



# ZERO TO THREE<sup>®</sup>

November 2010 Volume 31 No. 2

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*Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families*

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## **Putting Reflective Supervision Into Practice**

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Mindsight and Reflective Practice

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Reflective Supervision Across  
Disciplines and Settings

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Honoring Diversity and Increasing  
Cultural Understanding

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The Need to Develop an  
Evidence Base

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Leading Reflective  
Supervision Groups

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## THIS ISSUE AND WHY IT MATTERS

“Supervision exists to provide a respectful, understanding and thoughtful atmosphere where exchanges of information, thoughts and feelings about the things that arise around one’s work can occur” (J. Pawl, quoted in Parlakian, 2001, p.4). During the past three decades, ZERO TO THREE has been promoting the use of reflective supervision as an essential process for professional development in order to effectively work on behalf of young children and their families. This issue of the *Zero to Three Journal* builds on that expanding body of work by examining how programs and practitioners are creating opportunities to deepen and broaden their approaches to reflective supervision across disciplines, settings, cultural divides, and through research and professional standards of practice.

Although many have written about the importance of reflective supervision and the centrality of relationships in working effectively with young children and their families, less is written about *how* to integrate reflective supervision into practice. Guest Editor Rebecca Shahmoon-Shanok and her colleagues explore some of the challenges and opportunities of putting reflective supervision into practice in the articles in this issue. For example, authors describe how reflective supervision and practice is put into action in the emotionally charged and technologically driven hospital neonatal intensive care unit, ways to incorporate reflective supervision in the training of allied health professionals working with children with special needs, the efforts of a multistate collaboration to build competence in using reflective supervision, and efforts to begin to build an evidence base for reflective supervision and practice. Seasoned supervisors also describe techniques for using reflection in their supervision sessions that will challenge readers to think creatively and can provide a springboard for rich discussion.

An additional feature article in this issue is an excerpt from the latest publication on reflective supervision from ZERO TO THREE, *Reflective Supervision and Leadership in Infant and Early Childhood Programs*. In their chapter excerpt, authors Mary Claire Heffron and Trudi Murch provide guidance for supervisors seeking to further develop their skills as team leaders in the growing practice of group reflective supervision.

We hope you find that this latest issue of the *Zero to Three Journal* on reflective supervision continues to build your resource library, enriches your practice, and ultimately enhances the knowledge, skill, and expertise you bring to your work with infants, toddlers, and their families.

Stefanie Powers, Editor  
spowers@zerotothree.org

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

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## [www.zerotothree.org/journal](http://www.zerotothree.org/journal)

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# Reflective Supervision and Practice

## *An Introduction to This Issue of Zero to Three*

REBECCA SHAHMOON-SHANOK

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With escalating fiscal constraints alongside the accelerating time pressures of modern life, incorporating reflective supervision practices into systems and programs is an enormous challenge. Nevertheless, an increasing number of leaders and providers across disciplines believe that slowing down to recollect, review, rethink, and then respond—to become reflective—is the essential key that unlocks the passageway to effective practice with very young children and those who care for them.

Back in the late 1980s and early 1990s, when the seminal ideas of reflective supervision and practice were being conceived, gestated, and born, it would have been impossible for those involved to imagine the advances achieved by the year 2010. It was not possible to foresee the degree to which this field—which was not yet a field—has become increasingly interconnected to benefit very young children and families or the extent to which reflective supervision as a core practice has been adopted as one of its basic tenets. (For more about the early history, see Eggbeer, Shahmoon-Shanok, & Clark this issue, p. 39; Eggbeer, Mann, & Seibel, 2007.)

The field has come a long way since then with journal issues and videotapes, as well as countless articles and books—one back at the beginning (Fenichel, 1992) and some very recent (Heffron & Murch, 2010; Heller & Gilkerson, 2009)—devoted to the topic of

reflective supervision and practice. The Zero to Three issue you have in your hands is, in part, a celebration of those contributions, gifts that are becoming embodied into ZERO TO THREE as a field of study and a movement and into zero-to-five systems, programs, and day-to-day practice among both leaders and providers.

However, at this point, as we ride the crest of a wave of deep recognition that relationship and reflective practice are the heart of our work, the field has only barely begun to find researchers both published (cf., Virmani & Ontai, 2010) and as yet unpublished, committed individuals and groups who are endeavoring to demonstrate its effectiveness. Perhaps more than any other stride, the enlargement of new research in reflective supervision is required to both advance and upgrade the field.

This issue of Zero to Three was shaped in a warm, tiny church during a flawless choral

concert I was privileged to hear on a freezing evening in early February 2010, just after Stefanie Powers, *Zero to Three* Journal editor, invited me to consider taking the role of guest editor. As the music rose and fell with early music canon—pristine a cappella voices connected together, mirroring our souls and one another—the authors and topics by now gathered here emerged as leitmotifs to the harmonies holding me. I left recognizing that, despite competing demands for my time and attention, I could not say no.

In the same way that the music led to the creation of this Zero to Three issue, the articles that follow are meant to be both celebratory and generative: for example, to combine seminal concepts, like Dan Siegel's idea of "mindsight"—which itself joins neurobiology and attachment theory—with those of reflective practice (Siegel & Shahmoon-Shanok, p. 6); to motivate the allied disciplines to develop a reflective spine within their degree programs and their professional organizations' considerations (Geller, Whiteman, & Rosenthal, p. 31); to stimulate possibilities for reflective practices to become embedded into medical and emergency settings (Steinberg & Kraemer, p. 15); to help all of us to think across differences (Stroud, p. 46); to advance the implementation of reflective practices across all 50 states (Weatherston, R. Wiegand, & B. Wiegand, p. 22); to share fresh strategies

with which to actually carry out reflective supervision (Foley, p. 58; Schafer, p. 62); to inspire new research (Eggbeer et al., p. 39); and to shed light on group reflective supervision (something that happens often but has rarely been written about) in juicy excerpts (p. 51) from Mary Claire Heffron and Trudi Murch's forthcoming book, *Reflective Supervision and Leadership in Infant and Early Childhood Programs* (2010).

Just as the choir's combined voices moved me to fantasize possible articles and to participate energetically in the development of this Zero to Three issue, the reflective supervisory relationship—like all relationships—is a co-construction. I have enjoyed a similar experience in numerous exchanges entailed in the production of this publication: In the concentrated and creative process of imagining, editing, and

cowriting a couple of articles here, my own understanding of reflective communication, supervision, and practice has been immeasurably enriched. The dear hope of all who have been involved in writing and editing this is that you, the reader, will experience a parallel process of dialogue—internally or with colleagues—and enhancement to your sense of understanding such that you may feel prompted to be in touch with the authors and editors with your comments, reactions, ideas, and examples. Meanwhile, thank you for caring about the evolution and adoption of reflective supervision within our conjoined world, wherein the pursuit of improved practice with infants, young children, their families, and their communities through reflection increasingly becomes the standard of the land. ¶

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**REBECCA SHAHMOON-SHANOK, LCSW, PhD,** is a ZERO TO THREE Board Member and a well-known clinician, teacher, and author. Her expertise includes parent development, assessment, and intervention; interventions with developmentally and/or traumatically challenged young children and their parents; peer play psychotherapy; child-parent psychotherapy; the interweaving of mental health services in community-based settings; and training, reflective supervision, and practice in the birth-through-preschool field. Educated and experienced as a clinical psychologist, social worker, and early childhood educator, she also has integrated concentrations in psychoanalysis and infancy studies.

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Effective leaders of infant–family programs create relationships characterized by trust, support, and growth among professional colleagues, parents, and children. These relationships profoundly effect the quality of services provided by infant–family programs. Reflective leadership is characterized by self-awareness; careful and continuous observation; and respectful, flexible responses that result in reflective and relationship-based programs. The following resources are available on the ZERO TO THREE Web site at [www.zerotothree.org/reflectivepractice](http://www.zerotothree.org/reflectivepractice).

### Three Building Blocks of Reflective Supervision

[www.zerotothree.org/buildingblocks](http://www.zerotothree.org/buildingblocks)

Describes the central elements of reflective supervision.

### Leadership Self-assessment Tool

[www.zerotothree.org/leadership-assessment](http://www.zerotothree.org/leadership-assessment)

Brief series of statements and reflective questions that offer insight into one's leadership style.

