions and exchanges that form the basis of meaningful RS/C.

Much of what has been written about the supervisee is from the domain of psychotherapists-in-training. Within that field, there is some acknowledgement that the supervisee could rate their supervisor across a number of dimensions important to the work and that supervisees' development as psychotherapists was a reasonable area of interest for study and research (Pack, 2012; Wilson, Davies, & Weatherhead, 2016). The literature in the early childhood field, however, has historically lacked a focus on the supervisee's experience. Although this shortcoming has changed in recent years with more attention being given to the supervisee (Early Head Start National Resource Center, n.d.; Heffron, & Murch, 2010; Heller, & Gilkerson, 2009), few resources for the supervisee experiences were available in the early 2000s.

Photo: © istock/g-stockstudio

During reflective supervision and consultation interactions, the professional learns to regulate emotions, integrate theory into practice, explore judgment toward the family and toward oneself, and use the feelings from one's own early experiences to better understand and support family relationships.

Complicating the lack of discourse about the experience of the supervisee was the escalation and broad promulgation of RS/C in early childhood programming. More and more types of services, from home visiting to Early Head Start to mental health consultation to coaching, were extending the use of RS/C and building in organizational expectations that RS/C would be provided to the full range of practitioners working in these systems. This attention to RS/C was hailed as progress, and programs got down to the business of filling supervisory positions and training new supervisors to be equipped to do the work. What remained unclear was how programs should be supporting the supervisee to think about the experience, how the supervisee could evaluate what was happening, and how conversation between supervisor and supervisee could begin to focus on the RS/C relationship and process.

This was the backdrop in the early childhood field during development of the RSRS (Ash, 2010). The tool was initially conceived of as a means to answer the question, "How do I know that my supervision is reflective?" The RSRS's focus on the supervisee's report placed the supervisee's perceptions and experiences in accord with the skills and competency of the supervisor. This focus on the supervisee's experience implied that the supervisee had agency, not only in the interactions in a supervisory session, but additionally, in the understanding and expectations of the experience itself.

The question as to what can be expected from RS/C emerged during the writing of the implementation manual for *Kid Connects: Integrated Health & Mental Health Consultation in Early Care Settings* (Ash, 2009). The *Kid Connects* model of early childhood mental health consultation to child care settings had been delivered in Boulder, Colorado, for more than 8 years, and the manual was written to support taking the model to scale. When composing the section on RS/C for *Kid Connects* consultants, the standard of practice for early childhood mental health professionals was to participate in RS/C. What was

not so clear was how to ascertain whether, from the standpoint of the supervisee, supervision was indeed reflective.

The RSRS was built to address the need to assess the supervisee's experience in RS/C by rationally and conceptually constructing questions that measured RS/C's core components. These core components were distilled by Ash (2010) from the literature on RS/C, from professional discussions with local and national experts, and from time spent as both supervisor and supervisee over many years in early childhood mental health roles. The resulting RSRS included 17-items rated on an "Almost Always," Sometimes," to "Rarely" scale (a "Usually" rating was added to a later revision). In the relatively short amount of time it takes to complete the RSRS (5 minutes), the supervisee has the opportunity to consider and reflect upon the core components of RS/C and then decide to what extent his own supervisor is facilitating these activities. The RSRS can also serve as a measure of supervisor fidelity to the RS/C model. Through supervisee ratings, the supervisor is able to gain external feedback on the extent to which she shows RS/C behaviors, or not. Alternately, the supervisor can complete self-ratings and reflect on her supervisory actions and attitudes. Although there is presently no established feedback protocol, RS/C supervisors have many options for capitalizing on and learning from completed RSRS scales. The RSRS may be completed after each RS/C meeting, monthly, or on any time frame that makes sense to the purpose. Feedback may be immediate or delayed, anonymous, individualized, or compounded into grouped statistics (e.g., mean scores by item). The supervisor is able to use RSRS scores as feedback to support current practice, identify areas of growth, and increase attention to facets of supervision that her supervisees identify as infrequent or lacking. Both the supervisor and supervisee, through their completion and reflection upon RSRS items, are reminded of the purpose and construct of RS/C, potentially increasing fidelity and quality of RS/C delivery.

The RSRS was developed in 2010 to support the *Kids Connect* project. Over time, as word of its existence spread, and with few, if any, other tools for assessing RS/C supervision adherence to core competencies and quality, requests for permission to use the RSRS increased. Although positively endorsed by its users, the psychometric properties of the RSRS had not been examined, and thus its utility as a measure of RS/C was supported by clinical experience and professional opinion only.

The Pennsylvania Early Intervention Reflective Supervision Project (PA-EIRS)

In 2011, Pennsylvania's Department of Human Services decided to invest training funds in RS/C training for 29 Part C Early Intervention (EI) supervisors. Part C EI is a federal- and state-supported system of services mandated through the Individuals With Disabilities Education Act (IDEA) to provide assessment and intervention for young children (birth to 3 years old) with disabilities (Hebbeler et al., 2007; IDEA, 2004). The Pennsylvania Early Intervention Reflective Supervision (PA-EIRS) project created a unique opportunity to design,

Table 1. Reflective Supervision Rating Scale Factors, Item Loadings, and Variance Explained

Factors and Items (% Variance explained, Cronbach's Alpha (α)		
Reflective Process and Skills (8.53%, α = .899) *Encouraging growth and skill development*		
Item	Question	Loading
7	...shows me how to integrate emotion and reason into case analysis.	.816
8	...has improved my ability to be reflective.	.873
10	...explores my thoughts and feelings about the supervisory process itself.	.852
11	...and I set the agenda for supervision.	.718
12	...thinks with me about how to improve my observation and listening skills.	.853
14	...encourages me to talk about emotions I have felt while consulting and working with families.	.699
Mentoring (7.06%, α = .851) *Providing a trusting, attentive, and collaborative learning relationship*		
Item	Question	Loading
1	...and I have formed a trusting relationship.	.862
4	...is engaged throughout the entire session.	.564
5	...is both a teacher and a guide.	.661
6	...makes me feel nurtured, safe and supported during supervision	.897
9	...allows me time to come to my own solutions during supervision	.678
13	...listens carefully for the emotional experiences that I am expressing.	.687
Supervision Structure (5.48%, α = .628) *Providing consistent and engaged supervision*		
Item	Question	Loading
2	...and I have established a consistent supervision schedule.	.857
3	...questions encourage details about my practice to be shared and explored within the supervision session.	.638
4	...is engaged throughout the entire session.	.610
Mentalization (4.15%, α = .856) *Understanding emotional, situational, and cultural influences on behavior*		
Item	Question	Loading
13	...listens carefully for the emotional experiences that I am expressing.	.675
14	...encourages me to talk about emotions I have felt while consulting and working with families.	.741
15	...keeps families' and children's unique experiences in mind during supervision.	.831
16	...wants to know how I feel about my consultation or practice experiences.	.763
17	...helps me explore cultural considerations in my work.	.792

implement, and measure the impact of RS/C training on EI supervisors. At that time, the goal was to collect evidence showing the effectiveness of RS/C training to justify its future and ongoing funding in early childhood systems. In retrospect, this project was also an opportunity to consider the "what" and "how" of measurement within RS/C.

The inclusion of the RSRS within the PA-EIRS project was, in some respects, serendipity and good luck. The PA-EIRS project needed to measure the impact of RS/C training on supervisor behavior. After a literature search produced no measures of RS/C, staff within PA-EIRS sought advice from RS/C experts at the 2011 ZERO TO THREE National Training Institute, at which time the RSRS was suggested. The first author (Gallen) was introduced to the second author (Ash), they identified the RSRS as a potential tool for the PA-EIRS project, and after exchanging emails, the RSRS was included within the PA-EIRS project as a measure of supervisor behavior at baseline and after 8 months of RS/C training. The first author (Gallen) also included the RSRS within a survey of supervision practices in Part C EI in Pennsylvania. Findings from each part of the project are described below.

Does RS/C Training Produce Change in Supervisor Behavior?

The RS/C training model and case study findings from the PA-EIRS project were previously described by Alexander and colleagues (Alexander, Gallen, Salazar, & Shahmoon-Shanok, 2012). The RSRS was used in this project to allow supervisees to reflect on the core components of RS/C and decide to what extent their own supervisor engaged in RS/C behavior, as a measure of supervisor exposure and adherence to the RS/C model, and supervisors completed the RSRS on themselves as a form of reflection on the extent to which they show RS/C behaviors, or not. Twenty-nine Part C EI supervisors completed 8 months of RS/C training with expert RS/C mentors and attended monthly regional group meetings. For data collection purposes, each supervisor was asked to recruit two of their present supervisees to participate in data collection. All supervisees and supervisors were asked to complete a baseline survey that included the RSRS and a final survey again including the RSRS at the end of 8 months of RS/C training. It is important to note that the 3-point scoring version of the RSRS was used in this project, and thus sensitivity to change over time may have been limited relative to the updated version of the RSRS. Preliminary results of the project have been presented at the ZERO TO THREE National Training Institute (Gallen, Salazar, & Brink, 2012) and described by Watson and colleagues (Watson, Neilsen Gatti, Cox, Harrison, & Hennes, 2014).

Comparing baseline RSRS ratings to those collected after 8 months of RS/C training, supervisees (*N* = 13) rated their supervisors as showing more frequent RS/C attitudes and actions on several RSRS items. Many supervisees rated their supervisors as already showing several RS/C attitudes or behaviors at pre-test, possibly making it difficult to measure incremental behavior change with RS/C training. Although not all items

achieved statistical significance, the desired increase in RS/C behaviors, whether moving from "Rarely" to "Sometimes," or "Sometimes" to "Almost Always," was evident for the majority of RSRS items. Gallen, Salazar, and Brink (2012) found statistically significant increases in RSRS ratings on 3 of 17 RSRS behaviors. These were Item 3 ("…questions encourage details about my practice to be shared and explored within the supervision session"), Item 9 ("…allows me time to come to my own solutions during supervision"), and Item 14 ("…encourages me to talk about emotions I have felt while consulting and working with families").

Gallen, Salazar, and Brink (2012) asked supervisors (*N* = 29), at baseline and 8 months, to self-report the extent to which they showed RS/C behaviors using a version of the RSRS phrased for supervisor self-reflection (e.g., "My supervisee and I…"). Supervisor self-ratings suggested that they perceived themselves as showing significant changes on 8 of 17 RSRS behaviors (Items 7, 8, 10, 11, 12, 14, 16, and 17) from baseline to follow-up. In spite of limitations such as small sample size and questions about the representativeness of the sample, these results do provide preliminary evidence that the RSRS is sensitive to change in supervisor behavior over time, that training in RS/C can produce measurable change in behavior identified by both supervisor and supervisee, and there is evidence to support the training model used in the PA-EIRS project (Alexander et al., 2012).

Although the RSRS appeared to be sensitive to changes in RS/C attitudes and behavior with training, additional PA-EIRS project findings suggest that the changes that did occur in supervisors with RS/C training may have translated into real changes in supervisee experience and practice, and potentially child and family outcomes. As the PA-EIRS project proceeded, it became clear from participant comments that the project's meaning and impact was exceeding expectations. In order to capture this phenomena, open-ended questions were added to the follow-up survey. Consistent with narrative studies of RS/C impact, PA-EIRS participants overwhelmingly affirmed the positive benefits of RS/C. Samples of participant comments are included in the box Changes in Supervision Experience.

RS/C in Part C EI

The first author (Gallen) also included the RSRS in an online survey distributed to Part C EI service provider agencies throughout Pennsylvania in 2011 prior to initiating the PA-EIRS project. One hundred fifty-four providers completed the survey. Because at the time the survey was distributed data was not collected statewide to identify the number of independent providers in PA, the representativeness of this sample and thus generalizability of these results to other Part C populations is unknown. With this limitation in mind, we, the PA-EIRS Research team (Willford, Smith, and Franco in collaboration with Gallen and Ash) used data from this survey to evaluate important psychometric properties of the RSRS. These results were recently presented at the World Association

---

Changes in Supervision Experience

Sample comments from participants in the Pennsylvania Early Intervention Reflective Supervision Project

Structural Changes
"The way she [the supervisor] has started to ask questions has changed."
"Since the start of the project, I have had scheduled monthly meetings with my supervisor."
"I have noticed that the pacing of our sessions has slowed…the sessions are much more relaxed."

Relationship Changes
"I have found that her responses during our sessions have softened a bit and have, indeed, become more reflective. I appreciate this."
"It is a richer, easier experience—more of a conversation rather than an explanation of how things are going."
"We have both tried to think of ways that we can work through some difficult situations."
"She is helping me to come to my own conclusions by being a supportive and trusting sounding board … and through asking the right questions."

Supervisee Behavior Changes
"I became more prepared and had specific topics to discuss."
"I have noticed that I have been more thoughtful about why I react the way I do."
"I have been more mindful of the effect I can have on others."

Changes in the Relationship With Their Supervisor?
"It's [the relationship has] become stronger, and I feel that she is someone that I can go to with questions/concerns without judgment."
"Since the start of this project, I think that my supervisor and I have grown closer and that she has gotten to know me better as an individual."

Noted Negative Experiences
"It can be annoying when she asks so many questions about how I feel and I just want to vent."
"I was told I needed to put myself out there more often, and I was called to task for that."
"I often wonder if this is the presupposed idea my supervisor has of how a case manager should be/act, or is she really trying to help me be more reflective in my work with the families?"

Have You Noticed Any Changes in the Quality of Your Work in Early Intervention?
"I feel that I am now more understanding of the fact that I cannot do it alone."
"I am less frustrated with the difficulties of some of the families. I feel like I have a partner to keep them in mind with me."
"I just try and give them more time to express their concerns."
"Families are able to get all of my time in a session. It is easier for me to focus on them … because I have a 'place' to discuss those concerns [supervision]."

---

of Infant Mental Health (Gallen, Franco, Smith, Ash, & Willford, 2016; Willford, Franco, Smith, Ash, & Gallen, 2016). The RSRS was found to have excellent internal consistency (α = .935), supporting one type of reliability of the questionnaire. *Internal consistency* is a statistic of how well items on the scale in

question measure the same idea or construct. The excellent internal consistency (on a 0 to 1.0 scale) of the RSRS suggests that its 17 items consistently measure RS/C producing similar scores across items.

