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Step Back and Consider: Learning From Reflective Practice in Infant Mental Health

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Step Back and Consider: Learning From Reflective Practice in Infant Mental Health



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When early interventionist Kelly drives up to the apartment, she tells herself, “It’s okay, I can do this.” She gets out of her car, grabs her bag, and walks to the door. Dominic, an engaging 18-month old with developmental disabilities, sees her and waddles over with a big smile. His mom, Stephanie, walks out of the kitchen, holding her 6-month-old baby girl. Kelly has been working with this family for about 2 years. She first started working with DeMarco, Dominic’s

4-year-old brother; about the same time that DeMarco transitioned to preschool services, Dominic qualified for services. Recently, Kelly has been working with Stephanie on ways to engage in reciprocal play with Dominic through games, songs, and books and to encourage him to use words and gestures to request preferred items.

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Dominic reaches for a toy phone nearby. Kelly starts to engage in pretend play with him when DeMarco comes in, grabs the phone from Dominic, and hits him in the head. Stephanie yells at them to stop and forcefully grabs DeMarco by the arm and drags him to the kitchen. Kelly plays with Dominic while she waits for Stephanie to return, but his brother comes back into the room and starts hitting him again. Stephanie yells from the kitchen, DeMarco yells back, and Dominic starts to cry. Stephanie returns to the room, sits on the couch, and commands DeMarco to sit with her. Stephanie turns on the television and tells DeMarco to “shut up” and “leave your brother alone.” Eventually, Kelly resumes her work with Stephanie and Dominic while the baby sister crawls over and climbs in Kelly’s lap.

As Kelly reviews her goals for the session, she realizes that she did not accomplish much, but her time is over and she has to rush off to meet the next family. As she packs up to leave, Dominic starts to cry, as does the baby. DeMarco screams, “Shut up, I can’t hear.” As Kelly walks to the car, she notices that she’s relieved to be leaving and that she’s starting to feel hopeless about her work with the family. Kelly wonders how Stephanie is feeling. Kelly sees so much potential in all the children but really worries whether or not she is making any difference. She makes a note to share this with her reflective practice group.

Like many early interventionists, Kelly reports that she feels ineffective and overwhelmed with her work (Watson, 2006). Kelly is not alone. Early interventionists and other related service providers who

work with families in their homes face a host of challenges (e.g., family and community violence, stressed families, and issues associated with poverty). Furthermore, supporting families “takes us into challenging psychological areas of a parent’s life, thoughts, and feelings” (Erickson & Kurz-Riemer, 1999, p. 107). Over time, this can be emotionally and mentally draining for the early interventionist.

Additionally, the children and families who receive early intervention services are becoming increasingly diverse in composition, cultural, and ethnic makeup (Lynch & Hanson, 2004). Families come in all shapes and sizes, including two-parent families, single-parent families, and families of divorce, as well as blended, multigenerational, homeless, foster, and migrant families. Family diversity may include diversity in culture, sexual orientation, economic status, work, and religious beliefs. According to the National Association for the Education of Young Children (2005), more than 30% of all school-age children in the United States come from homes in which English is not the primary language. Moreover, it is estimated that by the year 2023, children of color will compose more than half of all children in the United States (Bernstein & Edwards, 2008). While these challenges can make the work both rewarding and overwhelming, there is little opportunity for early interventionists to understand and integrate the multiple dimensions of working with families in their homes.

One way to provide this opportunity is through reflective practice, which is used in different fields, such as education and mental

health. The educational form of reflective practice has been around since the 1930s (Dewey, as cited in Pedro, 2006); it is a problem-solving process that facilitates examination of behavior and responses to behavior. It takes into consideration multiple factors, integrating knowledge, skills, and experience, and it involves stepping back from the issue, reflecting on contributing factors, and brainstorming possible solutions.