### Leadership as a Way of Thinking

[www.zerotothree.org/way-of-thinking](http://www.zerotothree.org/way-of-thinking)

Addresses the question of what it means to be a leader and three perspectives through which to view leadership.

### What is Reflective Leadership?

[www.zerotothree.org/reflective-leadership](http://www.zerotothree.org/reflective-leadership)

Describes key characteristics of reflective leaders.

# Reflective Communication

## *Cultivating Mindsight Through Nurturing Relationships*

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*Reflective supervision is a relationship for learning (Fenichel, 1992). The partnership nurtures a process of remembering, reviewing, and thinking out loud about a specific child, the people who surround that child, and what happens, or does not, between them. It could be said that reflective supervision enhances vision, clarifying what is seen and even what is see-able. In a real sense, the effect of reflective supervision is that it nourishes “super vision”—the ability to see further, deeper and more (Shahmoon-Shanok, 2006, p. 343).*

**H**ow can something so “soft”—a relationship—penetrate so deeply? What happens between people when they earnestly communicate over time? How does one understand the process when one person is a learner and the other a nurturer? Between a daughter and her father? Between a supervisee and reflective supervisor?

In this article, we begin with relationships and then explore how individuals know another person and the nature of communication between people that nurtures the layered skills of social and emotional intelligence. At the root of these abilities is a central process called *mindsight*, which is how an individual sees the internal world of the mind (Siegel, 1999, 2010a). Mindsight is a fundamental skill that permits individuals to “see” the mental world within themselves and within others. Combining insight and empathy, mindsight also enables them to envision relationships as how two minds connect—and even to know how the brain of each person comes to resonate with the nervous system’s signals from the other. While external behaviors are perceived by the eye, ear, or sense of touch and individuals’ senses enable them to see, hear, and feel physical objects and their motion in the world, the internal life of the mind is perceived through a different set of neural circuits. These neural regions

of the brain are ready to grow with experience, shaping them from the earliest days of people’s lives. Relationships with others that focus on the internal nature of mental experience promote these mindsight circuits to increase their connectivity and function. Whether an individual is sensing her own inner mental life or empathically attuning to the internal world of another person as a supervisor does in reflective supervision with individuals or small groups, mindsight sums up the capacity of peoples’ brains to make the images that represent the world of mental activities, as well as the mental activities themselves. Just as the process called *metacognition* involves thinking about thinking, mindsight entails a form of metarepresentation in that it reveals how the mind sees itself. Beyond having a thought, mindsight permits one to see directly the qualities of thinking as a form of mental activity.

Mental activities include the familiar capacities of thought, feeling, intention,

and memory. They embrace the experience of hopes, dreams, attitudes, and desire. An individual’s mental life also involves the experience of perception, recognition, understanding, knowing, and awareness. Although each individual may possess these mental elements as a familiar part of her life, the ability to perceive them as mental

### Abstract

This article integrates ideas about mindsight with the concepts of reflective supervision and practice in the birth-to-3 field. Mindsight is the ability to have insight and empathy for the mental experience of self and others, along with the ability to sense the patterns of shared communication of energy and information exchange within relationships. The authors explore how the flow of energy and information in the context of nurturing relationships through reflective supervision supports the capacity to develop mindsight. Mindsight also refers to the neural mechanisms beneath mental and relational life. Nurturing a resilient mind within reflective communication is both art and science. The authors propose that openness, objectivity, and observation create the ability to monitor and then modify mental life itself, an internal and interpersonal set of processes that promote healthy self-regulation and emotional balance.

activities—to know individuals are thinking or feeling and not just becoming lost in a train of thought or an emotional surge—is something that may require learning and can improve with practice. That is what reflective supervision is for, the development of mindsight as a skill of knowing about a provider’s own—and her clients’—mind.

In the world of research and theory, terms such as intersubjectivity, mentalese, mentalization, mind-mindedness, reflective function, and theory of mind have been used, along with mindsight, to capture this notion that individuals can conceive of a mind—their own, as well as others—and not just have one. (See box Terms for the Ability to Conceive of Our Own and Others’ Minds.)

These concepts have helped illuminate the nature of development, pointing to the importance of reflecting on the internal nature of mental life as a crucial component in secure parent–child attachment—in child, in parent, and in early relational development, as well (Fonagy & Target, 2005; Grienberger, Slade, & Kelly, 2005; Siegel, 1999; Slade, 2005). In the attachment world, this capacity to mentalize as measured by reflective function has been proposed to be the crucial underlying mechanism of secure attachment (Fonagy, Gergely, Jurist, & Target, 2002). As Arietta Slade has stated:

*Mentalization integrates ways of knowing that are at once cognitive and affective; it is, in effect, the capacity to think about feeling and to feel about thinking (M. Target, personal communication, December 11, 2003). Thus it refers, in part, to a cognitive process, namely an individual’s understanding. In this sense, it is a metacognitive process akin to perspective-taking, and “metacognitive monitoring” (Main, 1991). In the language of psychoanalysis, it is somewhat like insight. At the same time, it refers to an emotional process, namely the capacity to hold, regulate, and fully experience emotion, in this sense akin to, but not the same as, empathy (which does not imply regulation). It refers to non-defensive willingness to engage emotionally, to make meaning of feelings and internal experiences without becoming overwhelmed or shutting down. The complex processing and integrating that is inherent in high reflective functioning bespeaks emotional richness and depth, and a capacity to appreciate and experience the dynamics of an internal and interpersonal emotional life (2005, p. 271).*

As readers may be aware, secure attachment in the very early years has been demonstrated to lead to far better child outcomes many years later (Sroufe, Egeland, Carlson, & Collins, 2005). Mindsight as a concept extends these helpful scientific views on



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**Secure attachment in the early years leads to far better child and parent outcomes many years later.**

## TERMS FOR THE ABILITY TO CONCEIVE OF OUR OWN AND OTHERS’ MINDS

These are related theoretical constructs as well as observable, evidence-based capacities associated with the development of secure attachment in the first 2 or 3 years of life. Secure attachment is rooted in the quality of affective interchange initiated by the parent to support her child and the capacity to perceive and respond to the mental life of the child beneath outward behavior.

### **Mentalese:**

Using words that reflect the mental activities beneath behavior, such as “feeling,” “thinking,” or “remembering” (Fodor, 1975).

### **Mentalization:**

The ability to have a “theory of mind,” to think in terms of the mental world that drives behaviors and is within the self and the other (Fonagy & Target, 1997). It is the “process by which we realize that having a mind mediates our experience of the world” (Fonagy, Gergely, Jurist, & Target, 2002, p. 3).

### **Mind-mindedness:**

Thinking in mental terms when considering the interactions of self and others (Meins et al., 2002).

### **Mindsight:**

The ability not only to see the mind and have insight and empathy for the mental experience of self and others, but to sense the patterns of shared communication of energy and information exchange within relationships; simultaneously, it refers to the neural mechanisms beneath mental and relational life (Siegel, 1999).

### **Reflective Function:**

The measureable functions that emerge with mentalization which describe the developmental achievement in which children acquire the capacity to mentalize the thoughts, feelings, intentions, and desires of self and others (Fonagy, Target, Steele, & Steele, 1998). It is mentalization operationalized (Fonagy et al., 2002, p. 3).

### **Theory of Mind:**

The term used in developmental psychology for reflective function, it connotes the view that a child has a “theory” that others have an internal subjective life like the self (Bretherton & Beehly, 1982).



**A relationship comprises the sharing of the flow of energy and information between two people.**

reflective function and secure attachment, integrating what processes occur within the brain (and the distributed nervous system extending throughout the body) and those that occur within the experienced and non-conscious world of relationship.

Here we take the opportunity to explore nurturing relationships and how one individual can support the development of mindfulness in another through reflective communication over time with a reliable, respectful partner. Such relationships include that between parent and child, teacher and student, therapist and client/patient, and between reflective supervisor and supervisee. Whichever nurturing relationship is in focus, mindfulness is a central feature of how growth is promoted within these interpersonal learning experiences. It is not coincidental that the ripple feature of relationships, especially the hierarchical ones described here, called *parallel process*—that is, what happens in one set of relationships has an impact on the other key relationships each person in the first has—is a lively one.