We next subjected RSRS to Principal Components Analysis (PCA), a statistical method used to summarize the structure and/or "components" within a measurement scale. When a scale shows structure through PCA, it supports the validity of the scale as a measure of whatever it is trying to measure, in this case, RS/C. PCA on the RSRS showed one overall factor and four sub-scale factors explaining 68.47% of the variance within EI provider responses, showing evidence that the RSRS has validity as a measure of RS/C. We named the four sub-scale factors identified through PCA on the basis of item content including: Reflective Process and Skills (6 items), Mentoring (6 items), Supervision Structure (3 items), and Mentalization (5 items). Strong sub-factor reliability was demonstrated for the Reflective Process and Skills (α = .899), Mentoring (α = .851), and Mentalization (α = .856) subscales and moderate reliability for the Supervision Structure subscale (α = .628). Together, these results suggest that the RSRS measures RS/C overall and in sub-domains both reliably and validly. Demonstrating the strong internal consistency of the overall RSRS and the reliability of the subscales is useful both in clinical and research settings to measure and track RS/C in the early childhood workforce. We have planned future studies to redo PCA with different EI samples.

Next we addressed whether scores on the RSRS are associated with other measures they should be related to if RS/C is effective practice for supporting early childhood staff. Higher RSRS scores would indicate that supervisors showed "more" RS/C behavior, whereas lower scores would indicate "less" RS/C behavior. For RS/C to be considered "effective" practice, there needs to be evidence showing that more RS/C behavior is associated with benefits for early childhood provider staff (Eggbeer et al., 2010). These questions fall under the category of validity; does the RSRS accurately and effectively measure what it is supposed to measure? Concurrent Validity, a subtype of validity, refers to the association between a measure (e.g., the RSRS) and other measures of interest completed at the same time. The same 154 Part C EI providers described above completed, at the same time, the RSRS and measures of job satisfaction, work-life balance, and supervision quality questions, the Secondary Traumatic Stress Scale (STSS: Bride, Robinson, Yegidis, & Figley, 2004), a measure of symptoms related to the secondary exposure of trauma through one's work, and the Professional Quality of Life Scale—5th Edition (Stamm, 2010), a self-report tool measuring Compassion Satisfaction (pleasure one derives from one's work), Burnout (work related exhaustion, frustration, anger, and depression) and Secondary Trauma. Pearson Correlations between the RSRS total and factor scores, and the concurrent measures

Presently, RS/C remains a process-oriented intervention whose components are still being defined, and there is not yet a clear understanding of what to measure and how to measure it.

showed significant correlations found in the expected direction across many of the included measures.

These results show that when supervisees rated their supervisor higher on the RSRS they also gave higher ratings on job satisfaction (r = 0.467), quality of supervision (r = 0.655), work-life balance (r = 0.264), and Compassion Satisfaction (r = 0.237). RSRS scores were inversely associated with Burnout (r = -0.184), STSS total (r = -0.23), and Avoidance (r = -0.253) subscale scores. In other words, the higher a supervisee rated her supervisor on the RSRS, the lower the supervisee rated her own symptoms of Burnout and Secondary Traumatic Stress overall, and Avoidance symptoms specifically. At the RSRS factor level, each RSRS factor showed significant correlations with several of the measures as expected, with Mentoring (Quality of Supervision, r = 0.744; Job Satisfaction, r = 0.456; Work-Life Balance, r = 0.329; STSS Total, r = -0.320; Arousal, r = -0.359; Avoidance, r = -0.234; Burnout, r = -0.255; Compassion Satisfaction, r = 0.197) and Supervision Structure (Quality of Supervision, r = 0.413; Job Satisfaction, r = 0.308; Work-Life Balance, r = 0.213; STSS Total, r = -0.321; Arousal, r = -0.292; Avoidance, r = -0.341; Burnout, r = -0.2584; Compassion Satisfaction, r = 0.194) showing the strongest associations across measures and correlated significantly, and in the expected (and hoped for) direction for 8 of 10 outcomes. Reflective Process and Skills correlated significantly with 5 out of 10 of the measured variables (Quality of Supervision, r = 0.539; Job Satisfaction, r = 0.438; Work-Life Balance, r = 0.223; Avoidance, r = -0.202; Compassion Satisfaction, r = 0.198) and Mentalization correlating significantly with 3 of 10 measured variables (Quality fo Supervision r = 0.573; Job Satisfaction, r = 0.378; Compassion Satisfaction, r = 0.234). *Discriminant validity* provides evidence for a test when that test does not correlate with variables it should not correlate with. For example, ratings on the RSRS should not be associated with age or ethnicity because these are not variables that should be influenced by RSRS scores. Results demonstrated discriminant validity as the correlations between the RSRS Total and factor scores and age and ethnicity were not significant.

Although in need of replication with other populations, in different geographical areas, and in larger samples, these results do offer initial support for the validity of the RSRS. These results provide evidence that RS/C attitudes and actions, when implemented at higher rates according to supervisee report, are associated with positive supervisee attitudes and experiences previously predicted and described in the RS/C literature, but not yet empirically validated. Finally, it is important to note that the RSRS Mentoring and Supervision Structure factors associated significantly with several variables. Examining item content within these factors (see Table 1) suggests that qualities of the supervisory relationship, such as engagement, trust, nurturance, and consistency, may serve as unique contributors

to the impact of RS/C. Future research should examine the unique contributions of specific RS/C components to positive outcomes.

Conclusion

Measuring and monitoring the quality of innovative interventions, such as RS/C, "is often overlooked, or given lower priority than measuring outcomes" (Domitrovich et al., 2008, p. 7). The development of validated assessment tools to measure fidelity to the RS/C model and the quality of sessions is a necessary step in establishing RS/C as evidence-based practice. Ash (2010) applied theory and experience to the development of the RSRS as a tool useful in clinical settings for guiding supervisees in the RS/C experience, and for attaining feedback for supervisors providing RS/C. The RSRS was later used to assess supervisor and supervisee experiences in a state Part C EI system and used to measure change within an effort to promote the use of RS/C in that system. The RSRS was found to be reliable and to have a factor structure that supported its positive psychometric qualities. Associations with important measures completed at the same time suggested that when a supervisee reports that his supervisor engages in higher rates of RS/C behavior or attitudes, he also reports higher rates of job satisfaction and Compassion Satisfaction, and rates his supervisor as being of higher quality. Higher ratings on the RSRS were also found to be inversely related to lower scores on measures of Secondary Traumatic Stress and Burnout. RSRS results demonstrated that Part C EI supervisors who engaged in 8 months of RS/C training showed increases in RS/C behaviors and attitudes. The supervisees, subsequently, described their supervision as enhancing their experience of the supervisory relationships and connected this to improved quality of services provided to very young children and their families. As such, these preliminary findings may suggest that the RSRS is sensitive to change in RS/C practices over time, supporting the training RS/C training model used in this project. There are certainly many "next steps" to take, and many more questions left unanswered. The RSRS, thus far, has shown promise as an inexpensive, quick, and easy-to-use measure of RS/C that has initial evidence supporting its psychometric qualities. These qualities support its potential usefulness in future efforts to answer some of those questions.

Robert T. Gallen, PhD, is a licensed clinical psychologist and professor of practice at the University of Pittsburgh where he coordinates the Master of Science in Applied Developmental Psychology program. He was founding president of the Pennsylvania Association for Infant Mental Health and is a fellow in the ZERO TO THREE Academy. He teaches courses in infant mental health and evidence-based practices.

Jordana Ash, LCSW, IMH-E® (IV), is director of early childhood mental health in the Colorado Office of Early Childhood, Department of Human Services. She is the first to hold this position, which represents public-private partnership and state-level commitment to the role. Ms. Ash previously held the position of senior program manager of early childhood services at Mental Health Partners in Boulder, Colorado. She developed the award-winning, nationally recognized Kid Connects: Integrated Health and Mental Health model of early childhood mental health consultation. She is the author of the *Kid Connects Implementation Manual*, a three-volume resource for communities replicating the Kid Connects model. She is an Irving Harris Graduate in Child Development and Infant Mental Health at the University of Colorado Denver and is an instructor with the Harris Program. She achieved Endorsement for Culturally-Sensitive, Relationship Focused Practice Promoting Infant Mental Health® as an Infant Mental Health Mentor-Clinical in 2010.

Conner Smith received his bachelor of science in psychology-neuroscience from Slippery Rock University. His research focuses on the effects of prenatal drug exposure on brain development. He is currently a clinical manager at George Junior Republic and plans to attend medical school.

Allison Franco earned a bachelor of science in psychology from Slippery Rock University and is currently a graduate student within the master's of social work program at California University of Pennsylvania. She is the current graduate assistant at the Women's Center and End Violence center. As an undergraduate, Allison's research focused primarily on empathy.

Jennifer Willford, PhD, is an associate professor of psychology at Slippery Rock University. She is the director of the neuroscience program and core faculty for the Honors Developmental Psychology program. Her research, for the past 20 years, has focused on at-risk children and the impact of prenatal drug exposure on the development of the brain and cognitive behavior. She teaches courses in research methodology, neuroscience, drugs and behavior, and positive psychology.
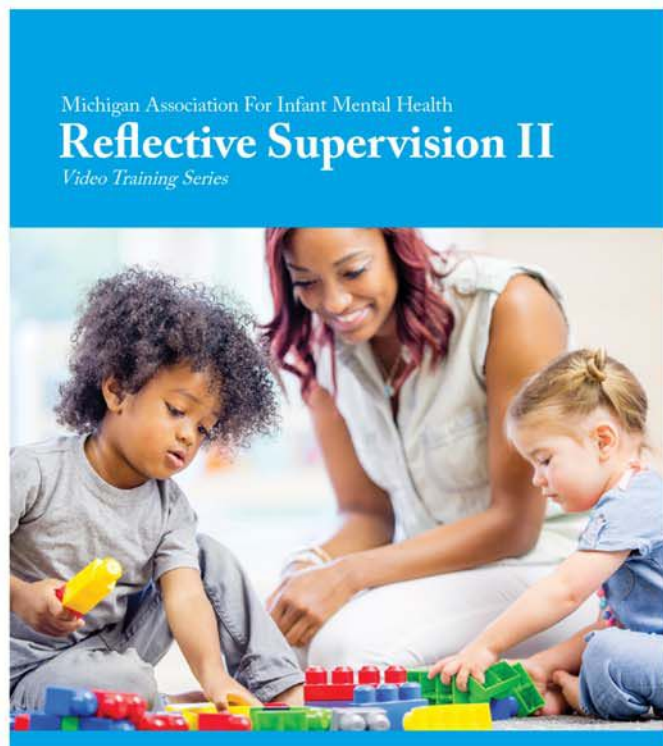
References

Alexander, L., Gallen, R. T., Salazar, R., & Shahmoon-Shanok, R. (2012). Fighting fires with reflective supervision in a state early intervention system: Trading an axe for Mr. Roger's slippers. *ZERO TO THREE, 32*(6), 32–37.

Ash, J. (2009). *Kid Connects: Integrated health and mental health consultation in early care settings.* Unpublished manuscript.

Ash, J. (2010). *Reflective Supervision Rating Scale.* Unpublished assessment tool.

Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M., & Czajkowski, S. (2004). Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from the NIH Behavior Change Consortium. *Health Psychology, 23*, 443–451.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 14*(1), 27–35.

Domitrovich, C. E., Bradshaw, C. P., Poduska, J. M., Hoagwood, K., Buckley, J. A., Olin, S., ... Ialongo, N. S. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion, 1*(3), 6–28.

Early Head Start National Resource Center. (n.d.). A collection of tips on becoming a: Reflective supervisee. Retrieved from https://eclkc.ohs.acf.hhs. gov/hslc/tta-system/ehsnrc/docs/rs-supervisee-info-sheet.pdf

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science, 1,* 1–3. Doi:10.1186/1748-5908-1-1

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Toward an evidence base for reflective supervision. *ZERO TO THREE, 31*(2), 39–45.

Fenichel, E. (1992). Learning through supervision and mentorship to support the development of infants, toddlers, and their families. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers, and their families: A source book* (pp. 9–17). Washington, DC: ZERO TO THREE.

Gallen, R. T., Franco, A., Smith, C., Ash, J., & Willford, J. A. (2016, June). *Validity of the Reflective Supervision Rating Scale.* Poster presented at the 15th World Association of Infant Mental Health Conference, Prague, Czech Republic.

Gallen, R. T., Salazar, R., & Brink, M. B. (2012, December). *Reflecting on early intervention supervision.* Poster presented at the ZERO TO THREE National Training Institute, Los Angeles, CA.

Gilkerson, L. (2004). Irving B. Harris distinguished lecture: Reflective supervision in infant–family programs: Adding clinical process to nonclinical settings. *Infant Mental Health Journal, 25*(5), 424–439.

Hebbeler, K. M., Spiker, D., Bailey, D., Scarborough, A., Mallik, S., Simeonsson, R., et al. (2007). *National Early Intervention Longitudinal Study (NEILS): Early interventions for infants and toddlers with disabilities and their families: Participants, services, and outcomes.* Retrieved from www.sri.com/neils

Heffron, M. C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs.* Washington, DC: ZERO TO THREE.

Heller, S., & Gilkerson, L. (Eds). (2009). *A practical guide to reflective supervision.* Washington, DC: ZERO TO THREE.

Individuals With Disabilities Education Improvement Act, 20 U.S.C. § 1400 et seq. (2004).

King, H. A., & Bosworth, H. (2014). Treatment fidelity in health services research. In L. M. H. Sanetti & T. R. Kratochwill (Eds.) *Treatment Integrity: A foundation for evidence-based practice in applied psychology* (pp. 15–33). Washington, DC: APA Publications.

Pack, M. (2012). Two sides to every story: A phenomenological exploration of the meanings of clinical supervision from supervisee and supervisor perspectives. *Journal of Social Work Practice, 26*(2), 163–179.

Sanetti, L. M. H., & Kratochwill, T. R. (2014). Introduction: Treatment integrity in psychological research and practice. In L. M. H. Sanetti & T. R. Kratochwill (Eds.), *Treatment integrity: A foundation for evidence-based practice in applied psychology* (pp. 3–11). Washington, DC: APA Publications.

Siegel, D. J., & Shahmoon-Shanok, R. (2006). Reflective supervision for an integrated model: What, why & how? In Foley, G. and Hochman, J. (Eds.), *Mental health in early intervention: A unity of principles and practice* (pp. 343–382). San Francisco, CA: Jossey-Bass.

Stamm, B. H. (2010). *The concise ProQOL manual.* Pocatello, ID: ProQOL.org.