Reflective practice in the field of infant and early childhood mental health incorporates the same components as defined above, and it requires interventionists to pay explicit attention to the emotional and relational aspects of working with families. It provides early interventionists with an opportunity to explore a range of responses that they experience in their work, from conceptual difficulties about intervention to emotional reactions to families. Through this exploration, early interventionists have an opportunity for open dialogue and a safe place to express and explore their feelings and those of the children and the families. Through this exploration, early interventionists gain insight and perspective that help shape interactions and interventions with families and children. The purpose of this article is to expand on the traditional definition of reflective practice and discuss reflective practice from an infant and early childhood mental health model.

What Is Reflective Practice?

In this section, we define reflective practice as it has developed in the field of education

and contrast that with the definition and use of the term in the infant mental health field. In both fields, reflective practice can be a component of professional development and the supervision of preservice and in-service educators (Acheson & Gall, 1987; Gilkerson, 2004; Sandall, Hemmeter, Smith, & McLean, 2005).

A “Traditional” Approach to Reflective Practice in Education

Schon (1983, 1996) provided one of the earliest contemporary definitions of *reflection*. He suggested that reflective practice consists of a set of technical skills that interacts with experience, which may involve a teacher’s thinking aloud and sharing ideas and suggestions on how to work with a child. Through the process of reflection, teachers actively use their skill set and intuitive knowledge, gained through experience, to help them solve problems and improve their teaching ability (Pedro, 2006).

Reflection, as defined in the Division for Early Childhood (DEC) of the Council for Exceptional Children’s recommended practices (Sandall et al., 2005), is a “systematic and ongoing review, critical analysis, application, and synthesis of knowledge, skills, and dispositions specific to working with children birth through 5 with disabilities/developmental delays and their families” (p. 210). DEC recommends that reflective practice be an integral part of personnel preparation programs so that this reflective process becomes natural and a routine practice and continues beyond preservice. A critical part of

“Through this reflective process, professionals can extend their understanding of their current practice, identify and solve intervention challenges, and enhance their professional skills.”

reflective practice is pausing and stepping back to examine complex situations. It is through this pause that the early interventionist can examine the problem and begin to assess what is working well and what needs to change.

The traditional process of reflective practice, as used and defined in educational settings, occurs within the individual or takes place with other individuals, such as mentors or supervisors. When done with others, reflective practice involves a give-and-take where both parties listen and ask questions. The focus is on the presenting problems and exchanging ideas specific to the observable behaviors. Typically, the facilitator guiding the discussion may ask questions such as “What do the data tell you about the child’s progress?” How do you explain why this occurs this way?” “Based on these data, what might you do differently?” The focus is on examining the specific observable behaviors of the early interventionist to help improve his or her skills and instruction (Acheson & Gall, 1987; Goldhammer, Anderson, & Krajewski, 1989). Through this reflective process, professionals can extend their understanding of their current practice, identify and solve intervention challenges, and enhance their professional skills (Buysse, Sparkman, & Wesley, 2003).

Reflective Practice as Developed in the Field of Infant Mental Health

While reflective practice as defined above is an important and effective practice in education, it may not provide enough support to

address the emotional stress and impact on early interventionists working with families facing multiple risks, as well as families from diverse backgrounds. In addition, it does not necessarily emphasize the dynamics of the relationships between parent and child and between parent and early interventionist. Attention to these dynamics can play an important role in defining and implementing interventions. This type of reflective practice partly evolved within the multidisciplinary field of infant mental health (Weston, Ivins, Heffron, & Sweet, 1997).

Reflective practice from the infant mental health literature expands and focuses on how early interventionists feel about their work. Here, reflective practice can be summarized best by asking, “What did you do and most importantly how did you feel about what you did?” (Gilkerson, 2004, p. 428). One of the first steps in a reflective practice group is to acknowledge the feelings experienced by the provider as a result of working with the child and family (Strain & Joseph, 2004). To do this, reflective practice is never solitary; it is always shared (Schafer, 2007).