### What Is a Relationship?

AS WE DIVE into our discussion, we begin by examining the title of our article, in reverse. What actually is a relationship? In the most basic analysis, a relationship comprises the sharing of something between two people. That something can be considered the flow of energy and information. Right now, between you the reader and us, the authors, we are sharing energy and information flow. Energy is the “capacity to do something” as physicists define it. Energy comes in the various forms recalled from basic science studies. The

energy of light, heat, motion, electricity, and chemical reactions is all part of a physicist’s toolbox. What, though, is the energy shared in a relationship? Just the same as in basic physics—you are taking in the photons of light to read these words—and then your brain is using electrical and chemical energy to move from photons on your eye’s retina to activation of neural circuits in your brain. A relationship can be defined in part by how individuals share or exchange flows of energy with one another. Yet relationships also involve the sharing of information.

### And what is information?

Information is something that symbolizes something other than itself. In other terms, a *word* is a set of squiggles on a page or sounds in the air (molecules moving through space) that stand for something other than those squiggles or sounds. The phrase *Golden Gate Bridge* is not the structure over San Francisco Bay, it is a packet of information that symbolizes the bridge. Certain patterns of energy flow, such as a word, carry symbolic meaning; those swirls of energy are called *information*.

Relationships are created by the sharing of energy and information flow. *Flow* means that something moves across time. So individuals create relationships with each other by way of how they exchange this stuff, patterns of energy, and their symbolic meaning. As energy and information are exchanged between two people over time, the patterns of these configurations of flow shape the quality of the relationship that is formed. As described shortly, the type of exchange varies greatly from relationship to relationship. Those exchanges that respect the internal world of each person

cultivate the ability to see the mind—to develop the reflective skill of *mindsight*.

### Nurturing: How a Person Promotes Another’s Growth

IF A NURTURING relationship is defined as one that helps the growth of one or more members of the relationship, then how is that achieved? What does it mean to nurture someone? How do providers help clients change and grow? How does someone grow to “become” something (Pine, 1985; Shahmoon-Shanok, 1990)?—a dancer?, a pilot?, a driver?, a social worker?, a physical therapist? A parent?

A reliable, responsive service provider—no matter the discipline—is able to be aware of self and other and is also able to promote regularity, reflectiveness, and relational capacities in another being (Shahmoon-Shanok, 1990, 1991, 1992, 2006, 2009; Shahmoon-Shanok, Gilkerson, Eggbeer, & Fenichel, 1995)?

In the world of attachment research, mentalizing abilities are central to secure attachment and are revealed in measurable *reflective functions* that can be seen in how parents reflect on their own or their child’s internal world of mental experience (Fonagy & Target, 2005; Slade, 2005).

In terms of brain functions, when caregivers use these *mindsight* circuits to perceive and respond to this mental landscape of self and other, they likely induce the activity of similar *mindsight* regions in the child’s own brain. The study of neuroplasticity reveals how the activity in the brain can give rise to structural changes in the connections among the activated neural groups. In this way, relationships and the interpersonal communication they entail can produce changes in the activity and then in the physical networks in the brain. When these interactions are filled with *mindsight*, it is these mentalizing circuits that are stimulated to become active and grow. These circuits are generally the midline areas that rest beneath the forehead—a part of an interconnected circuitry located primarily in the prefrontal region of the brain. When putting all of these research findings into one perspective, it has been found that when communication promotes a perception of the mind, it strengthens these middle prefrontal areas. It is the functions of these middle prefrontal areas that are found as outcomes of secure parent–child attachment as well as in the practice of *mindful awareness*, which we discuss next. Being *mindful*, in brief, is a way of being fully present in life. In this receptive state, parents can attune to their children and create the compassionate connections that are at the heart of security (Siegel, 2010b). Simply put, when

a parent sees the mind of the child and reveals this in the reflective communication in their relationship, the child will develop the neural circuitry enabling her to see her own mind and then to have the capacity to see the mind of others.

In reflective supervision, as in any teacher–student, parent–child, provider–client relationship, nurturing is done with purpose: to assist in the growth and sustenance of compassionate human beings. However, in the case of reflective supervisor–supervisee, specific teaching of the clinical process of helping others to develop their own mindsight skills can be taken even further. In that special relationship, whether the supervisee is an educator, an occupational therapist, physical therapist, or speech-language pathologist, a mental health or medical practitioner, an arts therapist, or a paraprofessional, these professionals are cultivating enhanced emotional intelligence as a precise set of skills to meld with a provider’s disciplinary knowledge and dexterity. This increasing awareness and mounting social–emotional strength enables providers to sustain a kind of mellowness, a balanced sense that by practicing reflective thinking together, they will uncover the path of progress with and for their clients.

In reflective supervision, providers are not alone, nor should clients be left alone, even if the past has left them wounded enough not to trust or want them. Consider, for example, the parent who is mandated to get treatment for himself, or for the child, or for both. In meeting the needs of widely diverse children, parents, and coworkers, providers find many who challenge their skill set as these clients come their way, say, people who do not keep their appointments or others who make a provider feel like screaming, “I want out!” because the client has a foul odor or is repeatedly rude. The practice of reflecting with a more experienced teacher over time fosters a provider’s ability both to connect with hard-to-reach clients and to maintain relationships for growth with them over the life of a particular clinical involvement.

By its nature, reflective supervision is a process composed of several essential elements. First, it repeats with regularity over time. Like any practice, it builds upon itself. It could be described as an upward spiral of learning, doing, observing, and reflecting: learning, doing, observing, and reflecting . . . learning, doing, observing, and reflecting . . . learning, doing, observing, reflecting, learning, doing. The spiral pattern repeats and is absorbed, then repeatedly reabsorbed within each partner.

Second, reflective supervision is a relationship based on respect. Although there are differences in developmental stage,



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### Being mindful is a way of being fully present in life.

authority, and power, and, in fact, the supervisor is usually in the position of giving a grade or an evaluation, that power is generously shared within reflective supervision (Gilkerson & Shahmoon-Shanok, 2000, p. 50; Shahmoon-Shanok, 1991, 2006, 2009). When supervision is unfolding as it should, the supervisor encourages the evolution of trust by the ways in which he manifests its democratic underpinnings. That can occur because the supervisor is identified with the supervisee’s progress; with mindsight as guide, the supervisor fosters empathic collaboration, exploration, and understanding to reinforce the supervisee’s strengths, mutually noting the supervisee’s *growing edge*, those areas that are more difficult and that may require closer attention. Everyone’s interests are served when the supervisee thrives: Thus, supervisors “do unto others as they would have them do unto others” (Pawl & St. John, 1998, p. 7) as they role model how to be with others.

Third, reflective supervision develops the arts of remembering and reconsidering. “Without recollection, there can be no reflection” (Shahmoon-Shanok & Geller, 2009, p. 610). In order for reflective supervision to work, the supervisee has to recall to mind what he observed. He has to remember. This kind of memory is a skill that becomes sharper with repetition. Different disciplines encourage different forms of remembering and reporting, but all require reviewing complex recollected material (cf. Shahmoon-Shanok & Geller, 2009).

Finally, given space limits, let us pause to appreciate the particular significance

of exercising the mindsight skill in work with very young children and their key caregiver(s). Even though it is an exaggeration to say that the extent of what transpires nonverbally increases as the age of the child decreases, there is something about the special challenges—and exceptional potential—of working with babies and children so young that they are appropriately only conceived of as existing in the circle of their parent’s care (cf. Winnicott, 1975). So much of what providers perceive in work with young children and their parent(s) is nonverbal and exists within and between each member of the dyad or triad: that is, reflexes, skin tone, movement, pace, eye contact, rhythm, and sounds—to name the barest few. Profound parallels emerge and persist, which are, for the most part, nonverbal, often hovering on the periphery of consciousness: the parent with her baby (baby with parent); the parent with her remembered past caregiver(s) (baby with an accumulating array of different impressions of parent); the parent with her actual parent(s) (new grandparent, with her child as parent, revival of her own memories of her child’s babyhood and of what she knows of her own); parent with provider–supervisee (provider–supervisee with parent); provider–supervisee with reflective supervisor (reflective supervisor with supervisee and remembered past supervisees and supervisors). Each is finding her way into new roles within these dawning, new relationships. These functions lie in the realm of mindsight, often unspoken, lingering

or lurking at the outer fringes of awareness; they are modified through the reflective, regulating process of the supervisory relationship that mediates awareness and understanding for both partners, especially for the provider–supervisee. (See Figure 1.)