Tomlin, A. M., Sturm, L., & Kock, S. M. (2009). Observe, listen, wonder, and respond: A preliminary exploration of reflective function skills in early care providers. *Infant Mental Health Journal, 30*(6), 634–647.

Tomlin, A. M., Weatherston, D. J., & Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant Mental Health Journal, 35*(1), 70–80.

Virmani, E. M., & Ontai, L. L. (2010). Supervision and training for child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal, 31*(1), 16–32.

Watkins, C. E. (2015). The alliance in reflective supervision: A commentary on Tomlin, Weatherston, and Pavkov's critical components of reflective supervision. *Infant Mental Health Journal, 36*(2), 141–145.

Watson, C., & Neilsen Gatti, S. (2012). Professional development through reflective consultation in early intervention. *Infants & Young Children, 25*(2), 109-121.

Watson, C., Neilsen Gatti, S., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. In E. Nwokah & J. A. Sutterby (Eds.), *Early childhood and special education, advances in early education and day care*, Vol. 18 (pp. 1–25). Bingley, UK: Emerald Publishing.

Willford, J. A., Franco, A., Smith, C., Ash, J., & Gallen, R. T. (2016, June). *A Principle Components Analysis of the Reflective Supervision Rating Scale.* Poster presented at the 15th World Association of Infant Mental Health Conference, Prague, Czech Republic.

Wilson, H. M. N, Davies, J. S., & Weatherhead, S. (2016). Trainee therapists' experience of supervision during training: A meta-synthesis. *Clinical Psychology & Psychotherapy, 23*(4), 340–351.

ZERO TO THREE. (2016). *Three building blocks of reflective supervision.* Retrieved from https://www.zerotothree.org/ resources/412-three-building-blocks-of-reflective-supervision

Measuring Process Elements in Reflective Supervision

An Instrument in the Making

Karen Moran Finello
WestEd Center for Prevention & Early Intervention
Sacramento, California

Mary Claire Heffron
Berkeley, California

Barbara Stroud
Palo Alto, California

Abstract

Reflective supervision is increasingly mandated in evidence-based infant and early childhood programs and is, therefore, experiencing rapid expansion across the United States. The growing interest in reflective supervision has led to new questions about how to train, support, and gauge the competency of supervisors who are supporting and educating providers. However, to date, most research has been qualitative, small-scale, and exploratory in nature with very few defined constructs. This article describes an instrument currently being piloted that was designed to assess the presence and quality of essential process elements of reflective supervision using digital recordings.

In infant and early childhood programs, reflective supervision is considered a valued practice used with increasing frequency to support providers in a variety of roles working with infants, young children, and their families. While providing support, the practice of reflective supervision also consciously builds the capacity of the provider to use interventions that enhance the reflective capacity of parents and caregivers and to monitor program quality and outcomes. Reflective supervision has been used within a wide range of infant and early childhood programs, including infant mental health, home visiting, early intervention, child welfare, family support, and early education. It is increasingly seen as a key part of trauma-informed practice intended to improve the social, emotional, and overall development of children from birth to 5 years old and their families (Van Berckelaer, 2011).

Reflective supervision has been described in some detail in numerous articles and books, and a study identified the growing consensus regarding elements of reflective practice

and supervision as core components of infant mental health and relationally focused work for young children and families across systems (Tomlin, Weatherston, & Pavkov, 2014). The implementation of an evidence-based practice requires training in areas such as supervision, coaching, and other forms of support that help providers to effectively implement new approaches or develop more skill in their interventions (Blase, Van Dyke, & Fixsen, 2009). The implementation literature on workforce training provides three important premises: (a) high-quality training can be an effective approach to workforce development; (b) professionals must be able to work in an environment that allows them to effectively implement training strategies that they have learned; and (c) supervision, monitoring, and mentoring are critical to the process (Finello, Hampton, & Poulsen, 2011).

Kilminster and Jolly (2000) reviewed the literature to examine supervision practices and concluded that the "quality of the relationship between supervisor and trainee is probably the

Photo: Kiwi Street Studios

Reflective supervision has been used within a wide range of infant and early childhood programs, including infant mental health, home visiting, early intervention, child welfare, family support, and early education.

single most important factor for effective supervision" (p. 828). Gibbs (2001) hypothesized that early supervisory relationships may be a critical factor in staff retention and their own later supervision styles and called for a focus on learning through reflective practice. Gibbs further maintained that supervision is a challenging and "highly skilled job which warrants specialized training and support" (p. 331), and that it is essential for organizations to give a strong message about the critical role that supervisors play. However, to date, most research on supervision has been qualitative, small-scale, and exploratory in nature with very few defined constructs.

Within the infant and early childhood field, there has been considerable interest in addressing the lack of research related to the efficacy of reflective supervision (Eggbeer, Shahmoon-Shanok, & Clark, 2010) and in developing an evidence base for this practice. There is a need for clear and specific training and ongoing mentoring for reflective practice facilitators/supervisors, along with organizational support and a strong evaluative component which can measure the efficacy of reflective supervision and its impact on agency infrastructure, staff attrition, and direct work with young children and their families. In order to do this, it is essential to identify not only the critical elements necessary for training and support of high-quality reflective supervisors but also how skill-based training in reflective supervision is actually applied in programs. In addition, it is urgent that methods be established to provide feedback and suggestions to professionals providing reflective supervision in order to help them improve their practice and to those seeking initial endorsements as reflective practice supervisors and mentors.

Assessing Quality in Reflective Supervision

As interest in reflective supervision has grown, so has the movement toward a definition of its critical components and

quality indicators, standards to address basic competencies required to provide reflective supervision, and the emergence of paper and pencil tools to examine supervision quality (Tomlin et al., 2014). Recognizing the need for standards, in 2009, a task force in California focused on infant-family and early childhood mental health developed guidelines and personnel competencies for reflective practice and for reflective practice "facilitators." The guidelines and personnel competencies were designed as a first step toward providing a more comprehensive description of reflective supervision which could then be used as the basis for providing training and support for reflective supervisors in the birth to 5 field. These guidelines followed work beginning in the 1990s to ensure the quality of infant-family and early childhood services throughout California, with the mission of supporting the development of competent personnel in communities across the state. The work was conducted within the auspices of the California Center for Infant-Family and Early Childhood Mental Health (2012), supported through the WestEd Center for Prevention and Early Intervention. It was guided by visionary leaders in early childhood mental health as well as affiliated associates from a variety of related early childhood organizations committed to working together to build strong linkages across early childhood systems, to providing expert advice and guidance, and to developing formal training guidelines and recommended personnel competencies for practitioners. These guidelines were published and made available through the California Center website and are currently described in the California Compendium of Training Guidelines, Personnel Competencies, and Professional Endorsement Criteria for Infant-Family and Early Childhood Mental Health (California Center for Infant-Family and Early Childhood Mental Health, 2016).

Although the California Compendium specified the experience, training, competencies, and hours of supervision needed for endorsement as reflective supervisors, a need remained for a mechanism to measure or rate an individual reflective supervisor's use of reflective supervisory processes. Such a rating, along with feedback on the skills exhibited, was important to the process of endorsing individuals to provide reflective supervision or to mentor other reflective supervisors.

An opportunity to address this measurement gap arose as one of the co-authors conducted an evaluation of issues contributing to family and staff attrition in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funded programs (U. S. Department of Health and Human Services, Health Research and Services Administration, 2016) across California between 2011 and 2016. The MIECHV competitive grant in California focused on 10 communities that reported significant family and community risk factors, including (but not limited to):

• histories of domestic violence,

• histories of substance use,

• high rates of neighborhood crime,

- family involvement in the child welfare system or histories of child abuse,

- young maternal age or recent transition from the foster care system,

- cultural and language barriers,

- limited access to prenatal care,

- geographic isolation,

- high rates of infant mortality and low birthweight,

- transportation and housing issues, and

- low utilization of health and social services.

The intent of the grant was to use quantitative and qualitative evaluation methods to rigorously monitor and document factors contributing to enrollment and retention of the highest needs populations as identified by sites, with the ultimate goal of building knowledge to support the improvement of the service delivery system for home visiting in California. The project was designed to build a comprehensive, high-quality maternal and early childhood system and to improve coordination of services within high-risk and hard-to-engage communities in order to reduce the impact of toxic stress on child and family development.

During the initial phase of the MIECHV program, evaluators determined that family risk factors had a significan impact on home visitors' ability to manage caseloads, cope with unmet family needs for mental health services, and provide the "holding" environment needed by many of the young mothers living in extreme poverty and with significant trauma and abuse histories. Although reflective supervision is mandated within the evidence-based home visiting programs adopted by the California MIECHV program, most supervisors reported a lack of skills and ability to apply the principles with staff who were sometimes resistant to the idea of reflective practice. Almost all identified a need for deeper training and support in providing reflective supervision to home-based staffs. Part of the evaluation efforts were thus focused on determining gaps in the training and mentoring of reflective supervisors, developing mechanisms to begin to fill those gaps, examining staff ratings of the reflective supervision process, designing pilot scales to allow reflective supervisors to rate their level of confidence and skills in providing this type of supervision, and providing recommendations to home visiting program leadership and funders around additional needs in reflective supervision and staff retention. We were able to leverage the work already being conducted with reflective supervisors in the California MIECHV-funded home visiting programs and expand on the work by initiating development of the Reflective Supervision Competency Scale (RSCS; Finello, Heffron, Stroud, & Kocsis, 2016) described in this article. Leaders in the field of reflective supervision worked with the California MIECHV external evaluation team to develop a tool which would permit observation and rating of segments of supervisory sessions using digital recordings of the sessions.

Almost all identified there is a need for deeper training and support in providing reflective supervision to home-based staffs.

Development of the RSCS

Although checklists and self-assessments are extremely valuable, we were convinced that there was value and a need for an instrument that would use digital recordings to permit us to observe and measure critical elements of reflective supervision, the notion of a reflective stance, and the internal process of the supervisor. We were all familiar with Victor Bernstein's work with home visitors using videotape of home visiting sessions with families, review of those tapes by supervisors with the home visitors, and occasional consultation for the supervisors including tape review and discussion in groups to support the supervisors in deepening their skills (Bernstein, Campbell, & Akers, 2001). As consultants and trainers, some of the RSCS instrument developers had used videotapes both of home visiting sessions and of supervision sessions to build the skills of individual supervisees and, at times, had shared these materials in confidential supervision groups. This work using videotapes often prompted the question from those being videotaped about what was being examined, along with specific questions about intent, logistics, and confidentiality. We began to discuss how an instrument that laid out core process elements, contained clear directions, and answered basic questions about its use would support our own on-going training efforts, self-assessment and growth in practitioners, and a variety of other evaluative purposes.

The RSCS was designed to observe and evaluate process elements considered by many experts to be critical for effective supervision in any organization or agency. An instrument that can identify and measure the presence or absence of key supervisory process elements (and, particularly, qualities of interpersonal interactions between the supervisor and supervisee) will allow individuals to chart their growth in professional development as supervisors. Such a measure may also allow agencies to become more confident that reflective supervision is being implemented with fidelity. The use of this kind of instrument will help programs, researchers, and

Risks in the family and community are usually experienced by very young children through the effects of such risks upon their parents.

others to promote use of best practice elements of reflective supervision. Infant and early childhood endorsement systems, individual agencies, systems of care, as well as researchers and evaluators can potentially use this instrument to address a variety of training and evaluation needs.

In considering the elements that could be observed, such as communicative body language, affective tone, and pacing, we also began to wonder about the supervisor's self-awareness and internal processes that guide the session and drive the selection of questions and comments. We knew from our own experience that the real-time video recording process would be useful but wondered how we could get at the supervisor's internal processes. These internal processes are key to the supervisor's decisions about how to ask questions, what to pursue, when to let go, and when to intervene if a supervisee seems to be missing a critical perspective or is being derailed by a blind spot in his thinking. Because of this need, we decided to add a one-page narrative to accompany the instrument that would ask the supervisor completing the digital recording to write about what he was thinking as he conducted the reflective supervision segment captured in the digital recording. Several prompts were added, including, "What were you sensing, feeling, and thinking during this recording?"

As we considered how we might move this idea of measurement of key processes in reflective supervision, a number of other questions arose. For example, could these processes be measured in the dynamic field of relationship-based work that

supports flexibility in our diverse communities, while adhering to the primary values of relational health so foundational across the infant and early childhood fields? Fortunately, the field has provided strong content to guide reflective supervision (see Learn More box). In addition, all authors are experienced supervisors and trainers committed to the development of such an instrument. A first step in developing the RSCS involved extensive discussion about process elements of reflective supervision and the reflective relationship, and thinking about how to use measurable terms to evaluate these elements through observation. Our primary process targets became the following:

- attunement to the supervisee and the process

- emotional regulation in the supervisor and co-regulation skills with the supervisee(s)

- collaboration and trust in the relationship to allow for reflection and introspection

- attention to issues of culture and diversity within the supervision relationship and service provision

- balance in the session between macro and micro elements, between process and content, between being with versus gentle guidance, between self and client, between program mission and program, and between work requirements and ethical issues

- addressing a variety of clinical and administrative challenges while using a reflective lens

With a working definition of process elements in place, the next step was to produce objective criteria for each of the concepts. We wanted the criteria to be broad enough to contain a host of situations and approaches that would work across settings and program types. For example, we knew that emotional regulation and co-regulation are key process elements, but that such regulation can show up in many different ways during reflective supervision. We knew that our criteria for these process elements needed to be clear enough so that anyone using the instrument would be able to recognize and rate the process elements. We agreed to use a Likert-type scale of measurement to indicate whether each element was "not yet in evidence," "demonstrated partially," or "fully demonstrated." The next task was to generate a list of observable behaviors for each process element, such as, "The reflective supervisor shows mindfulness of own experience" (e.g., avoids constant referral to her own experiences, slows down process as needed, uses a gentle voice to help calm, ties own affective experience during conversation to help illustrate understanding). We tested this list of behaviors using a 20-minute reflective supervision segment. We then pared down the number of items to allow for more efficient review of the multiple elements at play during a supervision session.