Central to this approach is the belief that all learning and development take place within the context of relationships, including the learning of parent, child, and early interventionist (Marsili & Hughes, 2009; New Mexico Association for Infant Mental Health, 2008). Therefore, reflective practice occurs within the relationship context of a trusted facilitator and colleagues. During a reflective practice meeting, the facilitator and team members attend to the characteristics and dynamics

of the relationships and the perspectives of parent, child, and early interventionist, including the past experiences of each. In this type of meeting, the facilitator uses gentle inquiry and open-ended questions to explore issues such as “How are things going for you?” and “What do you think that might be about?” As the early interventionist responds to these questions, the facilitator and team create a safe, nonjudgmental place where she or he can say aloud all that she or he thinks and feels about the child, parent, and situation. In this process, the team shares the responsibility that the early interventionist has in working intimately with children and their families. Notice in the vignette below how the facilitator uses open-ended questions and validates Kelly’s concerns and feelings.

FACILITATOR: Kelly, you said you wanted to talk today. How are things going?

KELLY: I had another really hard visit with Stephanie. I feel like it doesn’t matter whether I’m there or not because I never really get to work with Stephanie. I came prepared to model and discuss with Stephanie how things are going, but we hardly get to talk about anything because of the chaos. And more and more Stephanie doesn’t seem interested. She was either not in the room at all, or she was yelling at the kids. I left there feeling upset and thinking, “What is the point!”

FACILITATOR: And you’ve been going to this family for a long time. Has it always been like this?

KELLY: No, not in the beginning. I think it’s been harder to connect since this last baby was born. When Stephanie had her first baby, she was 16 and lived with her mom. She had the second baby a couple of years later and I started visiting around then. She was really overwhelmed with two kids but she participated in our visits. But then she got kicked out of her mom’s house and stayed in a shelter for a while. She met this new guy there, the youngest baby’s father, and they got this place together. I’m frustrated because I really want to support Stephanie as a parent, but it just seems like there are so many needs and not enough of me to go around.

FACILITATOR: So you feel like you’re supposed to meet everybody’s needs?

KELLY: Well, no, not really, but I can’t stand to see what’s happening. I worry about Stephanie, the kids, everybody. DeMarco’s behavior is getting worse. He hits, throws things, and yells at Stephanie and the other kids. And I’ve been worried about the way Stephanie looks—tired, drained, and irritable. She isn’t responsive to anything we discuss. It makes me wonder.

FACILITATOR: Have you thought of talking to her about it?

KELLY: About my concerns? No, well, yes, but I’m not sure what I’d say. On one hand, things look pretty bad over there. But on the other hand, she is taking care of the boys. She never misses a visit. The boys seem to be well fed and

clean. I’ve even observed her singing songs to redirect Dominic or distract him. So sometimes she’s able to do it, but I’ve seen it less and less with each visit.

FACILITATOR: What do you think that might be about?

KELLY: You know, I don’t know. I remember when DeMarco was little; she seemed to like him much more. Maybe it’s his age; maybe she finds it harder to deal with kids when they’re old enough to talk back. Come to think of it, I’ve noticed that she’s gotten meaner with Dominic too, now that he’s saying “No!” to her.

FACILITATOR: So you’ve seen a change in her behavior with the kids, particularly as they get older.

In this scenario, the facilitator uses open-ended questions (e.g., “How are things going?” “What do you think that is about?”), active listening (“So, you’ve seen a change in her behavior?”), and putting feelings into words (“So you feel like you’re supposed to meet everybody’s needs?”). These are all components of reflective practice. Table 1 contrasts examples of different types of questions that may be used in educational reflective practice versus infant mental health reflective practice. The next section describes how to implement reflective practice as used in the field of infant mental health.