Everything providers do with people, every response and feeling they have about them, is determined by what is in their minds. Because the mind determines behavior, it is the mind that teachers, providers, parents, and reflective supervisors are or can be trying to nurture. *Psyche* means soul, intellect and mind. In the field of interpersonal neurobiology, a core aspect of the mind is defined as an “embodied and relational process that regulates the flow of energy and information.” At the core of people’s mental lives is the internal texture called *subjective experience*, sometimes experienced within consciousness. Yet seeing the mind as also possessing a central regulatory aspect enables providers to make a working proposal of what a strong and healthy mind would be. If nurturing relationships promote such qualities of mind, then that is a good place for us to turn next.

### Cultivating Mindsight Through Relationship

**M**INDSIGHT IS THE ability to know that individuals have a mind, not just simply have one. This ability, which

includes flexible perspective taking (one can stand in another’s shoes), enables individuals to sense the inner world of themselves and of others. Beyond just having this important set of insight and empathy skills, though, mindsight enables people to take a step outside their automatic reactions and emotions so that they can actually reflect on them. Indeed, mindsight permits a regulatory function, with its two central features. Think of when you drive a car. To regulate the car you must not only determine its direction and speed (with the steering wheel, accelerator, and brakes), you must also perceive where you are going (keeping your eyes and ears attentive). The motion of the car—the flow of your auto—is shaped by how you monitor and then modify that flow.

So, too, it is with the regulatory role of the mind. When individuals cannot clearly monitor the internal flow of energy and information, what they perceive is jumpy and unclear. Imagine holding a video camera on a trampoline as you jump up and down. The recording you make would be fuzzy and without clear details. Now if you stabilize the camera, putting it on a tripod off the trampoline, for example, you are able to make a recording that reveals more depth and clarity, rich with detail.

By helping providers learn how to regulate their reactions and emotions in the process

of learning to witness—becoming aware of themselves, nurturing relationships enable them to see more clearly. What they are seeing is the internal world of their thoughts, feelings, memories, intentions, perceptions, dreams, attitudes, hopes, and expectations. In short, nurturing relationships help providers develop a stabilized mindsight lens. With this calmer window into the world of the mind, they can invest in understanding themselves and others with more clarity. Providers can see themselves, their emotions, past, and present and how they relate to their clients—as individuals, dyads, or families—with richer and deeper dimensions and with more empathic clarity. With this enabled self-awareness, providers can better use their own internal life as a bridge linking themselves to others and as an instrument of growth.

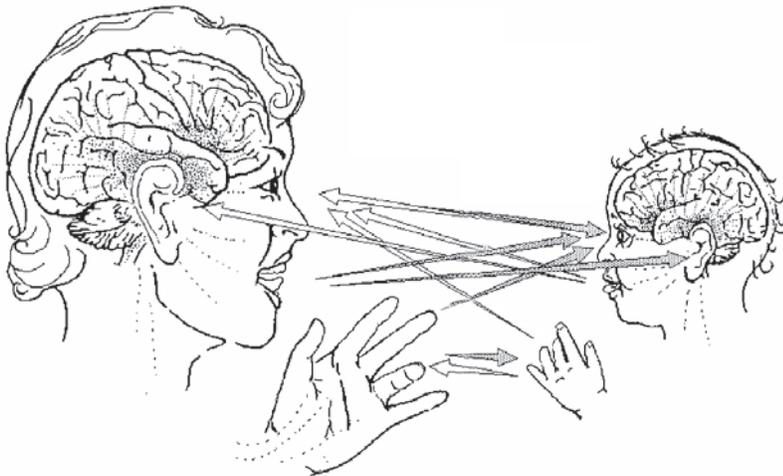
Beyond monitoring more clearly, mindsight also helps providers to modify the flow of energy and information toward health. To understand what this really means, the next logical step should be taken, which is answering the following question, “What is a healthy mind?”

### Defining Health as Integration

**T**HE INTERDISCIPLINARY FIELD of interpersonal neurobiology offers a working definition of the mind and of mental health. It is consistent with the ZERO TO THREE description of the factors associated with *infant mental health*, a summarizing term for social–emotional wellness. Through the synthesis of a wide range of sciences, from anthropology to neuroscience, health can be seen as having the fundamental mechanism of the movement of a system that is the most flexible and adaptive. This state is achieved by a certain process called *integration*. *Integration* is the linkage of different elements into a functional whole. Consider a choir singing *Amazing Grace*. Each member of the choir finds her or his own intervals yet joins with the others to achieve a flowing state of harmony. This is how each member becomes differentiated while being linked. The science of integration reveals that when linkage of differentiated elements does not occur, the system moves to either chaos or rigidity. With integration, harmony is achieved.

With a stabilized mindsight lens, providers can see clearly into their own or other’s mental flow of energy and information. They can then use this monitoring clarity to detect when chaos or rigidity is present. With this enhanced perspective, providers know what to do at these moments—they can look for how aspects of their inner life are not differentiated or evolved and then promote their specialized growth. They can then nurture their linkage. Consider a toddler with his mom in the supermarket. If the mom gives

Figure 1.



Relationships are created by the sharing of energy and information flow. Encapsulating what is coming to be widely known as interpersonal neurobiology, this figure appeared in a 1989 article by Colwyn Trevarthen at virtually the same time that ideas about reflective supervision were taking shape. Entitled “The modalities of mother–infant bidirectional exchange” in a chapter called the “Development of Early Social Interactions and the Affective Regulation of Brain Growth”, the drawing suggests the lively engagement of all sensory–perceptual domains in and by both parties. The impact upon brain development is suggested, particularly in the younger, more vulnerable partner. Each prompts an effect upon the other, whether the dyad includes parent and child, as suggested in this drawing, or two adults including, for example, a reflective supervisor and supervisee.

Source: C. Trevarthen (1989). The modalities of mother–infant bidirectional exchange. In Curt von Euler, Hans Forssberg and Hugo Lagercrantz, *Neurobiology of Early Infant Behaviour*, published 1989, reproduced with permission of Palgrave Macmillan.

an abrupt “No!” to his request for candy, the interaction may soon fall apart, with the child collapsing into a tantrum. The mom is not honoring their differences or her son’s volition—he is tempted by seeing the candy. If interactions like that happen repeatedly, their relationship will soon become rigid or chaotic. Harmony will be absent because the integration that could have occurred through *mindsight* is missing.

When healthy parent–child relationships are examined, the process of integration is found at their core. Parents who honor their child’s unique characteristics and do not try to constrain a child to be only what they expect of the child will likely be fostering secure attachment. Honoring differences yet cultivating compassionate communication is the essence of healthy nurturing relationships. From the beginning of new life, such parents are mostly able to use their *mindsight* capacities to respect their child as a separate, full-fledged human being, and, although it may at times be difficult for them, they are gradually, over the years, able to transfer their guidance, which gradually evolves to trusting their child as a capable individual on her own.

In teacher–student relationships as well, the younger person’s own special talents and interests need to be honored and explored for that relationship to thrive. In a similar way, meta-analyses of many studies of psychotherapy reveal that the most robust predictor of a successful outcome is the therapist’s own open presence. This presence is revealed in an empathic ability to sense the internal world of the client and to actively seek and openly respond to feedback on how the therapy is going (Norcross, 2002).

Nurturing a healthy relationship at its most fundamental level means cultivating integration within and between two people. What occurs within generative reflective supervisory relationships becomes transferred via parallel process into the relationship between provider and parent that, in turn, nurtures the growth of *mindsight* on the part of the key people caring for a child. When the capacity to sense the mind is awakened, it exerts a positive influence on others. In the section that follows, we explore an aspect of parallel process called *reflective communication*.

## Reflective Communication

**T**O CULTIVATE THE ability to monitor and modify the flow of energy and information toward health—toward integration—people employ, foster, and practice reflective communication. This is essentially how the connection between two people uses *mindsight* to promote a strong, resilient, and healthy mind in each person.