Next Steps

Upcoming tasks include consultations with reflective supervision specialists about potential piloting and examination of reliability and validity across multiple supervisors in varied

geographic locations and program types. We also plan to use digital recordings of reflective supervision sessions from a volunteer group of already endorsed or highly skilled reflective supervisors to further explore the reliability of the instrument and receive their feedback. The goal is to ensure that the process elements and behavioral descriptors are recognizable and seen as similar by a group of independent reviewers experienced in providing reflective supervision. The second step will be to use the RSCS scale with beginning supervisors who are in the process of learning reflective supervision skills to determine if the instrument is useful in identifying strengths, areas of needed growth, and areas where a particular element is absent. In choosing participants to pilot this new tool, diversity of ethnicity, settings, and discipline will be important. Following several rounds of field testing, the co-authors will reconvene and systematically review the pilot testing to make necessary adjustments in the items and structure of the instrument. The scale will then be sent out for another review by experts in the field, trainers, and practitioners who would be potential users of such an instrument. Parallel to these processes, we will be in discussion with program administrators, policymakers, and supervisors to develop a process for digital taping that would be accepted by programs; that will meet privacy needs of the agencies, supervisee's, and clients; and that will meet health care privacy standards.

Summary and Significance

There is increasing recognition of the cumulative and persistent impact of risk conditions that threaten the well-being of infants and young children and the population as a whole, described by Shonkoff and his colleagues as "toxic stress" (2012), and research shows that the number of children impacted is growing significantly. Risks in the family and community are usually experienced by very young children through the effects of such risks upon their parents, who may either buffer the risks or exacerbate them (Calkins, 2011; Zeanah & Zeanah, 2009). Research notes the important role of nurturing and sensitive parenting upon early development; thus, risk conditions most likely to reduce maternal responsiveness and sensitivity (e.g., maternal depression, substance use, domestic violence) can have serious and lasting impacts on the young child (Goodman & Brand, 2009; Ostler, 2008; Shonkoff, 2006; Wachs, Black & Engle, 2009; Yates, Egeland, & Sroufe, 2003). In fact, the quality of early relationships is a basic determinant of healthy social, emotional, and behavioral development in infants and very young children (National Scientific Council on the Developing Child, 2008; Sroufe & Fleeson, 1986). Therefore, targeting high-risk populations who are most likely to be experiencing depression, substance abuse, and domestic violence has the potential to significantly buffer and reduce levels of toxic stress associated with child abuse, foster care placement, child behavioral and parent-child interaction problems (Finello & Poulsen, 2011). These facts highlight the critical need to hire and retain skilled service providers who are able to work to address the wide variety of risks that threaten relational health in very young children and their families. It is critical

to recognize that effective intervention for vulnerable, high-risk populations demands highly qualified providers who are receiving appropriate support and opportunities for reflection about the challenges encountered in their daily work. Service providers need and deserve a form of supervision that supports them in engaging with families in ways that impact the families' capacities to nurture and support themselves and their very young children.

According to Blase and her colleagues (2009), the process of implementation of quality evidence-based programs should include "installing the infrastructure and processes needed to …sustain effective services over time and across practitioners" (p. 14). The RSCS described in this article is a tool that we hope will be used in the important process of the implementation and sustainability of evidence-based and evidence-informed practices supporting providers who are serving very young children and families living in adverse circumstances and coping with significant risks in their daily lives. By ensuring that reflective supervisors are receiving the training they need and actually applying essential elements of reflective practice in their work with the providers that they supervise, programs will increase their capacity to improve service delivery, increase staff and family retention, and improve family satisfaction and outcomes in the important and challenging work being done in infant and early childhood programs.

Authors' Note

The Reflective Supervision Competency Scale is available from Karen Moran Finello. Email her at kfinell@wested.org.

Learn More

Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers, and their Families: A Source Book
E. Fenichel (Ed.) (1992)
Arlington, VA: ZERO TO THREE

Reflective Supervision and Leadership in Infant and Early Childhood Programs
M. C. Heffron & T. Murch (2010)
Washington, DC: ZERO TO THREE

Finding the Words, Finding the Ways: Exploring Reflective Supervision and Facilitation
M. C. Heffron & T. Murch (2012)
Sacramento, CA: California Center for Infant-Family & Early Childhood Mental Health @ WestEd Center for Prevention and Early Intervention

A Practical Guide to Reflective Supervision
S. S. Heller & L. Gilkerson (Eds.) (2009)
Washington, DC: ZERO TO THREE

Karen Moran Finello, PhD, is an applied developmental psychologist with a specialization in birth to 5-year-olds and their families. She has been the principal investigator for the external evaluation for the California Maternal, Infant, and Early Childhood Home Visiting Competitive Program and provides training and technical assistance nationally to Part C early intervention and home visiting programs. Dr. Finello is endorsed as an Infant, Family and Early Childhood Mental Health Specialist and a Reflective Practice Facilitator Mentor by the California Center for Infant-Family and Early Childhood Mental Health and has provided reflective supervision for more than 30 years to home-based infant/toddler/early childhood program staff. Previously an associate professor at the University of Southern California Keck School of Medicine and at the California School of Professional Psychology in Alliant University (Los Angeles), she is currently a project director in the WestEd Center for Prevention and Early Intervention. She has directed home visiting programs for NICU graduates, very young children with behavioral and mental health issues, and children under 3 years old at risk for developmental problems since 1983. Dr. Finello has extensive clinical, training, and research expertise in early intervention, infant and preschool behavior, assessment, home visiting, and reflective supervision. Her current work includes direct service, outcome research, and teaching on both the pre-service and in-service level for interdisciplinary infant-family and early childhood professionals. She has provided consultation to school districts; hospitals; and community, state, national, and international organizations in the areas of infant mental health, early childhood development, reflective supervision, and program development.

Mary Claire Heffron, PhD, is a clinical psychologist with an extensive history in the field of infant and early childhood mental health. Dr. Heffron held leadership positions in the Early Intervention Services Program at University of California San Francisco Benioff Children's Hospital Oakland for 25 years, and, since her retirement in 2015, has remained engaged with these programs as a consultant and mentor. Dr. Heffron is a member of the workgroup that has developed and implemented the Infant Family and Early Childhood Competencies, Personnel Competencies, and Endorsement System in California and is active in those efforts, specifically focusing on reflective facilitation and mentorship. She is the co-author of a widely used text on reflective supervision and the author of multiple articles and a DVD on the topic. Currently, Dr. Heffron is involved in a number of national and local projects designed to develop and deepen reflective supervision practice in public health, infant mental health, home visiting, and family support programs.
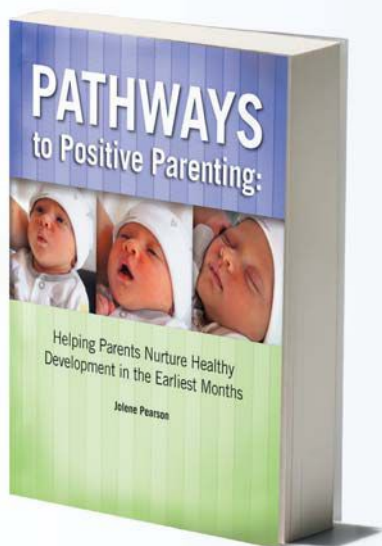
Barbara Stroud, PhD, is a licensed psychologist with more than two decades worth of culturally informed clinical practice in the early childhood development and mental health. She is a ZERO TO THREE Graduate Fellow and holds prestigious endorsements as an Infant and Family Mental Health Specialist/ Reflective Practice Facilitator Mentor with the California Center for Infant-Family and Early Childhood Mental Health. Embedded in all of her trainings, publications, clinical service models, and consultation are the practices of reflective supervision, sensitivity to cultural uniqueness, and a focus on relational health. Presently, Dr. Stroud is among the distinguished faculty of the University of California Davis Extension, Napa Infant-Parent Mental Health Fellowship. Dr. Stroud is particularly passionate about the unique needs of children of color in the mental health and foster care systems and has had a long history of working with the Los Angeles County Department of Mental Health to infuse reflective and culturally mindful course of action in developing service programs that support the goals of a relationship-based framework within the context of a government contracted organization.

References

Bernstein, V. J., Campbell, S., & Akers, A. (2001). Caring for the caregivers. In J. N. Hughes, A. M. LaGreca, & J. C. Conoley (Eds.), *Handbook of psychological services for children and adolescents* (pp. 107–131). New York, NY: Oxford University Press

Blase, K. A., Van Dyke, M., & Fixsen, D. (2009). Commentary on evidence-based programming in the context of practice and policy. *Social Policy Report, XXIII (*III), 14–15.

California Center for Infant-Family and Early Childhood Mental Health. (2012). *Home*. Retrieved from http://cacenter-ecmh.org/wp/home

California Center for Infant-Family and Early Childhood Mental Health (2016). *California compendium of training guidelines, personnel competencies, and professional endorsement criteria for infant-family and early childhood mental health.* Sacramento: WestEd.

Calkins, S. D. (2011). Caregiving as coregulation: Psychobiological processes and child functioning. In A. Booth, S. M. McHale, & N. C. Landale (Eds.), *Biosocial foundations of family processes.* National Symposium on Family Issues, (pp. 49–59). New York, NY: Springer.

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *ZERO TO THREE, 31*(2), 39–45.

Finello, K. M., Hampton, P., & Poulsen, M. K. (2011). *Challenges in the implementation of evidence-based mental health practices for birth-to-five year olds and their families: Issue brief based on National Think Tank on Evidence-Based Practices in Early Childhood.* Sacramento, CA: WestEd Center for Prevention & Early Intervention.

Finello, K. M., Heffron, M. C., Stroud, B., & Kocsis, P. (2016). *Reflective Supervision Competency Scale.* Sacramento, CA: WestEd.

Finello, K. M., & Poulsen, M. K. (2011). Unique system of care issues and challenges in serving children under age 3 and their families. *American Journal of Community Psychology, 49*(3), 417–429.

Gibbs, J. (2001). Maintaining front-line workers in child protection: A case for refocusing supervision. *Child Abuse Review, 10*(5), 323–335.

Goodman, S. H., & Brand, S. R. (2009). Infants of depressed mothers: Vulnerabilities, risk factors and protective factors for the later development of psychopathology. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health*, (3rd ed., pp. 153–170). New York, NY: Guilford Press.

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in clinical practice settings: A literature review. *Medical Education, 34*(10), 827–840.

National Scientific Council on the Developing Child. (2008). *Mental health problems in early childhood can impair learning and behavior for life.* (Working Paper No. 6). Retrieved from www.developingchild.harvard.edu

Ostler, T. (2008). *Assessment of parenting competency in mothers with mental illness.* Baltimore, MD: Brookes.

Shonkoff, J. P. (2006). A promising opportunity for developmental and behavioral pediatrics at the interface of neuroscience, psychology, and social policy: Remarks on receiving the 2005 C. Anderson Aldrich Award, *Pediatrics, 178*(5), 2187–2191.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., … & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*, e232-e246. doi: 10.1542/peds.2011-2663

Sroufe, L. A., & Fleeson, J. (1986). Attachment and the construction of relationships. In W. W. Hartup & Z. Rubin (Eds.) *Relationships and development* (pp. 51–71). Hillsdale, NJ: Erlbaum.

Tomlin, A. M., Weatherston, D. J., & Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant Mental Health Journal, 35*(1), 70–80. DOI: 10.1002/imhj.21420

U. S. Department of Health & Human Services, Health Research and Services Administration. (March, 2016). *Demonstrating improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A report to Congress.* Available at http://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/reportcongress-homevisiting.pdf

Van Berckelaer, A. (2011). *Using reflective supervision to support trauma-informed systems of care.* A White Paper developed for the Multiplying Connections Initiative. www.multiplyingconnections.org

Wachs, T. D., Black, M. M., & Engle, P. L. (2009). Maternal depression: a global threat to children's health, development, and behavior and to human rights. *Child Development Perspectives, 3*(1), 51–59.

Yates, T. M., Egeland, B., & Sroufe, A. (2003). Rethinking resilience. A developmental process perspective. In S. S Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 243–266). New York, NY: Cambridge University Press.

Zeanah, C. H., & Zeanah, P. D. (2009). The scope of infant mental health. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health*, (3rd ed., pp. 5–21). New York, NY: Guilford Press.

Strengthening Reflective Capacity in Skilled Home Visitors

Linda Gilkerson
Erikson Institute

Jaci Imberger
Taos First Steps
Taos New Mexico

Abstract
This article describes the FAN (Facilitating Attuned Interactions) approach to attunement in relationships and how it serves as a framework for reflective practice in an exemplary home visiting program. The authors highlight the role of the FAN as a tool for "reflection-in-action" and as a guide for "reflection-on-action." The process of learning the FAN combines formal training with mentored practice within the reflective supervisory relationship. There is a parallel process for the supervisor who is mentored by a FAN trainer through a similar reflective process. Home visitors reported changes in the perspectives and practices as they incorporated the FAN into their reflective practice, as did the supervisor as she grew in her capacity to provide reflective supervision.

Taos First Steps is a state-funded home visiting program which serves 170 families from pregnancy through their child's first 3 years who are living in Taos County, New Mexico. The program is 10 years old and has a strong foundation in infant mental health practice with the parent-child relationship as its central focus. The staff consists of both very experienced and new home visitors, a data coordinator, and the program supervisor. The team is trained in emotional intelligence, trauma-informed practice and trauma stewardship, Circle of Security, Infant Massage, Keys to Caregiving, and reflective practice. Of the nine home visitors, seven have their infant mental health endorsement. The supervisor is deeply committed to the use of reflection as a way to build capacity in both parents and in the staff. Four years ago the supervisor and several staff attended an introductory training on the FAN (Facilitating Attuned Interactions; Gilkerson et al., 2012; Heffron et al., 2016), an approach to engagement in relationships and reflective practice. The structure that the FAN approach provides for reflection was immediately attractive to them, as was the emphasis on Mindful Self-Regulation which seemed to fit so well with their work on emotional intelligence. Here we describe their journey toward infusing the FAN into their reflective practice with families and within the supervisory relationship.

FAN: A Framework for Engagement and Reflective Practice

The FAN is a model for engagement in relationships and a framework for reflective practice. The theory of change guiding the FAN is attunement. *Attunement* in helping relationships is defined as feeling connected and understood. The felt experience of being understood opens the possibility for change and for trying new ways. One important guideline of the FAN is to first see the child the parent sees or more broadly, to first see the world the parent sees. From this empathic stance, parents can feel heard and more open to seeing their child differently and parenting in more flexible ways.