Implementing Reflective Practice

Reflective practice can be instituted in a group or through

Table 1
Comparison of Types of Reflective Practice Questions

Traditional Reflective Practice	Reflective Practice From Infant Mental Health Field
<i>How is Dominic's intervention plan coming along?</i> Learning takes place through a give-and-take where each listens and asks questions.	<i>How are things going?</i> Learning takes place within the context of relationships, including the supervisor relationship.
<i>What happens when you go for your visit? What specific things do the children do while you're there?</i> Assume that both have the knowledge and that the focus is on presenting problems and ideas specific to behavior in a collaborative, problem-solving way.	<i>Has working with this family always been like this? So you feel like you're supposed to meet everyone's needs?</i> Assume that both have knowledge and that the focus is on attending to the dynamics of and feelings about the relationship.
<i>What have you tried? Why do you think it isn't working?</i> Supervisor helps supervisee discover the way to intervene with the problem and make better decisions about next steps	<i>What makes you think about that? So you're wondering what is different about things now . . .</i> Supervisor uses gentle inquiry to explore the interventionist's emotional experiences related to the issues, to understand the underlying dynamics (culture, beliefs, attitudes, behaviors) and to inform the intervention—as well as the circumstances of the child and family.
<i>You seem to have arrived at a better solution to this challenge. Can you imagine how you might use this approach in a different situation?</i> The supervisor fosters the interventionist's ability to self-reflect and then generalize effective actions to other situations.	<i>And he's feeling hopeless, just like his mom and you . . .</i> The supervisor fosters the ability to self-reflect and opportunities to experience the same type of support that one provides to children and families (parallel process).

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 one reflective supervision
 between an early
 interventionist and her
 supervisor or in a group.
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one-to-one reflective supervision between an early interventionist and her supervisor (Mann, Boss, & Randolph, 2007; Wightman et al., 2007).

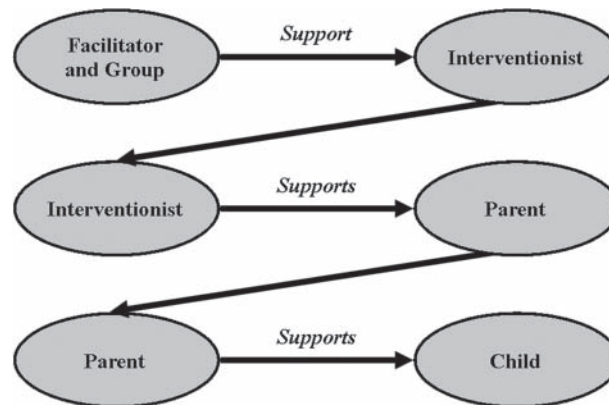
One-to-One Reflective Supervision and Parallel Process

In the one-to-one model, reflective practice is implemented in the form of reflective supervision. Here, the supervisor and the supervisee meet regularly and discuss how the supervisee feels

about her or his work with families. Parlakian (2002) described this type of supervision as “characterized by active listening and thoughtful questioning by both supervisor and supervisee” (p. 2). The reflective supervision model provides a systematic way for early interventionists to explore feelings about working with families, to help decrease burnout, and to increase staff satisfaction and morale (Watson, 2006).

In reflective supervision, the supervisor meets regularly with

Figure 1
Parallel process in early intervention



Parallel process refers to the concept that the quality of interactions in one part of the system reinforces similar patterns of interaction in other parts. In this model, the facilitator and reflective practice group maintain a safe and supportive relationship with the interventionist so that he or she can provide trusting relationships with families. This is accomplished in part through open-ended questions, such as “What do think that is about?” and “How does that make you feel?” In turn, this provides the parent with firsthand experience of a consistent and supportive relationship. One way to do this is by interpreting the parent’s comments. An example of this may be “So, it must be hard to attend to everyone’s needs.” Finally, this allows the parent to provide that same type of relationship for his or her child by using similar support, such as “I wonder if you’re feeling mad that you didn’t get to go first. How about I help you wait for your turn?”