For many providers reflection is natural: They focus on the internal nature of mental life, not just on the externally observable feature of behaviors. *Mindsight* permits them to sense the mind and emotions behind action. Now you can tell that we are asking you to think a bit outside of the box in this article. We could have just written, “To develop emotional and social intelligence, one needs to know about thoughts and feelings.” Although this would be true, presenting our approach in this way would not allow us to do a number of crucial things. We would not be in a position to define the mind itself. In addition, we then would not be in a position to offer a scientifically based view that goes further: This is a view that enables one to understand how to nurture a healthy mind—in herself or in others—and to understand how this process is interwoven with the brain and interpersonal relationships at several levels of function simultaneously.

So, as a start, we can say that nurturing relationships will be most effective if they help the learner to reflect on the important skills involved in monitoring the flow of the mind and modifying that flow toward integration. This is how *mindsight* skills within reflective communication is taught. Thus, when a reflective supervisor murmurs out loud, “Wow, I wonder how it is for that Hispanic mom when she takes her speech-delayed 3-½-year-old to the playground in her all-White neighborhood” to her supervisee, she is inviting her to imagine the feeling mental world of the quiet, reserved mother, someone who may feel isolated, but who

may not previously conceive of mentioning her isolation to the White speech-language pathologist trying to reach her. In the caring to comprehend, this example allows one to glimpse how reflective communication with an aware, egalitarian partner supports the effort toward cross-cultural competence. When providers acknowledge and respect differences and promote linkages, they are promoting an integrative form of awareness.

In attachment relationships, communication is seen in the reflective dialogues in which a parent encourages a child or teenager to see the feelings that propelled her behavior. The question, “What was going on in you when you decided to go downtown by subway after 11 PM” asked with empathic evenhandedness, will help a youngster remember and review her actions. The parent is stating that she knows there is a mental life beneath behaviors. Learning how emotions shape thinking, perceptions, and actions is an important component of what parents teach children as in “Joey, did you see Maleeka’s face when you grabbed her truck?” Such learning happens in bits and pieces, accruing over time, and when practiced becomes the basis of emotional intelligence.

As a reflective lull before moving further along in this article, the reader may want to gaze once more at the animated, brain-to-brain communication drawn into Figure 1; it becomes possible to visualize the “circles of communication” of which the late Stanley Greenspan often wrote and spoke (1992, pp. 229–230), which exert an impact upon the central nervous systems of each partner,



PHOTO: ©STOCKPHOTO.COM/STEVE DEBENFORT

**Mental activities include the familiar capacities of thought, feeling, intention, and memory.**

whether they be parent and child as suggested in the sketch, therapist and client, teacher and student, or peer and peer.

When a child also learns from his parents or other nurturing people in his life how social interactions are influenced not only by feelings, but also by expectations, perceptions, and memory, the art of empathic understanding is further developed. Your perception of something is different from another's—and each may have elements of the truth. This is a form of *metacognition* in which the nature of thinking itself is thought about. When two people do it together, regularly cultivating their shared attention as happens in the practice of reflective supervision, asking each other questions about motives, emotions, intentions, actions, and more—those of the client, those of the supervisee, and sometimes those of the supervisor—it is likely that each will add to what can be seen, and then to what can be planned as a helpful next step. Implicit in these processes is the evolution both of good judgment and the solid ethical foundations of the infant–early childhood field as a whole, across the many disciplines that make it up.

Studies of deaf children who are raised by sophisticated sign-language parents reveal that if communication includes “words” about the internal world, children will develop these metacognitive skills well (Peterson & Siegal, 1999). However, if deaf children are raised by parents who cannot “articulate” the inner nature of the mind—using mentalese words referring to *thoughts, feelings, attitudes, expectations, perceptions, and memories*—then those children will not develop these important skills they need to understand the inner world of self and other. As Helen Keller (Keller, Sullivan, & Macy, 1903) wrote in her autobiography, her mind was born when she first shared a common word with Anne Sullivan as she learned the word *water*: With one hand held gently by her teacher in the flow of liquid from the pump, the other hand enfolded her teacher's fingers that stroked “w-a-t-e-r” on her palm. Within that insight flash, Helen realized that she had a mind and that her teacher did as well. With

Anne's mind and her own dawning one, they could share the physical perception “water.” “That living word awakened my soul” (Eakin, 1999, pp. 66–67 referring to Hellen Keller's autobiography, as quoted in Siegel & Hartzell, 2003, p. 53).

Reflective communication stirs the mind to come alive with novel, vivid insights, questions, and ideas. When people learn to share this invisible but absolutely real subjective nature of their mental lives with one another, a whole new dimension of being alive—a going further and deeper into more places—emerges in each person's life. This becomes the important perceptual ability of learning to monitor the internal stuff of one's subjective life with more stability and depth as it springs up and is recognized and nurtured in reflective supervision.

We can propose that reflective communication also strengthens the mind by enhancing the ability to modify energy and information flow toward integration. Let us further consider the setting of a reflective supervisor–supervisee relationship. If the supervisee is learning or continuing to work in the field of mental health or any of the allied professions who work with the pregnancy through 5 years age range, such as working with high-risk families filled with stress and vulnerability, then the supervisor will have a few elements of challenge that may be illuminated with the *mindsight* approach we are suggesting here.

As the supervisee and reflective supervisor become involved with one another and the work, the relationship between them can serve as a mirror of the process being explored in the high-risk family. In other words, the supervisee can use the connection with her supervisor to explore his own inner world without judgment. Another aspect of parallel process, this open, receptive setting invites supervisee and guide to participate in a living exploration of what is happening right there in the room together. With supervisees who are already trusting, the potential of this process can be articulated directly by the reflective supervisor early in their work with one another, otherwise it might have to wait until trust emerges.

A *mindsight* approach encourages the supervisor–supervisee pair to address the question, “Where is the mind?” in order to render the mind of the supervisee—and ultimately of the people in the families with whom she is working—healthier, stronger, and more resilient. When returning to the working definition of the mind as “an embodied and relational process,” one realizes that the regulatory aspect of the mind dwells in both the nervous system of each person and in the connections between one another. The reflective supervisor can encourage each

of them, both supervisor and supervisee, to bring reflection to the nature of how the sharing of energy and information flow (relationship) and the neural mechanism of that flow (the embodied brain) can be strengthened by moving these toward integration, toward health. This requires openness to whatever arises within and between two people so that the shared mental–emotional experience can create the proper sense of safety and respect that deep reflection and growth require.

Knowing about the brain and how it develops in response to experience offers a constructive way to see more clearly one part of what shapes the mind. For both teacher–student and parent–child relationships, a direct discussion of the brain can be extremely helpful. When a parent “flips his lid” in rage, for example (Siegel, 1999; Siegel & Hartzell, 2003), taking the essential step toward repair and reconnection with the child may be facilitated by understanding how the higher prefrontal cortex of the brain temporarily loses its coordinating role in balancing the lower brainstem and limbic regions where reactivity emerges. This “low-road” state of brain function is an example of impaired integration in that the differentiated upper and lower areas are no longer in communication. Now there is separation without connection. To make a repair (cf. Shahmoon-Shanok, 2000), integration within the parent and then with the child must be facilitated. Repair is healing in that it makes the connection whole in the linkage of differentiated parts as they move toward a more integrated state.

As the reflective supervisor and supervisee move forward in their work together, and thus in their relationship, it becomes possible to reflect on the deep nature of mental development from a new vantage point. The supervisee can bring in observations of the many signals within family interactions that can then be examined through this lens of integration as health. Once the supervisee has the basics of *mindsight* within his own growing set of capacities, new understandings of the clinical work with families becomes possible. What before may have felt like a blur of confusing or emotionally volatile interactions can now be seen with greater clarity and steadiness.

Although we do not have room here to review all of the steps of *mindsight's* stabilizing, regulating lens, three elements of its sturdy tripod can help one see more clearly into the internal world: openness, objectivity, and observation.

*Openness* is the way a person lets go of judgments and prior expectations and lets themselves just see and sense things as they are, even when they feel uncomfortable. Say, for example, a supervisee feels attracted to the

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P. Gilbert (2010)  
Oakland, CA: New Harbinger Press

good-looking parent of a child she home visits; the desire could become an impediment to the treatment. In reflective supervision, the supervisor manifests this open spirit and has described the importance of frankness. As the supervisee comes to trust that inherent invitation to note and describe even something that feels is embarrassing or humiliating, she becomes able, through their relationship, to face and accept it. This is how an individual creates a state of receptivity to what is, rather than distorting what she sees by the active filtering of what she thinks should be going on. An intense sense of “should” can distort the ability to see and accept what is.