Reflection-in-Action

The process of attunement requires the ability to read affective and behavioral cues, to understand internal states (e.g., needs and motivations), and to remain flexible so as to offer interactions that most fit with what the other person is available for in that moment. Attunement also includes tending to mismatch and working toward repair, which involves reading cues about what is not working and shifting as needed. Thus, attunement is a form of reflection-in-action or "thinking on your feet." (Schön, 1983)

The FAN operationalizes attunement through matching four core processes to the kind of interaction the parent is most able to use in the moment. These four core processes are: Empathic Inquiry, which is used when the parent is experiencing feelings; Collaborative Exploration, which is used when affect is contained and the parent wants to think through an issue; Capacity Building, which is used when the parent needs information or is ready to try a new way; and Integration, which is used when the parent has insights or sees new meaning. (See Figure 1)

At the heart of the FAN is the practitioner's ability to maintain a reflective posture throughout the interaction. *Reflective posture* is the ability to be fully present, monitor affect and engagement cues, offer interactions using the core processes that are attuned to the parent's readiness, and observe the parent's responses. The practitioner is continually assessing attunement by asking the reflective question: "Is this working?" When there is a misattunement, that is when the parent is in one wedge of the FAN (e.g., Feelings) and the home visitor offers interventions from another (e.g., Doing), the home visitor notices and readjusts the interaction to more closely meet the parent where they are in the moment. Because of its reliance on the continual conceptualization of what one is observing, feeling, and doing, and how one is impacted by these experiences, the FAN relies on the reflective capacity of the practitioner (Fenichel, 1992).

There are clearly times when a practitioner is unable to maintain this stance and becomes dysregulated or thrown
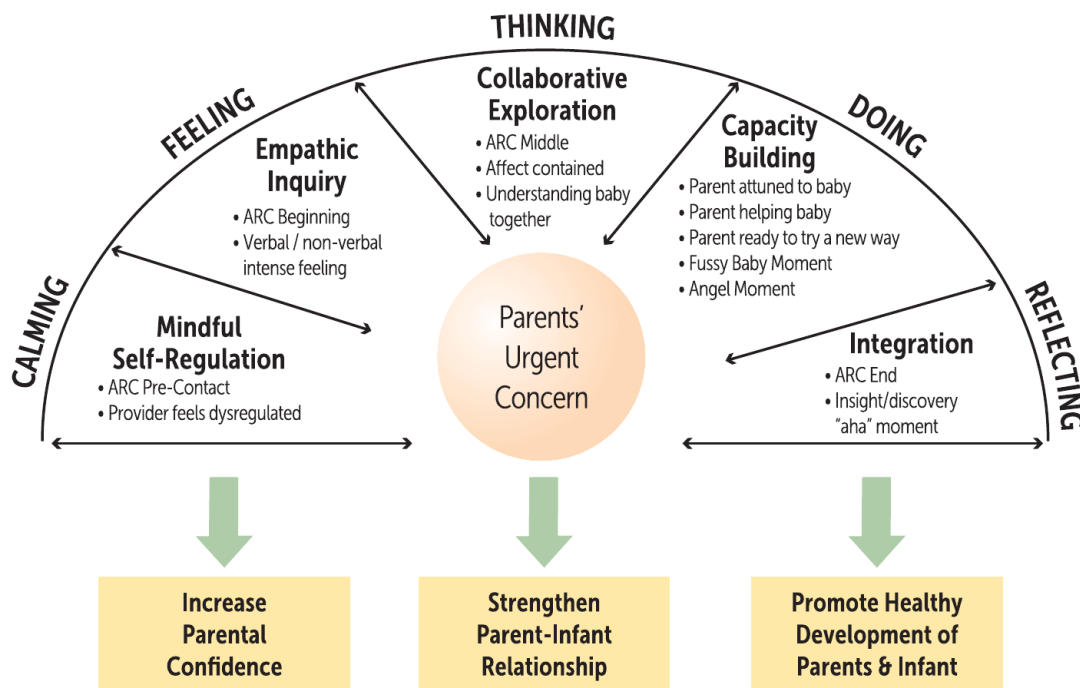

One important guideline of the FAN is to first "see the child the parent sees."

off balance. The fifth FAN process, Mindful Self-Regulation, is a reflection-in-action rebalancing tool. Mindful Self-Regulation is an intentional process that requires awareness and tracking of one's own internal state (e.g., body sensations, feelings, urges, needs, and thoughts) and the active use of self-regulatory strategies, such as breathing, self-talk, and imagery, to bring oneself back to balance in the moment. The goal of Mindful Self-Regulation is clarity: regaining balance so that you can see clearly and make decisions about how to reconnect with new awareness (Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996).

Figure 1. Fussy Baby Network® FAN, Facilitating Attuned Interactions

© Gilkerson 2010, rev 2016
Erikson Institute Fussy Baby Network

In addition to the FAN attunement process, the careful pacing of engagement is another form of reflection-in-action. The FAN deliberately uses pauses to slow down the interaction and allow time for the parent to process and respond. For example, in Empathic Inquiry, home visitors are encouraged to validate feelings, then pause and allow time for the parent to absorb and respond. When giving information, home visitors are encouraged to give input in small doses and then explore the meaning to the parent. This careful pacing is designed to help the practitioner respect what the parent can take in the moment and offer the just right amount of information.

The ARC of Engagement (Figure 2) provides a structure to pace the visit and give the practitioner and parent time to reflect on their experience. The suggested pacing begins with preparation. Prior to meeting with the family, the practitioner takes time to assess her own state and pause to reflect on that state, breathe, and prepare to be present. Early in the meeting, the home visitor invites the parents to reflect on their current parenting experience (e.g., How has it been *for you* to care for your baby this past week? *or* What has it been like for you to be a mom [or a dad] this week?). Toward the middle, the visitor checks in (e.g., Are we getting to what was most on your mind?) At the end, the home visitor invites the parent to reflect on their child (e.g., If you were to describe your baby in three words today, what would you say?) and reflect on the meaning of the visit to the parent (e.g., What would you like to remember/take with you from our time together?).

Reflection-On-Action

The FAN is learned and sustained in practice through guided reflection-on-action (Schön, 1983). Following a 2-day Level I FAN core training for the whole team, the home visitors move into a 6–8 month Level II Facilitated Practice period during which they complete reflection tools on eight visits and review these tools in reflective supervision to reconstruct and reflect upon their visits. The reflective sessions are structured by the ARC questions. The supervisor guides the process by asking questions similar to the ones the home visitor asks the parent: What was it like for you to be with this family on this visit? Are we getting to what was most on your mind? What would you like to remember from our time together? Is there something that you would like for me to remember?
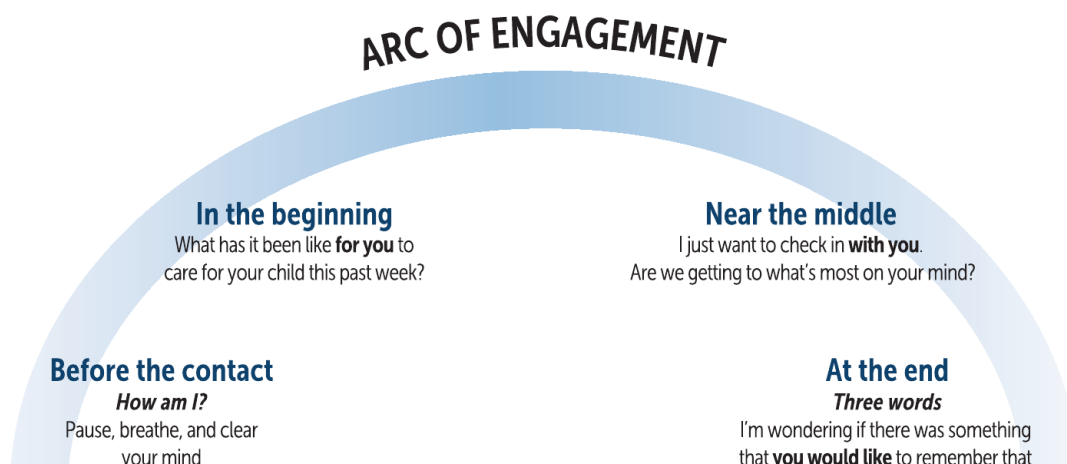
The reflection tool contains three reflective questions for each process. The home visitor fills out the first of three questions for each process prior to the session and then the supervisor guides reflection on all the questions for each core process during their time together. Here are sample reflective questions for two core processes:

Mindful Self-Regulation: What thoughts, feelings, and physical reactions were you experiencing that led you to know that you needed to go to Mindful Self-Regulation? What did you do to help regulate these feelings in the moment? How did you feel this worked for you?

Empathic Inquiry: What cues did the parent give you, both verbal and nonverbal, that let you know he was ready for/needing Empathic Inquiry? What were two or three of the strongest feelings that the parent expressed during the visit? What do you think you said or did that encouraged the parent to express these feelings?

While the staff are engaged in a reflective learning process with their supervisor, the supervisor is engaged in a parallel process with the FAN trainer to develop her skills on the Supervisor FAN (Gilkerson & Heffron,2016). The Supervisor FAN helps the supervisor simultaneously keep the supervisee's concerns, the supervisor's concerns, and the program

Figure 2. ARC of Engagement

ARC OF ENGAGEMENT

In the beginning
What has it been like **for you** to
care for your child this past week?

Near the middle
I just want to check in **with you**.
Are we getting to what's most on your mind?

Before the contact
How am I?
Pause, breathe, and clear
your mind

At the end
Three words
I'm wondering if there was something
that **you would like** to remember that

© Gilkerson 2016

standards in mind. Using the same core processes, the supervisor reads the supervisee's cues and attempts to meet her where she is and move with her on the FAN. The ARC of Engagement is used to guide the supervisor in organizing the supervision session. The ARC reminds the supervisor to: prepare prior to starting, start with the supervisees' experience, check in with the supervisee in the middle, and slow the end down for reflection. The Supervisor FAN Learning Tool asks the supervisor to map out the flow of the session, noting which core processes were used and respond to a series of reflective questions for each core process. Later, the supervisor processes the Learning Tool in mentoring sessions with the FAN trainer. Sample reflective questions include:

Mindful Self-Regulation: What led you to go to Mindful Self-Regulation during the supervision? What strategies did you use to regain your regulation and attention, and how effective did you feel they were? Looking back, were there other moments when Mindful Self-Regulation might have been helpful?

Collaborative Exploration: Describe two things you said or did that helped you gain an understanding of the supervisee's concerns? Describe the child, family, or issue that the supervisee sees. Describe the child, family, or issue that you hold in your mind. What was the supervisee's theory of the problem?

After a home visitor has received his Level II certification on the FAN, the visitor enters Level III Sustained Practice in which he periodically uses the tools in supervision to reflect upon the work. The FAN debriefing process is also evoked when the home visitor feels stuck. Simple reflective questions often open up a deeper conversation that allows the home visitor to see the situation through a different lens. Questions include: What did this experience evoke in you? Where do you think the parent was on the FAN? Where were you? Looking back at the interaction, what do you think was happening for you? For the parent? Has anything shifted for you as you have been reflecting on this encounter?

Infusing the FAN Into Reflective Practice

In this section, we describe how the FAN was infused into this program using the reflective learning process and what impact this had on the staff and supervisor. Each of the nine team members and the supervisor were asked to write down how the FAN training had impacted their practice. The following represents a summary of their responses.

Staff Openness and Supervisor Commitment

The supervisor and staff's prior exposure to the FAN created a receptive climate. The staff's willingness to participate, even those who were more skeptical, and openness to learning were keys to its success. The supervisor believed that the FAN complemented and integrated the previous training the staff had received and was committed to following the Level II certification requirements—step by step. This commitment provided the steady framework which held the staff through the almost year-long process.

Fit With Program Values

Because the FAN supported the accomplishment of core program values, including empathic communication and reflective practice, the FAN was seen as a framework for engagement in all facets of the program. Thus, each team member from the supervisor to new and experienced home visitors, to the data supervisor who does Medicaid enrollment participated in the full training sequence including the reflective tools and their discussion during reflective supervision.

Holding the Frame

The supervisor's consistent implementation of the Level II process was critical to the successful implementation of the FAN. To complete the certification, an extra hour of supervision was added for each staff member each month. The staff completed the tools right after their visits and brought the completed tools to the FAN supervision session. If a staff member did not have the tools ready, the meeting was rescheduled: "we did not do them on the spot." It was more work for the staff to write up the reflective tools and some, more than others, felt the FAN was a new language. The supervisor validated their willingness to try because she deeply believed that the FAN would enhance their practice.

Accepting Differences and Giving Control

Although the response to the FAN was mixed at first, everyone was open to trying. Some were eager and felt they had waited a long time for the training. Others felt the FAN was unnatural, like a "foreign language" and too scripted. Responding to their individual needs, the supervisor offered flexibility within set boundaries as she gave staff control over how many families and with which families to use the FAN. She asked new staff who were just learning their roles to choose one element of the FAN where they felt most comfortable and encouraged them to practice this until they were more confident. New staff often chose the beginning or end of the ARC and made notes on their charts prompting them to remember to ask the questions for the selected FAN process. By completing the reflection tools and talking through what was difficult or what they did not understand, the staff naturally built their confidence and competence within the supportive relationship with the supervisor.

Benefit of Guided Reflection

The FAN Learning Tool provided the team with a structure and guide for reflection, which can be an elusive concept to put into practice. Because the supervisor was learning too, she felt that having scripted questions was particularly helpful. By the end of the fourth session, the supervisor described their mutual growth in this way: "We started to embrace the slogan: 'Any time we talk about the FAN, we deepen our awareness and our skill...We were all practicing together.'"

Visual Presence of the FAN

The supervisor hung a large FAN poster in her office that served as a "visual compass" for their discussions. Staff receive a laminated letter-size (8½ x 11) FAN and smaller, pocket-sized FAN as memory aids. As one staff member said: "The FAN never fails you as long as you remember to use it."

Compassionate Process for Growth

The FAN framework provides a gentle way for practitioners to look at themselves and their interactions and discern which interactions are working well and which are more difficult. The supervisor found that reviewing the tools with the staff revealed what core processes they were good at and comfortable with and which ones they needed to work on. Some knew where they would struggle and this was confirmed whereas others discovered their area of growth through the reflective process. The staff was willing to look into the mirror and see what they brought to the situation. The supervisor described the FAN reflection as a "magical process... a compassionate way to talk about areas of growth in a non-threatening way. I loved that as a supervisor."

What Did the Staff Learn and Experience?

Reflective posture is the ability to be fully present, monitor affect and engagement cues, offer interactions using the core processes that are attuned to the parent's readiness, and observe the parent's responses.