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This type of interaction allows early interventionists the opportunity to experience the same type of support they provide to families and children, all the while learning to problem-solve the challenges they encounter in their work with them.
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individuals or small groups of staff members to discuss experiences, thoughts, and feelings related to the work. The role of the supervisor is to provide support and knowledge to guide the early interventionist in decision making, offer empathy to help explore reactions to the work, and help the supervisee manage the stress and intensity of working with families (Parlakian, 2002). This type of interaction allows early interventionists the opportunity to experience the same type of support they provide to families and children, all the while learning to problem-solve the challenges they encounter in their work with them. In the infant and early childhood mental health literature, this is referred to as *parallel process*. One way to remember the meaning of

parallel process is through the phrase “Do unto others as you would have others do unto others” (Pawl & St. John, 1998, p. 3). This interaction with the supervisor models a way of “being and doing” with families that recognizes the power of trusting relationships and sets aside time to reflect on what children and their families are experiencing (Pawl & St. John, 1998). As a result of being heard and closely attended to by the supervisor, the early interventionist can better listen to families and discover what is important to them regarding the children and themselves (Heffron, Ivins & Weston, 2005). Finally, when parents experience being listened to and supported by the early interventionist (in some cases for the

first time in their lives), they may be more able to understand the behavior and provide support to their children. Figure 1 illustrates parallel process.

Group Reflective Practice

Group reflective practice is similar to one-to-one reflective supervision except that the supervisor may not be involved and, instead, a facilitator guides the reflective practice process with a group of colleagues. The facilitator can be a mental health consultant, program director, or peer. Regardless of the type of reflective practice, the key is to develop a safe and supportive environment in which early interventionists may discuss their work.

The following reflective practice dialogue demonstrates how the interchange between the facilitator and Kelly unfolds using reflective practice based in infant mental

health work. Recall that Kelly came to her reflective practice group feeling overwhelmed, ineffective with her own skills, frustrated with the lack of services provided to the family, guilty that she could not do more, and truly worried about the children. Notice in the second part of this vignette how the facilitator provides support to Kelly and allows her to explore her experiences and feelings with this family.

FACILITATOR: So you've seen a change in her behavior with the kids, particularly as they get older.

KELLY: Yeah, it's like she takes what they do so personally. It's like she can't see the good in what they do, particularly DeMarco. She gets mad about everything he asks for, and she says "No!" to him constantly. And the boys have some really good skills, too. They play pretend together, like to play with instruments and toys. You know, they really engage together when given the chance.

FACILITATOR: So that makes it even harder for you, then?

KELLY: Yes! I see that they could do so much and go so far if Stephanie would help them. But I can't reach her. It's like something has changed and she's not open to the kids anymore. Maybe I'm starting to feel the way she does, that this is hopeless. She used to tell me that "this is hopeless, things will never change." Maybe she's right. I've worked with her for nearly 3 years now, and all I can see is that she had one more baby, is with



a no-good guy, and is acting like the little boys are out to get her.

FACILITATOR: Do you think that's how she feels?

KELLY: What, that they're out to get her? She told me that! She said sometimes DeMarco acts like he's her boyfriend, like he's the man of the house. I reminded her that he's just a little boy. It made me feel really sad to hear him blamed like that.

FACILITATOR: I can imagine—you've known this little boy since he was a toddler. How do you think this might be affecting her parenting?

KELLY: I think she can't see that he needs her help. She acts like he's all grown up and fights with him like he's her age. I never thought about it until now, but I think she's acting like he *is* her age.



FACILITATOR: What do you think that's like for DeMarco?

KELLY: I think it makes him desperate! He doesn't know how to manage himself—he's just a little kid, and here his mom is fighting with him about the most basic things. No wonder he's acting out all the time.

FACILITATOR: What do you mean?

KELLY: Well, maybe he's acting out because he's desperate for her help. Maybe he just doesn't know what to do and just feels frantic; maybe that's why he's hitting and running around screaming.

FACILITATOR: So maybe she's responding to how he is acting and doesn't know how he's feeling.

KELLY: Yes! I bet that's it. She just wants it to stop. I bet she doesn't realize that he's just a desperate little boy who wants his mom to help him

FACILITATOR: And he's feeling hopeless, just like his mom and you.

KELLY: Yes! He probably feels like no one is helping him. And I'll bet she's feeling like that too. She's been so tired and irritated and so overwhelmed by parenting three kids that she just doesn't know what to do any more.

FACILITATOR: Just like you've been feeling.