*Objectivity* is the ability to sense that a thought, feeling, or memory is simply an activity of the mind, not the totality of who a person is. Being objective enables one to know that a feeling is not a fact, that a thought comes and goes, that a memory is coming from the past and does not have to imprison a person in the present or the future. Thus, in the example just above, with the greater insight and acceptance promoted in reflective supervision, the initial attraction and simultaneous mortification are likely to lose their powerful grip, shift, and become a vehicle for insight.

*Observation*, the third leg of the mindsight tripod, enables one to see clearly by building the narrator function of his mind. He can sense his self sensing, observe himself observing. When harnessed in an appropriate way, observation can decouple an individual from the automatic pilot of habits and recurrent obsessions. Observation naturally has the risk of making one feel distant from the richness of his directly experienced life. So learning to use this facet well means not running from feeling feelings fully. This is what unfolds within the stabilizing relationship for learning what is called

reflective supervision. Two minds collaborate together with openness, efforts at objectivity, and observation focused on coming to know others deeply for the purpose of assisting them develop their own mindsight and cultivate a health-promoting reflective stance.

Taken as a whole, openness, objectivity, and observation create a stabilized ability to monitor and then modify mental life itself, an internal and interpersonal set of processes that promote healthy self-regulation and emotional balance. In general discussions about reflective supervision these topics are sometimes referred to as “self and other regulation” and “awareness of self and other”. Traditional mindful awareness practices can serve as a gateway to achieving these abilities.

An individual can move more fully into the integrative, regulating functions of mindsight by learning about the many important ways in which generative, developing relationships and the embodied brain contribute to the differentiation and linkages at the core of health. One such integrative practice is called the “wheel of awareness” (Siegel, 2010b, pp. 93–98), and this can be taught within various teacher–student relationships. (See the Learn More sidebar for this and additional resources.) A visual metaphor for how an individual can become more fully aware and integrate—differentiate and link—elements in her inner or outer worlds, the wheel integrates mindful practices from the East with the theories and performance of Western therapies.

Nurturing a resilient mind within reflective communication is both art and science. Starting with a person’s own abilities as providers and reflective supervisors, and then helping others develop the mindsight skills of attuned understanding and responsiveness, she is ready to define—and cultivate—a healthy mind in another. Together, patiently,

they exercise the muscles of reflective communication to transform and grow the mind, cultivating nurturing relationships bit by bit, repeating themes and variations over time. In a real sense then, the relationship for learning called reflective supervision utilizes the power, practice, and parallels of reflective communication to nurture mindsight, the aptitude to see further, deeper, and more clearly as individuals cultivate integration in their internal and interpersonal lives. ♪

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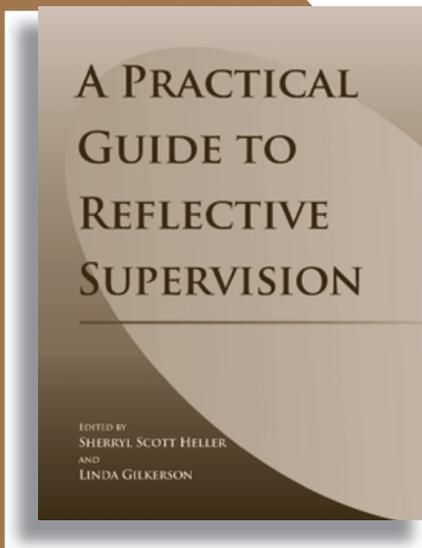
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# Cultivating a Culture of Awareness

## *Nurturing Reflective Practices in the NICU*

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Working closely with babies, young children, and their parents inevitably evokes a range of complex feelings and reactions. In response, the process of *reflective supervision*, the deepening of capacity for self-reflection so as to better empathize with the young child's or parent's perspective and respond more effectively, has been garnering increased attention. The reflective process directs attention toward inner experience and to thinking about—rather than acting upon—thoughts and feelings, especially the ways in which these are inevitably shaped in interaction with others. The practitioner is helped to become aware of her feelings and reactions in order to be able to understand and tolerate experiences of greater complexity, to better endure the attendant anxiety, and to remain emotionally available even in the disorienting face of ambiguity and uncertainty.

For the last 8 years, as psychological consultants each working 2 half days a week in a Level III neonatal intensive care unit (NICU), we have worked to create reflective spaces for staff, the families, and for and between ourselves. Brought in as part-time consultants—without staff supervisory responsibilities—to support families, we were quickly drawn to thinking about the burden of staff who confront brutal medical and emotional realities on a daily basis. When we started our work, family visitation policy changed to allow 24/7 access to the unit, which increased the frequency and intensity of the interactions between NICU staff members and families.

In a NICU—a setting saturated with fear, loss, and fragile hopes—opening up to one's own and others' experience means risking such disorientation and anxieties. Knowledge is often so dreaded it must be kept in the shadows, secreted from awareness. It requires exquisite effort to allow knowledge and experience to be thought about together so that present and past and future can be experienced and reflected upon in the present moment, which in the NICU often is a traumatic moment. The following vignette illustrates the powerful and unexpected ways in which the experiences of parents and staff can meet and generate new understanding.

*Mrs. X is a first-time mother of a critically ill surviving triplet. Concerned about the high risks associated with triplet pregnancies, her doctor urged her to reduce her pregnancy to twins, which she did at 12 weeks. Tragically, soon after, one of the two remaining babies died. Then, at 23 weeks her water broke and she was confronted with deciding whether she should risk delivering such an extremely premature baby. During the course of many meetings at*

### **Abstract**

The authors describe the challenges to nurturing reflective practices in a neonatal intensive care unit (NICU)—an environment in which life and death hang in fragile balance and where the need to defend against unbearable realities is natural, even an adaptive response. Working as consultants to this acute setting, the authors describe how they pay close attention to staff members' experiences of the parents and babies, encouraging them to reflect upon the feelings generated by these encounters. This article illustrates how the consultants' own experiences help them understand those of the staff and increase tolerance for reflective processes in NICU staff members.



### A NICU is a setting saturated with fear, loss, and fragile hopes.

her baby's bedside she has said that she never hesitated in the face of any of these decisions, yet, in other, less circumspect moments she has confessed in a low voice, "Perhaps I was negligent."

When we meet today at her son's bedside, it is an arduous 6 months since his birth, 2 months past her original due date. He lies hooked up to a breathing apparatus, feeding tube, and a tangle of IVs. The specter of severe neurological impairment hovers and haunts, but remains unspoken. The young nurse (who has worked with this baby over many months) has propped up a girl baby doll next to him, joking softly about "his favorite girlfriend." Mrs. X says, "Look how he looks at it! I think it reminds him of his sister!" The nurse is horrified, red with shame: "Oh! I am so sorry! I didn't mean for you to have to think about that!" The mother quickly replies, "It's ok. I don't think about the past; I'm just going to think about the future. We won't tell him about it. It would be too much for him to bear."

I (SK) am unnerved, both by the nurse's upset and by the mother's efforts to reassure her. And I feel unsettled by Mrs. X's intention to keep this secret. I venture, "You know, you might feel differently about this later." I go on: "Children often show that they know and even have sense memories of their siblings. Maybe you can honor your wish to not forget his sister." Suddenly the young nurse speaks up. "When I was a little girl, my mother was pregnant with twin boys. One of the babies died before birth. When my brother, the surviving twin, was 4, he started talking about wanting

to be a twin and then started insisting he was a twin. My mother told me the history but told me to keep this secret until my little brother was older. It was so hard for me; I think it was hard for my mother, too." Mrs. X is silent. She slowly says, "Maybe I will find some way to tell him. I will think about what you have said."

I feel tremendous relief, as I have often left our conversations feeling deadened by all that I felt I couldn't say, confused by a fullness so pregnant with emptiness. As I do so often, I consider what I risk in speaking up, what I lose in staying silent. We (the authors) are always asking each other if we are containing knowledge too traumatic to be spoken about or colluding with dissociative processes around guilt or shame.