The overarching theme for staff was that the FAN deepened their practice. They grew in reflective capacity including each area described by Heller & Ash (this issue, p. 22): self-knowledge, self-regulation, collaboration, process, authentic attitude, and multiple perspectives.

Structure and Meaning

One staff member summarized the impact this way: The FAN brought "structure to our visits while adding meaning to each one." The staff found that the FAN helped staff organize the visits, reminded staff to keep the timing in mind allowing for a more paced visit, and helped staff recognize when screening tools could be presented in a noninvasive way. The FAN structure helped keep the visits on track. For example, staff commented, "First by adding structure when I feel at a loss as to where a visit is going. I find myself going to the reflective questions in those moments." Or as another staff member noted, "We all know that home visits can go down many difficult-to-navigate pathways. I also feel my ability to find comfort with the questions has deepened and that they are meaningful to families as well as to myself. I have started using the questions... with my own family so I feel they are becoming a part of who I am."

Brave Practice

FAN allowed staff to have greater confidence and skill in a wider range of interactions. One team member shared that she had been learning to ask potentially difficult questions.

> Up till now I have been too nervous to alienate a client by asking a probing question... I am learning how to be open and curious and willing to hold space for any negative reaction to my question that might occur. I think my practice of [Mindful Self-Regulation] has provided me the tools I need for that possibility.

Self-Knowledge

As the supervisor observed, staff reported that the FAN helped them become more aware of their own tendencies and to embrace growth. It was not surprising that the patterns differ. For example, one team member shared, "I am also learning to spend a little time in the core process of capacity building, my weakest area, noting and taking advantage of learning moments that arise during a visit." Other staff who describe themselves as "doers" found that the FAN helped them stay longer in the hard places, becoming more comfortable with handling the strong feelings that can arise for both parent and home visitor.

Staff also took pride in their growth. "Collaborative exploration has been one of my most favorite areas to work on, and I'm definitely improving!" Another staff team member felt that increasing her skills in collaborative exploration helped her grow in ways that enhanced the program core value, "refraining from giving families our own suggestions has been First Steps' motto and to empower families to find their own way and what works for them."

"Languaging" Practice

The FAN offered the team a common language and way to name their experiences. "It feels good to have the language now around the practice we were already doing." The supervisor remarked that "the FAN fits perfectly with an infant mental health approach as we are able to name our feelings" and she also noted that the FAN allowed staff to describe what happened on visits in a way that everyone can understand. The supervisor noted that the staff were better able to label their own triggers and talk openly about their use of Mindful Self-Regulation; thus normalizing the dysregulation that is part of the intense work of home visiting and making it more possible to talk about what to do in these situations.

Knowing Where the Family Is

Home visitors are often encouraged to start where the family is but are not given practical ways to figure out where to start. The ARC helped the home visitors take the pulse at the beginning of the visit and continue to check in with the parent throughout the visit. The positioning of the parents' concern in the middle of the FAN keeps the spotlight on the parent's needs and concerns. "Using the FAN has given me a lot more information about where a caregiver is during a visit. By understanding what area [of the FAN] a client is in, I am better able to adjust my response and meet the needs of the client."

Internalization of Mindful Self-Regulation

Staff noted that Mindful Self-Regulation was a critical component of the FAN and allowed them to stay grounded and be more "open and curious." Many staff members described the FAN as being of double benefit, helping them in their personal lives as well as their professional lives.

I have identified a couple techniques for MSR that are really effective for me and through practice and repetition have integrated them into my work and life practices. I now feel that I am able to access these techniques without much effort or premeditation.

Seeing From the Other's Perspective

The FAN allowed the staff to see that they, at times, were imposing their perspective onto parents. They became aware of when they felt judgmental and wanted to pursue their own agenda. The supervisor noted that the FAN allowed them to "see the other and also be the regulated other." For the less experienced staff, there were many "ah-ha" moments around their home visiting and how much they wanted to give "buckets of information." The FAN conversations around the reflective tools helped them see that they were setting their own agendas for families without incorporating the family or the family's wishes. The program uses the analogy of a beach ball. When you are holding it yourself, you look at a situation through one color. When you turn the ball and look at it through another color, you are made aware of the other's perspective. Instead of going to Doing on the FAN, they expanded their use of Collaborative Exploration to understand the other's perspective and are guided by the mantra: "When in doubt, listen and ask one more question."

When giving information, home visitors are encouraged to give input in small doses and then explore the meaning to the parent.

From Transactional to Transformative

The FAN was embraced in all aspects of the program so families experience a coherent approach regardless of the activity. One staff member adapted the ARC questions for Medicaid enrollments, using an opening question such as "How is it going today?;" later asking "Did we address all of your concerns around your health insurance?" and finally, "How was this process for you today?" These questions helped the staff member to assess and meet the clients where they are and make appointments more meaningful for the client. For example, the client's chair is now repositioned so the client can see and be involved in filling out the application. When possible, the client sits at the computer while the staff provides assistance as needed. The appointments have become more collaborative and the process "more transformational to the client rather than just transactional."

What Was the Supervisor's Parallel Process of Growth?

Here we describe the supervisor's reflections on her growth.

Putting Reflective in Reflective Supervision

Because the FAN provides a coherent model for relationships and reflective practice, it is also used as a framework for reflective supervision. Up until her FAN certification process, the supervisor had always felt a bit unsure how to do reflective supervision. She was entering her fourth year and, like most program supervisors, had not had formal training in reflective supervision in her professional education. The supervisor identifies herself as "a fixer/do-er as a nurse by trade." When staff encountered a problem, her approach was to give suggestions. She was not sure how to move past the "reporting" aspect of supervision (e.g., I saw Jennie this week, all is good, no problems, she's been regular with her visit) and support them in reflecting on their work, especially if she felt resistance. "I didn't know the words to go deeper. For me, the structure for reflective supervision was what I was yearning for." Using the FAN review process was like adding a "visual video" of what the visit was like. Supervision could now focus on the process and the meaning of what was happening for the parent and the visitor. The supervisor felt less awkward and more confident because she had a structured process to follow. She added a "check in" box at the top of her notes and a "take away box" at the end to remind her of the ARC.

Felt Experience of the FAN

Although the supervisor was fully committed, the FAN certification process was a steep learning curve for her as well. "My stumbles were similar to the staff's, without the skepticism." She was learning to listen more and ask more questions and allow the staff to come to their own conclusions. The supervisor's use of the FAN was critical to the staff internalizing the approach as it provided the staff with the "felt experience of the FAN." Similarly, the supervisor experienced the FAN during mentoring calls twice a month

with the trainer—one focused on her sessions with the staff in using their reflective tools and the second focused on her use of the FAN in supervision. She used the mentoring sessions with the trainer to look both inward and outward about her own supervisory practice and reflective skills.

From Hesitancy to Confidence

A common fear that staff voiced was that families would not want to answer the end of ARC questions or would think they were too scripted. In actuality, their experience did not match their hesitancy. Families were fine answering the questions and often had new insights to share at the end of the visits. Guided by the FAN, the supervisor stayed regulated and used Collaborative Exploration to explore their concerns and asked questions which allowed the staff to recognize their own hesitancy. For example, the supervisor would inquire "What did you notice about the parent when you asked the last question?" and "How was this for you?" Through this process, the home visitors were able to see that the obstacle was their own discomfort, rather than the parents'. They moved from hesitancy to confidence in using the ARC. In parallel fashion, the supervisor gained confidence in her capacity to help staff sort through a troubling situation without the pressure to "fix it" for them.

Staying Regulated During Stressful Conversations

Mindful Self-Regulation helps the supervisor stay regulated during administrative supervision, when she needs to state a program requirement and ask the staff member what support they need to meet the requirement. She noted that the FAN has helped her pause and try to see what the home visitor sees, which allows her to empathize with the staff's situation while not necessarily changing the program standards. Her growing capacity for perspective taking has helped build relationships with the staff and create a safer space for them.

Sustaining the FAN Reflection Process

Moving forward, the supervisor's goal is to keep staff connected to the FAN in a fun, engaging, and meaningful way. Her plan has several elements. First, all staff will complete one FAN Learning Tool each month during reflective supervision. The supervisor has found that the FAN tool reflection often evolves into a deeper conversation about the work and notes "my best supervision sessions use the FAN." Second, the program will have quarterly reflective group discussions guided by the FAN as part of its Continuous Quality Improvement Process. During this forum, the staff will check in on the FAN process—what's working and what's not working; focus on a clinical topic related to the FAN, such as how to bridge from feelings to other aspects of a visit; or discuss a family using the FAN framework. Third, the FAN Self-Reflection Tool will now be used as part of the annual evaluation. The supervisor and supervisee will review the tool together, name strengths, and identify areas of growth. This review process will be used to guide professional development. The supervisor is moving into the FAN train-the-trainer program to consolidate her mastery of the FAN by teaching others.

Closing

FAN is now a shared framework for engagement in relationships and for reflective practice within the Taos First Steps program. The supervisor summarized it this way, "There is Mindful Self-Regulation to 'know thyself;' Empathic Inquiry to name the big feelings and create a holding space; Collaborative Exploration to listen and see another's way; Capacity Building to build confidence; and Integration to connect the dots." The staff and supervisor embody the qualities of reflective capacity and work each day from this base to support the well-being of young children and families.

Acknowledgments

Linda Gilkerson, PhD, is a professor and executive director of the Fussy Baby Network. She is the developer of the FAN and works with the Fussy Baby Network team to support its national and international sites in launching Fussy Baby Network programs or infusing the FAN into existing programs and systems of service. Her scholarship and program development focus on relationship-based, reflective practice. She is a long-time Board Member of ZERO TO THREE.

Jaci lmberger, RN, is the program manager for First Steps in Taos, NM, where she leads her team in infusing the FAN into their home visiting program. With her colleague Jana Bailey, she started the grass roots coalition Latch On to support breastfeeding mothers. Ms. lmberger received her Infant Mental Health Level 2 endorsement and is a Circle of Security Parenting facilitator. She brings extensive nursing experience to her role as a program manager and reflective supervisor.

References

Fenichel, E. (Ed.) (1992). *Learning through supervision and mentorship to support the development of infants, toddlers, and their families: A sourcebook.* Washington, DC: ZERO TO THREE.

Gilkerson, L., & Heffron, M. C. (2016). *Facilitating attuned interactions: FAN framework for reflective supervision.* Manuscript in preparation.

Gilkerson, L., Hofherr, J., Steier, A., Cook, A., Arbel, A., Heffron, M. C., Murphy, J. M. et al. (2012). Implementing Fussy Baby Network approach. *ZERO TO THREE, 33*(2), 59–65.

Heffron, M. C., Gilkerson, L., Cosgrove, K., Heller, S. S., Imberger, I., Leviton, A., ...& Wasserman, K. (2016) Using the FAN to deepen trauma-informed care for infants, toddlers, and families. *ZERO TO THREE, 36*(6), 27–35.

Heller, S. S., & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *ZERO TO THREE, 37*(2), 22–28.

Saakvitne, K. W., Pearlman, L. A., & Staff of TSI/CAAP (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York, NY: W. W. Norton & Company.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action.* New York, NY: Basic Books.

Training in Reflective Supervision

Building Relationships Between Supervisors and Infant Mental Health Specialists

Sarah E. Shea
Eastern Michigan University

Sheryl Goldberg
Michigan Association for Infant Mental Health
Southgate, Michigan

Abstract
This article describes a unique reflective supervision training series for community-based infant mental health (IMH) specialists and their supervisors that was designed to support the relational capacities of both supervisors and supervisees and to facilitate collaborative supervisory relationships. Qualitative evaluation results of the pilot training series indicate that the series had an impact on supervisors' sensitivity to reflection and on supervisees' capacities to use reflective supervision in their work with families. Findings suggest the training series supports professional development and also highlight the need for additional reflective supervision training content and useful assessment tools to measure the impact of reflective supervision on IMH practice.

In 2013, the Michigan Association for Infant Mental Health (MI-AIMH) developed and implemented a pilot reflective supervision training series designed for community mental health infant mental health (IMH) specialists and their supervisors working in community mental health agencies. This unique training series was borne out of the findings of a 2012 evaluation of an Advanced Competency-Based Training for IMH professionals, developed by MI-AIMH and Detroit-Wayne County Community Mental Health Authority and funded by the Ethel and James Flinn Foundation. The findings from this 2012 evaluation indicated that a majority of the sampled Level II IMH specialists seeking Level III endorsement demonstrated gaps in knowledge in the competency area of reflective practice, particularly with regard to reflective supervision (Boraggina-Ballard & Mills, 2013).

This reflective supervision training series was piloted with IMH supervisors and clinicians working in community mental health settings in Detroit-Wayne County, a community characterized by young children and families who are significantly impacted by poverty, community violence, and inadequate resources to address their needs (Zehnder-Merrell, 2015). The project sought to design, implement, revise, and refine a training curriculum for IMH supervisors and IMH supervisees who want to expand their capacity to engage in reflective supervisory relationships that benefit the families, infants, and toddlers for whom they provide mental health services. Funded by the Ethel and James Flinn Foundation, the project also included an evaluation with a quantitative component as well as qualitative interviews that were conducted by Eastern Michigan University 8–10 months following completion of the series. The quantitative findings provided preliminary evidence that the training series was effective in terms of supporting the reflective practice skills of IMH clinicians and supervisors and also presented an opportunity to pilot new measures designed to assess reflective practice skills and self-efficacy (Shea, Goldberg, & Weatherston, in press). The qualitative interviews, presented here, provide insight into the training series' impact on participants as well as exploratory findings regarding the

contemporary reflective supervision experiences of community mental health IMH specialists and supervisors, including strengths and challenges of the current reflective supervision model in these settings.