KELLY: Yes, isn't that something? It's like we all got a case of the "hopeless," like it's contagious or something! But I think I know what to do next time. I think I have to show Stephanie that we can understand what the kids are doing and we can satisfy them. I'll have to

remember that Stephanie is responding to what DeMarco is doing and does not know what he is feeling. I'll bet I can help her figure out what he and Dominic are feeling when they are acting out. She's pretty good at that with the baby. I'll bet it never occurred to her to try that with the boys!

FACILITATOR: We'll be eager to hear how your next visit goes.

Through the reflective discussion, Kelly is supported in not only what to do during her next visits with Stephanie but how to think about the meaning behind both Stephanie's and DeMarco's behavior. By experiencing a supportive "wondering" discussion about this family, Kelly experiences a nondirective, gradual development of hypotheses and solutions that serve as a model for her role in supporting Stephanie. Importantly, Kelly does not feel as hopeless and has generated some next steps in working with the family. As a result of being heard, Kelly can better listen to Stephanie and discover the things that are important and meaningful to her about her children and her (Heffron et al., 2005). This is an example of parallel process in action. Now let's see how this helps Kelly on her future visits with the family.

Today when Kelly drives up to the house, she is feeling more optimistic about her long-range plans with Stephanie and the children. The first thing that she wants to work on is repairing the relationship with Stephanie. She plans to begin this process by expressing her concern for Stephanie's well-being and

acknowledging how challenging it is to care for three young children. Her second long-range plan is to help Stephanie view the children's behavior from their perspectives. Kelly will demonstrate this by asking questions about the behavior, such as "What do you think DeMarco is feeling?" and "What do you think he needs when he's being aggressive?" Next, she wants to help Stephanie develop a plan to prevent and respond to DeMarco's challenging behavior. She plans to begin this discussion by asking Stephanie some open-ended questions about DeMarco, their interactions, and the challenging behavior. Finally, she wants to take time during each visit to reinforce and celebrate Stephanie's success.

A few weeks later, Kelly notices Stephanie taking time to listen to DeMarco, interpreting his behaviors, and offering him choices instead of arguing with him. Kelly's hopeful that Stephanie is beginning to incorporate some of the supportive ways of interacting that Stephanie has experienced in her interactions with Kelly.

The examples above illustrate several key elements of reflective practice. Through the dialogue at the reflective practice group, Kelly was able to understand more about how the family was feeling and how it had affected her emotions. Essential to reflective practice is the use of parallel process, as evident through the following elements of the interactions. The first element involves the facilitator's acknowledging the feelings associated with Kelly's intervention work and Stephanie's parenting. The second element brings attention to the strengths of the relationships between the early interventionist

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and the parent and between the parent and the child. The third element involves the use of open-ended questions by the facilitator and Kelly to wonder together, as opposed to one receiving directives from an “expert.” Both the facilitator and the interventionist, and the interventionist and the parent, used open-ended questions to explore together next steps. The final element illustrates the celebration of the accomplishment of small steps in the process—in this case, as Stephanie begins to incorporate a new quality of interaction with her children. In spite of the challenges remaining and the work to be done, the reflective practice process has allowed the early interventionist and the parent to think more clearly about the situation rather than remain stuck in a negative pattern of blame, hopelessness, and feelings of ineffectiveness.

Providing support through reflective practice addresses the needs of early interventionists to acknowledge the strong feelings that arise in their interactions with young children and their families. Reflective practice enhances their

capacity to continue to provide much-needed early intervention services through trusting, respectful, and effective relationships.

This article explores the differences between reflective practice as traditionally used in education and the way in which it is defined and implemented in the field of infant mental health. The idea of reflective practice is not a new approach, and being a reflective practitioner, regardless of the type used, is critical to ongoing professional development. Reflective practice, as used in the field of infant mental health, allows early interventionists to go beyond observable behaviors and specific skills and examine a variety of feelings and relationships associated with working with families and their children. This type of reflective practice does require a major shift in philosophy of the program and the supervisor-supervisee relationship. The appendix lists several resources that describe the steps to implement reflective practice and examples of reflective supervision in the field (e.g., Mann et al., 2007; Parlakian, 2001, 2002; Parlakian, & Seibel, 2001).