I reply, "You are worried about giving him too much to digest, but I'm also wondering if we can think about your secrets as your effort to keep things tucked away and emotionally out of reach, and also, as your way of holding your memories, and your grief, close." As I speak, I recognize I am also speaking to the nurse, wanting to reassure her that her playful gesture with the baby doll did not further traumatize Mrs. X, but instead opened up a space within which it was now possible to begin to reflect and remember and even to anticipate the future.

### Bringing Clinical Process to Nonclinical Settings

THESE ARE PARTICULAR challenges to bringing a more relationship-based and contextual appreciation to highly technological, acute, intense and intensive, high-risk medical settings, which Gilkerson (2004) called *cultures of action*. Everything

in this environment is structured toward keeping relationships, communication, even knowledge and experience fragmented and dispersed (Kraemer, 2006; Kraemer & Steinberg, 2006; Menzies, 1960). The NICU in which the authors work is housed in a large urban teaching hospital that serves a very wide metropolitan area and a population that is diverse racially, economically, and geographically. There are more than 60 babies, more than 200 nurses (day and night shifts), and 15 attending neonatologists, as well as shifting rotations of fellows, residents, house doctors, and nurse practitioners. There are subspecialists of every kind (e.g., cardiology, ophthalmology) as well as physical, occupational, respiratory, and feeding therapists, and social workers. Staffing is highly staggered; neonatologists are on-service for 3 weeks and may not return for several months. Nurses typically work 13 shifts of 12 hours each every month, and they may or may not return to taking care of the same baby after their days off. This structure can leave both parents and staff feeling that the connections are impersonal and fleeting. When relationships begin to be built, the inevitable comings and goings—of staff, of parents, of babies—may feel like a series of losses. Parents witness others' babies turn blue, "crash," even die; they may say goodnight to a family whose baby is in the next isolette and return the next day to find that baby not there. Or parents see others rejoice in going home after a baby has an extended complicated hospitalization. They valiantly hold back their envy. "When will it be our turn?" "I can't bear to see any healthy babies and their proud moms," they shamefully admit.

Many premature babies live on the unit for many months; others move through more quickly. Most will survive and even thrive; some will die shortly after birth, others quite unexpectedly after lengthy stays. Acuity (severity of medical diagnosis) is high and prognosis often unpredictable. Time moves staggeringly slowly and then speeds up with rushed intensity when a crisis erupts. Babies often progress in a two-steps-forward, one-step-back fashion, while parents ride a roller coaster of anxiety that leaves them vulnerable and reactive. In such an emotional environment, tensions can erupt suddenly between staff members and families. When there is an on-going relationship between the doctors, nurses, and parents these tensions are better managed.

Yet, sustained involvement is difficult and often resisted by NICU staff members. While detachment, denial, even dissociation buffer unbearable experiences, these modes of adaptation also may dismantle thinking and compromise empathy. For example,

until recently it was imagined that premature babies don't experience pain during medical procedures. In fact, research has shown that routine experiences such as injections and blood tests cause preterm infants to become even more sensitized to pain (Durrmeyer, Vutskits, Anand, & Rimensberger, 2010). However, additional research shows that when mothers hold babies during routine procedures, the babies experience less stress (Johnston et al., 2003).

It is a complex emotional task for staff members to absorb the implications of this research and change their practices in the NICU. For staff members to adopt new practices requires that they reflect about the ways in which even daily procedures cause premature newborns significant pain (Anand & Hall, 2008). And, to know that the mother's touch may ameliorate this pain means to hold in mind the many hours the baby lies alone in the isolette, unheld and untouched. This may be either because he is too unstable to be held or even be touched, or, too often, because the parent simply is not able to be present. We are deeply concerned about these absent parents and work hard to ensure that staff members are as well. We want them to actively notice: are parents coming? Asking questions? Holding their babies, doing skin-to-skin (also known as Kangaroo) care? Are they there for the feedings, working with the feeding specialist? Are we keeping in mind that parents who get involved from early on with their babies may develop stronger beliefs about their role as parents and that this may correlate with shorter length of stay? (Melnik et al., 2006) We know that this isn't always easy to keep in focus. When we first began our consulting work, we found walking around the unit and seeing babies lying alone to be almost unbearable. Now, we ourselves see how alarmingly easy it can be to let the mother's absence slip from mind. To notice that the mother isn't there is to notice that there is a baby without a mother. It is so easy to keep this shadowed and out of awareness.

## Cultivating a Culture of Awareness

**T**HE VIGNETTES THAT follow illustrate the wide variety of opportunities to build the reflective capacities of NICU staff members.

*Ellen, a NICU nurse for more than 20 years, is efficient, assured, cool-headed in response to crisis. She also has her own 5 children and many grandchildren, and she relishes the connections with her large and engrossing family network. Yet she was outspokenly against new policies giving parents 24/7 access to the unit. Ellen and others who have known neonatology from the days when parents were allowed to visit their babies only at very restricted times*

*believe that parents will burden staff members' already tense assignment, and that parents' anxiety, sadness, and grief even will "get in the way." "We can't do our jobs as well if they hover around, asking questions and watching us like hawks. We're the professionals. When you bring your car to the garage you leave it with the mechanic, you don't watch them fix it."*

*For the past 2 days, Ellen has been caring for a tiny preemie who frequently desats (his oxygen levels dangerously plummet) and needs to be bagged (receive oxygen pumped into the lungs through a tube). Last week, Mom was touching him when he desatted; the nurse needed to rush to help. Mom has not been in the NICU since. When I (ZS) ask, Ellen dismissively says, "Maybe she's home with the other kids." I think aloud about how Mom had been coming regularly and that Grandmother lived next door and was a great help. Could it be, I wonder, that Mom reacted to her baby turning blue while she was touching him? Ellen shrugs, all the while skillfully adjusting wires and lines connecting the baby to life-sustaining equipment. We then talk about another baby Ellen had worked with for many months whose mother who was in the NICU all day, every day. I ask if it is different for her to have a mom at the bedside. Again she shrugs, but then she starts to tell me about her youngest brother, now a grown man. As a child he was hospitalized for a significant time for undiagnosed fevers and her mom was not able to visit as there were so many other children. When her brother finally came home he sat*

*huddled on his bed and wouldn't talk for what she remembers as days and days. "I wonder if it was because no one was with him in the hospital? You know, my mother always tears up when she tells this story."*

We share our thoughts and invite their responses. Parents demonstrate humbling resilience and inexhaustible courage; just showing up day after day is an act of faith and endurance. Many parents have already suffered years of failed fertility treatments and prior pregnancy losses; many have been pregnant with multiples and have lost one or more of the babies through selective reductions or an intrauterine demise, or shortly after birth. In the wake of dashed dreams of a fantasized perfect baby, parents may carry enormous shame and guilt. Often they try to cope with these difficult feelings by obsessively collecting information, insistently asking questions, hovering, and second guessing, or, as in the example above in which the baby's mother stayed home, avoiding the NICU, too frightened to return. Understandably, staff may ignore absence or bristle and feel distrusted by questioning. One set of behaviors may have many roots, we suggest to staff members. We try to sow seeds of curiosity. We approach this challenge with staff directly and obliquely. The forces against such thinking demand that we be persistent. We "hang in" with nurses and doctors as we hope they will with the families. After an all-day staff retreat in which the central focus was the



**Until recently it was imagined that premature babies don't experience pain during medical procedures.**



**When mothers hold babies during routine procedures, the babies experience less stress.**

family's essential role in developmental outcomes (Steinberg, 2004), the doctors were clearly moved by the evidence that continuity of relationships matters and decided to change the rotation schedule from 3 weeks to 4, so that they spent more time on the unit with families. The experiment was abandoned after several months as the doctors felt too depleted by the 25% increase. "It's too long to be away from our research," many said. True. It is also emotionally and physically overwhelming. In its stead, over the past 2 years there has been a steady movement to assign each baby likely to have a long stay a "primary attending" who holds the thread of the story and oversees communication. Two steps forward, one step back.