Reflective Supervision Training

Reflective supervision in the field of infant mental health is a specialized approach to supervision that engages both supervisor and supervisee in exploration and inquiry extending beyond the facts of the case to include the experiential nature of the relationship with the infant or toddler and the family (Shahmoon-Shanok, 2006; Weatherston & Barron, 2009). The supervisory relationship is marked by a mutual commitment to engaging in the emotional content associated with practice with very young children and families (Eggbeer, Shahmoon-Shanok, & Clark, 2010; Shahmoon-Shanok, 2006; Weatherston & Barron, 2009; Weatherston, Kaplan-Estrin, & Goldberg, 2009; Weatherston, Weigand, & Weigand, 2010). The reflective supervisory experience provides supervisees with a relationship that can support the clinician's efforts to engage in relationship-based practice with families (Davys & Beddoe, 2009; Harvey & Henderson, 2014; O'Rourke, 2011; Watson, Gatti, Cox, Harrison, & Hennes, 2014; Weatherston & Barron, 2009; Weatherston et al., 2009). Reflective supervision is designed to support the clinician's reflective practice skills, a central component of IMH reflective practice competencies (MI-AIMH, 2002/2011/2015; Tomlin, Weatherston, & Pavkov, 2013; Weatherston et al., 2010). Therefore, training in this area is necessary to support the IMH workforce's efforts to improve the quality of relationship-based services for infants and toddlers and families (Weatherston et al., 2010). In addition, in light of the increased tension experienced by supervisors in dual capacities of administrative supervisor and reflective supervisor, such training is particularly important to strengthen reflective skills in settings where such skills may not be given priority (O'Rourke, 2011; Weatherston et al., 2010).

Training in reflective supervision should focus on supporting the practice behaviors and characteristics that have been identified as essential to reflective supervision. The findings from Tomlin, Weatherston, and Pavkov's (2013) study regarding essential characteristics of reflective supervision suggested that training should support supervisors' efforts to be "attentive, self-aware/self-reflective, able to observe skillfully, curious and engaged, compassionate, tolerant, and nonjudgmental" (p. 7) while also encouraging the supervisee's development of capacities for being "open, collaborative, and self-aware… non-defensive, having realistic expectations about supervision, and being able to ask for help" (p. 8). In addition, training in reflective supervision would also focus on how to create and maintain a supervisory experience that includes, "safety and trust, respect, and sharing of attention, power, and the 'journey' within the relationship" (Tomlin et al., 2013, p. 8). A team from MI-AIMH designed the pilot training series described in this article with attention to the existing theoretical and empirical knowledge regarding reflective supervision with the intent of addressing the supervisor's capacities and skills,

The supervisory relationship is marked by a mutual commitment to engaging in the emotional content associated with practice with very young children and families.

the supervisee's capacities and skills, and the relationship that is co-created in their supervisory collaboration (Heller & Gilkerson, 2009).

Participants

We recruited participants for the training series primarily from Detroit-Wayne County, and they all were employed in community mental health settings. Thirteen IMH supervisors participated in the training series, and each supervisor chose one supervisee to participate in the series with the exception of 2 supervisors who each chose 2 supervisees to attend, with a total of 16 supervisees participating in the series. The first four modules were designated only for supervisors, and 12 of the 13 supervisors attended all of these modules, with 1 supervisor absent from one module. Modules 5–8 were designed for both supervisors and supervisees. More than 80% of the participants (supervisors and supervisees) attended all four of these modules. The evaluator also conducted follow-up interviews 8-10 months following completion of the training series. The follow-up interview participants included 11 of the 13 supervisor training participants and 6 of the 16 supervisee training participants (2 of these supervisees shared a supervisor). Some training series attendees who did not agree to participate in

this follow-up interview cited a lack of time or availability to participate in the interview. Other attendees were no longer working at the agency that had supported their involvement in the training series and its evaluation and therefore could not be reached. Finally, some participants did not respond to the interview requests. Table 1 provides the demographics of the follow-up interview participants.

We did not collect data regarding the length of the supervisory relationship of participants; however, based on the information regarding the supervisees' length of IMH practice experience, we suggest that the supervisory relationship was relatively new

Table 1. Demographic Characteristics of Follow-Up Interview Participants

Supervisors *N* = 11 Supervisees *N* = 6		
Demographic	**Supervisors**	**Supervisees**
Gender		
Women	10	6
Men	1	0
Ethnicity		
African American	4	2
European American	5	4
Other	2	0
Age (years)		
22–29	0	4
30–39	5	2
40–49	2	0
50–59	4	0
Education/Discipline		
Social work	9	5
Psychology	1	1
Counseling	1	0
Infant mental health practice experience		
None	0	1
Less than 1 year	0	2
1–5 years	3	2
6–10 years	5	0
16–20 years	3	0*
Reflective supervisory experience		
None	1	0
Less than 1 year	2	0
1–5 years	7	0
6–10 years	1	0
Previous participation in reflective supervision training		
Yes	9	1
No	1	5

*=missing response(s)

for many of the participants given that half of the supervisee interviewees (50%, *n* = 3) had been in practice for less than a year.

Training Series Development

The training series, co-facilitated by two trainers, each with more than 25 years of experience providing reflective supervision and conducting IMH workforce training, included eight modules, each of which was 3 hours in duration. The eight modules, offered over the course of 8 months, were developed with attention to MI-AIMH's Competency Guidelines® (MI-AIMH, 2016) to meet the reflective supervision training needs of both IMH supervisors and supervisees (see Table 2). The first four modules were designed specifically for IMH supervisors, and the last four modules were created for both supervisors and their supervisees. All of the modules included use of lecture, discussion, and experiential opportunities, such as fishbowls, which involved a live supervision session between a supervisor and a supervisee focused on a particularly challenging case with the remaining participants observing and then reflecting on this supervision experience with the co-facilitators offering some guided discussion. The trainers also used videos and readings as tools in this training series.

The content of the first 4 modules is focused on the supervisor's role in creating and maintaining a reflective supervisory relationship with attention to the multiple demands experienced by supervisors in a community mental health setting. This portion of the training series provided supervisors with dedicated time to explore, discuss, and reflect upon their experiences of providing reflective supervision and reflective practice skills associated with creating a reflective supervisory relationship. The content of the last four modules was dedicated to acknowledging the mutuality of the reflective supervisory relationship and the ways in which both supervisor and supervisee contribute to and are impacted by this unique supervision experience. Supervisors were able to engage in relationship-based reflective activities with their supervisees in order to facilitate discussion and thoughtfulness about their reflective supervisory experiences.

Over the course of the pilot of this training series, the co-trainers participated in monthly feedback sessions with the evaluator. These feedback sessions elicited trainers' general feedback regarding the specific training module; their assessment of whether they adhered to the scheduled agenda for the module; an evaluation of any exercises, such as fishbowls, used during the module; a discussion of what they might do differently; and suggestions for how this particular training module might be replicated in the future. The feedback sessions illustrated the trainers' efforts to reflect on and critique each training module. The trainers used the findings that emerged from these sessions to adapt the training modules to fit the needs of the participants. Specifically, the trainers acknowledged in the early training sessions that there was often less time for discussion than participants and

Table 2. Description of Reflective Supervision Training Series Curriculum

Module	Module Title	Selected Activities
1	Essential Characteristics of Reflective Supervision	Peer consultation exercise designed to practice the skill of reflective listening
2	Building and Sustaining an Effective Supervisory Relationship	Fishbowl focused on a challenging supervisory relationship
3	Increasing Self and Other Awareness: The Impacts of Secondary Trauma, Cultural Backgrounds, and Differences in Personal Style/ Perspectives	Fishbowl focused on a challenging supervisory relationship
4	Balancing Administrative, Clinical, and Supervisory Tasks	Paired written exercise to practice role of listener and presenter with focus on both self and other
5	Co-Creating the Supervisory Relationship: Supervisees' Contributions	Supervisor-supervisee pairs discuss experiences of attachment and loss in context of infant mental health work
6	Parallel Process and Its Relationship to Best Practices With Families	Fishbowl focused on supervisee's challenging case
7	Reflective Supervision and Personal and Professional Growth for Supervisors and Supervisees	Small group exercise involving small groups of supervisors and small groups of supervisees focused on challenges of maintaining balance in reflective supervision and describing what they might need from their supervisor/supervisee in those challenging moments.
8	Using the Supportive Context of the Supervisory Relationship to Address Emotional Issues and Clinical Complexities	Fishbowl exercise focused on an experienced supervisor and their experienced supervisee's description of a challenging case.

trainers would have wanted. Trainers also acknowledged that the didactic material could at times be reduced in order to allow for more discussion time. The fishbowl exercise was modified to ensure that there was sufficient time to process the supervisory experience rather than spending the majority of the time discussing case content. In addition, the fishbowl experience was also modified to allow for discussion in the middle of the presentation so that the supervisor/supervisee pair, as well as observers, can inquire about responses and gain guidance, if needed.

The trainers' efforts to model reflective skills in the context of their working relationship consistently emerged as a central focus in the feedback sessions. The pre-planning consisted of several meetings between the trainers to develop objectives, content, and process experiences consistent with the project goals.

This new project called for a collaborative relationship similar to a well-functioning reflective supervision dyad, one in which a mutually respectful, compassionate atmosphere facilitates open exploration of ideas and experiences. The trainers' development of a collaborative relationship then allowed the co-created series to be dynamic, as well as reflective of the unique contributions of each trainer. The effective communication between the trainers with regard to their needs, agendas, and intentions served as a parallel to the supervisory relationship and as an additional parallel layer of learning for the participants that complemented the didactic material, discussions, fishbowls, and other exercises.

Data Collection and Instruments

The evaluator organized the qualitative findings according to the interview question. We present the most frequently identified response categories in the following section. (For additional information about the analysis of this research, see Shea et al., in press.)

Participant Measures

The qualitative component of the evaluation included participants' face-to-face interviews with an evaluator at Eastern Michigan University, where human subjects approval was secured. The evaluator, who was commissioned to conduct an evaluation of the training series including this follow-up study, designed the interviews in consultation with MI-AIMH experts in reflective supervision and training. The interviews were intended to explore participants' experiences of the training series, specifically with regard to their current reflective supervision practices in response to the training. In addition, these interviews offered participants the opportunity to identify and describe essential elements of reflective supervision, specifically with regard to the ways in which the participants understand and identify the parallel process experiences in the clinical relationship as well as the ways in which these parallel process experiences are then used in supervision to enhance the clinician's reflective practice abilities. These interviews were approximately 30–60 minutes in length and took place in the participants' agency setting 8–10 months following completion of the training series. The interviews did not solicit specific case information. The evaluator provided a copy of the questions at the time of the interview, and the interviewer read the questions aloud during the interview.

For supervisees, the interview consisted of six questions with an additional opportunity for participants to offer final comments about the training series, reflective supervision, or

both. The box Interview Questions lists the queries that were used. We discuss the three questions related to the training series in the following section. The interview included queries about the supervisees' experiences of the training series as well as more general questions about their definition and use of reflective supervision. For supervisors, the interview consisted of five questions with an additional opportunity for participants to offer final comments about the training series, reflective supervision, or both. Similar to the interview for supervisees, this interview included queries about the supervisors' experiences of the training series as well as more general questions about their definition and use of reflective supervision.

The interviews were tape recorded and transcribed. The evaluator coded the results using a grounded theory approach whereby there is no structured coding rubric used and the rubric emerges from the data, a common approach when working with exploratory data. The evaluator organized the responses thematically and developed categories on the basis of these identified themes. The evaluator further refined the categories to better describe the responses.

Participant Experiences of the Training Series

For the purposes of this article, only the results of the questions pertaining to the participants' experiences related to the training series are presented. The results are presented in three sections: Supervisor Results, Supervisee Results, and Additional Comments about the Training Series, which includes responses from both supervisee and supervisor participants.

Supervisor Results

When asked whether the training influenced their thoughts or work with supervisees, the majority of supervisors (63.6%, $n = 7$) responding to this question indicated that the training series increased their reflectiveness, which was defined as capacities to engage reflectively with their supervisees and their abilities to think more deeply about their role as a reflective supervisor and their reflective supervisory practices. Some examples of responses in this category include:

I think it's increased my mindfulness around it. So, I find myself thinking about it and wondering more about it. I am…I think I'm finding myself more sensitized to how my time with them is or is not affecting their work.

and

Yeah, it did. It kind of made me…it kind of gave me… permission to go deeper, and permission…you know when you work in this field, you get really caught up in the day–to–day lives of these clients, and having something like that training allowed me to go back and reflect on what am I actually doing with my clinicians, and kind of giving me more of a solid foundation.

In addition, a majority of the supervisor participants (54.5%, $n = 6$) indicated that learning from others impacted their reflective supervision experiences. "Learning from others" included learning experiences shaped by participants' involvement with and observations of other group members that influenced how they think about reflective supervision and the way they work with supervisees. For example, one respondent stated,

It was really neat, the different styles. I think that was something to take into consideration and to really think about. I think that gave me another window as to what might be happening with, in supervision for some people and it might be different from mine. It was really nice to see what the supervisors were doing: how they paused, how they sought more information from their staff. I thought that was helpful.

Another respondent stated,

You know I don't want to sound arrogant, the information shared wasn't necessarily new, but hearing about it again and in the context that we heard about it, and listening to folks talk about it kind of helped to heighten my awareness and sensitivity to it.

The final theme (54.5%, n = 6) indicated that the training series served as an affirming experience, meaning that the training series validated the supervisor's current reflective supervision experiences and reflective practice skills. Examples of such statements include: "It was good to hear like someone who's been doing it for so long to say 'Yeah, this way works, there is a point to this,'" and

> I feel more grounded in the idea that my reflective supervision is going to look different than [another supervisor], who's my co-supervisor, and that's OK, and that doesn't meant that one of us is doing reflective supervision right or wrong, it's just that we have different personalities and we're going to work differently.

Supervisee Results

When asked whether the training series influenced their work with infants and families and their relationship with their supervisor, half of the supervisee respondents (50%, n = 3) indicated that the training series positively impacted their work with families, which is defined as reinforcing the importance and value of truly listening to the parents and infants and toddlers or guiding the supervisees to use supervision in such a way that ultimately benefits their relationships with families. For example, one supervisee stated,

> So it might have helped me bring up those parallels of seeing how the supervisor can help me and how that can parallel into my sessions of how I can...And I think it helps me understand that parallel better so that I can takes cues from my supervisor to see how she is in sessions, and then use that in my own sessions.

The same number of respondents (50%, n = 3) indicated that the training series positively influenced their relationship with their supervisor by increasing the sense of connection between supervisor and supervisee. An example of this type of response is:

> Well, the relationship with my supervisor, we've always had a good relationship, but being able to be in the fishbowl with her, it was like tunnel vision. It was a connection that I didn't think we would have with a lot of people in the room. It was nice; it was like we were really connected. And I think we still carry that...and like, when we met today for an hour, we still just hold true to that, so I think the series helped us stay connected regardless of the chaos...sometimes the chaos that our families bring, or even just the environment, we still stay connected.