Appendix: Additional Resources for Implementing Reflective Practice

Articles and Guides

Center on the Social-Emotional Foundations for Early Learning. (n.d.). *Infant mental health and early care and education providers: Research synthesis*. Retrieved November 12, 2009, from <http://www.vanderbilt.edu/csefel/resources/research.html>

The purpose of this synthesis is to answer some of the most frequently asked questions that early childhood providers have about infant mental health, early social and emotional development, and the infant mental health system. Specifically, the guide discusses the definition of infant mental health; the importance of collaboration, promotion, and knowledge for early childhood providers; the prevention of infant mental health challenges; and interventions

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for children and families. promotion, and knowledge for early childhood providers, prevention of IMH challenges, and interventions for children and families.

Cohen, E., & Kaufmann, R. (2005). *Early childhood mental health consultation* (DHHS Pub. No. CMHS-SVP0151). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

This monograph addresses young children's mental health by providing a blueprint for child care providers to use when working with a mental health consultant. It includes information on ways to collaborate with mental health professionals and how to use these consultants in early childhood programs—including Early Head Start and Head Start programs, center-based child care, and family child care homes. It also details the role of program administrators and practitioners from the public and private sectors on promoting healthy development.

Heffron, M. C. (2005). Reflective supervision in infant, toddler, and preschool work. In K. M. Finello (Ed.), *The handbook of training and practice in infant and preschool mental health* (pp. 114-136). San Francisco: Jossey-Bass.

This chapter provides a description of the definitional, theoretical, programmatic, and competency requirements of reflective supervision. It also discusses some of the misperceptions related to reflective supervision.

Heller, S. S., Jozefowicz, F., Reams, R., & Weinstock, J. (2004, July). Starting where the program is: Three infant mental health consultants discuss reflective practice. *Zero to Three*, pp. 10-19.

This article highlights the experiences of three infant mental health consultants working in early childhood centers to implement reflective practice.

Norman-Murch, T., & Ward, G. (1999, August/September). First steps in establishing reflective practice and supervision: Organizational issues and strategies. *Zero to Three*, pp. 10-14.

This article discusses what one agency learned about building a relationship-based organization and promoting reflective practice. This article focuses on the initial stages of implementation related to the design and implementation of a supervisory system in nonclinical settings.

Parlakian, R. (2001). *Look, listen, and learn: Reflective supervision and relationship-based work*. Washington, DC: ZERO TO THREE.

The purpose of this guide is to assist organizations in implementing reflective supervision, and it shares ideas for building on existing reflective processes. The guide introduces the concepts of reflective practice and emphasizes the practice of one-on-one reflective supervision with direct service providers and administrative support staff. In addition, it includes specific techniques that can be used to establish this new way of being in an organization.

Parlakian, R. (2001). *The power of questions: Building quality relationships with families*. Washington, DC: ZERO TO THREE.

This guide discusses ways to use the "look, listen, and learn" model to help develop stronger relationships with families. It discusses specific strategies for overcoming common challenges to relationship building

Parlakian, R. (2002). *Reflective supervision in practice: Stories from the field*. Washington, DC: ZERO TO THREE.

This publication highlights four infant-family programs that are implementing reflective practices. Each profile is based on interviews with program staff, and each discusses why staff

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chose to use reflective practice, the key elements of the transition, and the outcomes that the program experienced after implementing reflective practice. In addition, the publication includes several tools designed to introduce reflective concepts to organizations.

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.

This guide includes a variety of stories developed to facilitate and stimulate individual reflection, encourage group discussion, and honor the enormous complexity of working with young children and their families. The main purpose of the stories is to help readers understand that "how you are is as important as what you do with children and families."

Websites

Name	Web Address
Center on the Social Emotional Foundations for Early Learning	http://www.vanderbilt.edu/csefel/index.html
National Mental Health Information Center	http://mentalhealth.samhsa.gov/
National Technical Assistance Center for Children's Mental Health	http://gucchdtacenter.georgetown.edu/

Note

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