Finally, half of the supervisee respondents (n = 3) also suggested that the training series increased their confidence; responses in this category described an increased sense of

Follow-up interviews offered participants the opportunity to identify and describe essential elements of reflective supervision, specifically with regard to the ways in which the participants understand and identify the parallel process experiences in the clinical relationship.

validation regarding current IMH work, reflective supervisory experience, or both. For example, one respondent stated, "And taking that time at the training series was really nice, because I think it's helped me to utilize it a lot more, and feel more confident and comfortable using supervision as I need it."

Additional Comments About the Training Series

When asked whether, based on their experience in the training series, there were elements of their reflective supervision experience that they wish were different, more than a third of all of the supervisor and supervisee respondents (41.2%, n = 7) indicated that they wished that the administrative tasks that interfere with reflective supervision were decreased or eliminated. Responses in this category cited a desire to increase the amount of time dedicated to reflective supervision and decrease the amount of time dedicated to administrative tasks such as case review, oversight of contact hours, and review of paperwork. It should be noted that 6 out of the 7 responses came from supervisors. The following statement provides an example of a supervisee response that describes an awareness of the ways in which administrative or other supervisor demands interferes with reflective supervision: "...Because there's been challenges agency wide with more demands being placed on our supervisors." A second example of such a response from a supervisor includes:

> Having that....It's always in the back of my mind, you know when I'm meeting with them, "Ok, but you didn't meet that client that day, how are you making up your hours," because you know, we have to meet that 4 hours a month minimum, or we have to meet that percentage now that [community mental health] demands. And as much as I just want to be present about that case and about that family and about the children, that's always there. And it's like this little internal battle that goes on in every supervision and I'm telling one side to just shut up for now, because I need to focus on this other stuff. And trying to trust, wanting to trust that if we're doing what's clinically appropriate for these families, everything else is going to line up. But then having the pressure of it has to line up right now—we can't wait, it has to line up now.

The same number of respondents (41.2%, n = 7) indicated that they wished for more time or greater consistency in their reflective supervision experiences. Responses in this category described a desire for more time for reflective supervision, or more consistent and dependable reflective supervision meetings, or both. It should be noted that the supervisee respondents (33.3%, n = 2) in this group used the term "consistency" and the supervisor respondents (45.5%, n = 5) referred to "time," in this response category. Some examples

of responses in this category include the following supervisor statement:

> I would say, I mean, it isn't realistic but I would say we need more time. I have, I have 12 direct staff now, I used to have 15, and so to set aside an hour for each of them can be very challenging, and an hour often does not feel like enough.

A supervisee stated,

> We're not always consistent about our meetings. So, that's probably something. And it's her and I, and we're probably, like, once a month versus every other week or weekly. So that would be a little bit better, I think we discussed before. Because, you know, consistency and having a schedule, so that would be a little thing.

The Impact of the Training Series

These selected qualitative results regarding the participants' experiences of the training series and the impact of the series on participants' IMH work and supervision suggest that the training series continued to have an impact on participants' reflective supervision and reflective practice skills 8–10 months after the training series concluded. However, it is important to consider some of the study's limitations. Specifically, the very small sample does not allow for broad generalization of the findings. In addition, this study was exploratory in nature, and the interview guides were piloted with this sample. Therefore the reliability and validity of the measures have not been tested. The grounded theory approach to coding used to analyze the qualitative data, while appropriate for such an exploratory study, creates an emerging coding tool that again is subject to reliability and validity concerns. Research on reflective supervision and reflective supervision training is minimal, and exploratory studies such as these provide some foundation for future investigation in this area (Shea et al., in press).

Although some of the material may not have been new for supervisors, they found that the training series affected the way that they engage in reflective supervision with their supervisees because they were able to be more reflective with their supervisees, and they also increased their reflection about their own work as reflective supervisors. Thus the training series served as a necessary catalyst for returning to a more reflective stance and ensuring that reflective supervision is based in the competencies associated with reflective practice. The ways in which the training series impacted supervisees' experiences with reflective supervision and with families support the current theoretical literature regarding the relational mechanisms that drive reflective supervision. Supervisees reported that the training series impacted their reflective supervision experiences by strengthening their relationships with their supervisors; increasing their confidence in their ability to use reflective supervision as a tool to assist in their work with infants, toddlers, and families; and strengthening their reflective practices in their IMH work with families. Although the study sample is small, the results highlight some important trends. Specifically, this finding aligns with the existing literature which suggests

that these three relational mechanisms are interconnected; the positive supervisory relationship provides a solid foundation for supervisees to be able to use the supervisory experience to inform their work with families and increase their confidence in their practice capacities (Eggbeer et al., 2010; O'Rourke, 2011; Shahmoon-Shanok, 2006; Watson et al., 2014; Weatherston & Barron, 2009; Weatherston et al., 2009).

The increased awareness of reflection experienced by supervisors following the training series serves to highlight some of the challenges encountered when providing reflective supervision. Supervisors suggested that, by and large, administrative duties present a major challenge to the provision of reflective supervision as such duties interfere with or interrupt the reflective supervisory experience. The "internal battle," referred to by one supervisor, is promising evidence that the training served to incite a change in practices because it is the tension between the new and old behaviors that demarcates the line of change; engaging in that battle to maintain a balance between the administrative and reflective supervision experiences suggests that the supervisor is maintaining a commitment to the reflective supervisory experience. Supervisors and supervisees expressed a need for more time. We hypothesize that this need is very much connected to the challenge of administrative duties because the multiple demands of a supervisor serving in an administrative capacity would inevitably raise the issue of not having enough time to maintain those responsibilities and attend to the role of a reflective supervisor.

While the connection between consistency and overburdened supervisors was recognized by and large by the supervisors, only one supervisee acknowledged the impact of additional responsibilities on supervisors on the reflective supervision experience. This may be an important point of discussion within the reflective supervision dyad and should be included

---

Learn More

Websites
Alliance for the Advancement of Infant Mental Health
http://mi-aimh.org/alliance/reflective-supervisionconsultation

Early Head Start: What Is Reflective Supervision?
https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/comp/reflective-supervision

Michigan Association for Infant Mental Health
http://mi-aimh.org/for-imh-professionals/endorsement/reflective-supervision-consultation

DVDs
Reflective Supervision Video Training Series I
MI-AIMH (2012)
Michigan Association for Infant Mental Health: Southgate, MI

Reflective Supervision Video Training Series II
MI-AIMH (2016)
Michigan Association for Infant Mental Health: Southgate, MI.

in future reflective supervision training content. It is, perhaps, tempting for supervisors to refrain from disclosing to their supervisees their sense of frustration or overwhelm regarding their multiple roles and responsibilities, but as evidenced time and time again in IMH practice, the unspoken dynamic often takes up significant space in the relationship and inhibits the growth of an authentic and meaningful connection. In addition, it may allow for avoidance of action so that inconsistent meetings can continue to occur unchecked and without discussion or further reflection. Similar to the ways in which clinicians working with families are guided to refrain from self-disclosure that would not serve the therapeutic relationship while also remaining authentic and committed to a real relationship with parents (Trout, 1987), supervisors can also straddle that boundary. Supervisors can perhaps be encouraged to consider whether, in some instances, acknowledgment of their additional duties and responsibilities or sense of being overwhelmed with their supervisees might expand the horizons of communication and serve to enhance the relationship. Such disclosure might serve as a parallel for the supervisee's efforts to model the rupture-repair experience for parents who need permission to be "good enough," in their efforts to attend to their infant's needs rather than perfectly attuned (Tronick & Beeghly, 2011).

Professional development opportunities such as this reflective supervision training series create dedicated time for early childhood professionals to think about the reflective supervision relationship and reignite or encourage a revisiting of principles endemic to this specialized form of supervision. The unique design of this particular training series promoted relationship building between supervisor and supervisee and provided opportunities for supervisor-supervisee dyads to observe and learn from other supervisee-supervisor dyads, essentially serving as a modeling technique. The findings from this evaluation indicated that this training model provides a promising approach to addressing the reflective practice competency skills for IMH supervisors and supervisees providing services in community mental health agency settings. Finally, the exploratory nature of research related to reflective

supervision speaks to the need for appropriate tools to measure these relational mechanisms as well as to track the outcomes for infants and toddlers and families (Gallen, Ash, Smith, Franco, & Willford, this issue, p. 30; Heller & Ash., this issue, p. 22; Shea et al., in press; Watkins, 2015; Watson, Harrison, Hennes, & Harris, this issue, p. 14; Watson et al., 2014). Such advancements will provide an evidence base to support preservation of reflective supervision in climates that threaten IMH professionals' access to this essential component of practice.

Authors' note

This paper is dedicated in memory of Douglas Davies, PhD, IMH-E®(IV), who was an integral part of this project.

Sarah E. Shea, PhD, LMSW, IMH-E® (IV), is an assistant professor of social work at Eastern Michigan University where she teaches in both the bachelor's of social work and master's of social work programs. Dr. Shea specializes in the areas of infant mental health practice and training, reflective supervision, attachment theory, the impact of trauma on infants and toddlers, and clinical treatment of children and families in foster care. Dr. Shea has been the principal investigator for the Michigan Association for Infant Mental Health's evaluations of training series designed for infant mental health specialists and supervisors. In addition, she has conducted research in the area of reflective supervision in infant mental health settings and the use of reflective supervision in clinical work with children in foster care.

Sheryl Goldberg, LMSW, ACSW, IMH-E® (IV), is the executive director of the Michigan Association for Infant Mental Health (MI-AIMH). She is in private practice providing reflective supervision/consultation for professionals in diverse practice settings that serve very young children and their families. She has more than 30 years of experience in home visiting, supervision, training, and supervision for the infant-family field. She has contributed a chapter to *Case Studies in Infant Mental Health: Risk, Resiliency and Relationships*, ZERO TO THREE (2002).

References

Boraggina-Ballard, L., & Mills, C. (2013). *An advanced, competency-based professional development training model for infant mental health clinicians.* Ypsilanti, MI: Eastern Michigan University College of Health and Human Services.

Davys, A., & Beddoe, L. (2009). The reflective learning model: Supervision of social work students. *Social Work Education: The International Journal, 28*(8), 919–933.

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *ZERO TO THREE, 31*(2), 39–45.

Gallen, R. T., Ash, J., Smith, C. Franco, A., Smith, S., Franco, A., & Willford, J. A. (2016). How do I know that my supervision is reflective?: Identifying factors and validity of the Reflective Supervision Rating Scale. *ZERO TO THREE, 37*(2), 30–37.

Harvey, A., & Henderson, F. (2014). Reflective supervision for child protection practice: Reaching beneath the surface. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare, and the Community, 28*(3), 343–356.

Heller, S. S., & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *ZERO TO THREE, 37*(2), 22–28.

Heller, S., & Gilkerson, L. (2009). *A practical guide to reflective supervision.* Washington, DC: ZERO TO THREE.

Michigan Association for Infant Mental Health. (2016). *Competency guidelines: Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®* (4th ed.). Southgate, MI: Author

O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. *Infant Mental Health Journal, 32*(2), 165–173.

Shahmoon-Shanok, R. (2006). Reflective supervision for an integrated model: What, why, and how? In G. Foley & J. Hochman (Eds.), *Mental health in early intervention* (pp. 343–381). Baltimore, MD: Brookes.

Shea, S. E., Goldberg, S., & Weatherston, D. J. (in press). A community mental health professional development model for the expansion of reflective practice and supervision: Evaluation of a pilot training series for infant mental health professionals. *Infant Mental Health Journal.*

Tomlin, A. M., Weatherston, D. J., & Pavkov, T. (2013). Critical components of reflective supervision: Responses from expert supervisors from the field. *Infant Mental Health Journal, 35*(1), 70–80.

Tronick, E., & Beeghly, M. (2011). Infants' meaning-making and the development of mental health problems. *American Psychologist, 66*(2), 107–119.

Trout, M. (1987). *Working papers on process in infant mental health assessment and intervention*. Champaign, IL: The Infant-Parent Institute.

Watkins, C. E. (2015). The alliance in reflective supervision: A commentary on Tomlin, Weatherston, and Pavkov's criticial components of reflective supervision. *Infant Mental Health Journal, 36*(2), 141–145.

Watson, C., Gatti, S. N., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. In E. Nwokah & J. A. Sutterby (Eds.), *Early childhood and special education, advances in early education and day care Vol. 18* (pp. 1–25). Bingley, UK: Emerald Publishing.

Watson, C. L., Harrison, M. E., Hennes, J. E., & Harris, M. M. (2016). Revealing "The space between": Creating an observation scale to understand infant mental health reflective supervision. *ZERO TO THREE, 37*(2), 14–21.

Weatherston, D. J., & Barron, C. (2009). What does a reflective supervisory relationship look like? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 61–80). Washington, DC: ZERO TO THREE.

Weatherston, D. J., Kaplan-Estrin, M., & Goldberg, S. (2009). Strengthening and recognizing knowledge, skills, and reflective practice: The Michigan Association for Infant Mental Health competency guidelines and endorsement process. *Infant Mental Health Journal, 30*(6), 648–663.

Weatherston, D. J., Weigand, R., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *ZERO TO THREE, 31*(2), 22–30.

Zehnder-Merrell, J. (2015). *Kids count in Michigan data book 2015: Child well-being in Michigan, its counties, and Detroit*. Lansing: Michigan League for Public Policy.

ZERO TO THREE
MEMBERSHIP

Make the connection.

CONNECT TO *Community.*
CONNECT TO *Education.*
CONNECT TO *Resources.*

ZERO TO THREE membership benefits include:

- Free virtual learning events presented by experts on topics that are critical to your work

- Reduced pricing on CEUs for numerous professional development activities

- Savings on tools and books from the ZERO TO THREE Bookstore

- A subscription to the *ZERO TO THREE Journal*

- Discounts on registration for the ZERO TO THREE Annual Conference

- Member-only newsletter

- Member Exclusive online resources

  ...And much more

Whether you are new to the field or have many years' experience, ZERO TO THREE is here to help you do your best work in support of young children everywhere. Become a ZERO TO THREE member today.

www.zerotothree.org/membership

ZERO TO THREE
Early connections last a lifetime

The Editorial Mission of the *ZERO TO THREE Journal*

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

ZERO TO THREE works to ensure all babies and toddlers benefit from the family and community connections critical to their well-being and development. Since 1977, the organization has advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools and responsive policies for millions of parents, professionals and policymakers.

How to Subscribe

- Call (800) 899-4301 between 9am–5pm, Eastern time
- Visit www.zerotothree.org/bookstore to place your order online day or night
- E-mail customer service staff at ZTT@brightkey.net