The NICU is a deeply shadowed place—death and damage stalk the halls, and traumatic anxieties are re-evoked each day the parent steps back onto the unit and approaches his baby's bedside. There are fragile babies born as early as 23 weeks gestation, weighing less than 1 pound, babies born with severe congenital anomalies or cardiac defects that require immediate life-saving surgeries, babies born with fatal chromosomal defects, and some babies with many of the above. The neurodevelopmental future for even those who will survive is often unknown. The unexpected has occurred in the most shocking of ways and, like any victim of posttraumatic experiences, parents are highly anxious, sometimes hypervigilant, sometimes deeply avoidant.

We talk a lot to staff about these parents. We hang out with them at the baby's

bedside—often without a parent present—chatting about anything and everything. Sometimes we are discussing the baby's status or the mother's state of mind; sometimes we hear about their frustrations; other times we learn about something going on in their own lives. There are many ways to nurture reflective capacities.

Sometimes we share our thoughts in email updates, teaching about postpartum depression or posttraumatic stress, or about the different ways that fathers and mothers handle the NICU experience. We email reminders:

*It is important to pay attention not only to parents who are stressed or seem to be having a difficult time but also to think about the people who aren't around. They could be depressed, traumatized, or feel they did something wrong to give birth to so critically ill a child. Perhaps they feel that they don't have anything good to offer.*

At the same time, we work to help them make sense of mothers who won't go home. Here, we remind staff about the hypervigilance that comes with trauma, and about normal "primary maternal preoccupation" (Winnicott, 1956/1975), and how this "watching over" may be a marker of attachment.

And, in ongoing efforts to encourage primary nursing, we stop by the bedside or write to pass on expressions of gratitude by a parent. "Mrs. S told me today that when you helped her hold her baby for the first time, only then, after 6 long weeks, did she first begin to feel like a real mother."

Interestingly, though we hold a lot in mind, we have also been blindsided by our own forgetting, our detaching from a particular moment so that we could meet the demands of the next situation.

*It is to be a full afternoon including meeting a visiting group of clinical psych PhD students. Before they arrive, I (ZS) circle the unit and see that baby B is not there. I ask the nurse. "Oh, he died suddenly last night—about 2 AM. Mom got there just in time and she was able to hold him." I think of Ms. B, a simple and graceful young woman with a chronic illness that made another pregnancy dangerous. This baby, now dead, was longed for, risked for. Over the weeks, as Mrs. B stood vigil by her baby's bedside, she made friends with a group of other mothers, and they supported one another. I look quickly around for these other moms but don't see them, and I have to meet the students. Afterwards I hurry to the parent support group that I facilitate. The group demands my total attention. We end after about 75 minutes and as I begin to walk down the hall, I am approached by three crying, agitated women. "Why didn't you tell us?" I remember what, moments before, in the press of current needs, I literally forgot. And I am swamped with feeling: sadness, guilt, concern, and alarm that I had not kept in mind what I had so deeply felt.*

As psychoanalysts we can make theoretical sense of the press of dissociative forces (the "forgetting" of traumatic experience) in the face of unbearable psychic realities. Still, the vulnerability to a "miscarriage of thought"—the loss of one's thinking self—is jarring. There are so many blind angles, densities, gaps, shifts, and absences of all kinds. There is also everyday familiar chit-chat. "How was your vacation?" "Hmm, is that the Zappos Web site?" "Great haircut." Photos of a wedding are shared just steps away from an isolette where a baby is being re-intubated. Life and death exist in a single moment and we can find ourselves subject to these incongruities, unexpected disruptions, and memory lapses.

When we can step back and reflect on them we become aware that these moments help us understand the forces at play for the nurses and doctors. We try to use our own experience as we encourage the staff members' reflective capacities by serving as memory keepers and linkers and trackers of experience. And we sometimes misstep: failures of empathy, overstepping, retreating too much are just some of the pitfalls. We talk to staff members, aware we are also talking to ourselves. "Remember this is a mom who...a couple who suffered through...Remember this when we speak of this or that, when we react to this or that..." The following vignette provides an example:

In the weekly psychosocial rounds, the attending neonatologist, responsible for the care of severely ill baby P, a surviving twin born at 24 weeks and hospitalized now for 7 months, expressed her concern that the mother didn't know how sick her baby was. "No one on the staff believes Mom knows what's going on," she worried. "The nurses are at their wits' end with her. She goes from doctor to doctor, trying to solicit different messages of hope. Doesn't she understand her baby will probably die?"

Feeling frustrated that there wasn't adequate opportunity to open up these concerns in a meeting that jumped from discussion of one baby to the next, and at a pace that left little room for careful reflection, I (SK) decide to contact this doctor by email later that evening. I tell her that I didn't think we had addressed her unease and say, "Perhaps it will help if we keep Mrs. S's story in mind—the 5 failed IVF attempts, the death of the twin in utero, which precipitated P's premature birth. We have to remember as well the very recent deaths of Mrs. S's father and her grandparents. Some part of her has to resist knowing the tenuousness of P's situation, which is why any flicker of improvement displaces the larger fatal inevitabilities. Denial, magical thinking, a concrete rooting in the present are her means of survival, but what can't be thought about cannot be processed or forgotten. She is confused and grief stricken, traumatized by the ways in which P is a constant reminder of his dead twin. She walks the hallways, grabbing other mothers and nurses, speaking to anyone who will listen about the 'other seven frozen embryos.' She holds on still to this omnipotent promise; it is as if she has forgotten the crushing cycles of hope, elation, and despair. I don't think she has digested any of her losses...we might say she is in a mindless place."

I close by saying, "You are trying to offer her the links between what has happened, what is happening, and what will likely happen, trying to provide her with a meaning-making safety net of sorts. It is possible, though, that her dread of knowing may be too great, which leaves you and the rest of the staff carrying daily all the burden and grief of mindfulness and knowing."

## Reflecting on the Impact of One's Words

FAMILIES, OF COURSE, want answers, want certainty, want to know what will be, and, of course, at the same time, they don't want to know (as suggested by Mrs. S's story above). These tensions are only complicated by the ways in which doctors sometimes respond to the anxious continual question of a parent: "How's my baby doing?"

Dr. C, a soft-spoken and thoughtful neonatologist, reports on a baby at a weekly interdisciplinary meeting of staff. He enumerates the multiple

problems the baby is burdened with: 28 weeks gestation, respiratory distress, possible limited vision, grade 3 brain bleed. He ends by saying, "He's fine" and moves on to the next baby in his charge. I (ZS) stop him and ask: "Can we go back to that first baby for a moment? With all the problems you listed, what does it mean to be 'fine'?" Dr. C looks up and says with earnest puzzlement, "I don't know. I guess I mean that there's nothing acute right now." This small moment led to a good discussion of what this may mean to parents, especially those who are numbing themselves with illusion or false hope, only to be stunned when they are then reminded at discharge of all the serious chronic problems that their baby is facing. (Grooman, 2004; Steinberg, 2006)

We find that we need to repeatedly remind doctors and nurses about what happens when information is filtered through grief, despair, and hope. For parents in a traumatized state, information may be impossible to grasp, meanings slip, and knowledge is ephemeral. Today, at this very moment, the focus is on the decreased need for oxygen support (good news); not, for now at least, on the profound anxiety about the intercranial bleed that could have serious neurological consequences, or even the lingering worry about the prolonged high oxygen levels over the last weeks, or months, and what that might portend for the neurodevelopmental future (bad news). What is said and what is heard, what is heard and what is understood need to be checked and rechecked. Yet the reviewing of prognoses can also be experienced as an incessant and intrusive sledgehammer.

Mr. and Mrs. O were asked to address the staff approximately 2 years after one of their 24-week twins was discharged, the other having died in the NICU after many months. They are a couple who won the hearts and minds of nurses and doctors alike—some families do. "Tell us your experience. What can we learn from you?" was the charge given to them. They took this very seriously and spoke soberly and gratefully for so much that had been offered. But they did ask that the staff not tell parents "over and over again" that their baby might possibly die, that things were dire. "We heard you. Being told again just steals our strength and our hope. Hope was our job, the only thing we could do."

Hopes, illusions, and stark realities shimmer in shadowy space and time while knowing and not knowing inevitably edge each other for attention. What are the borders, we regularly ask, between real optimism and denial? How do we help staff weather the intense interpersonal and intrapsychic demands? We move in and out of past, present, and future, looping around space and

time, engaging staff at all levels, parents, grandparents, and best friends, individually, in groups, as couples. Indeed, the unit is architecturally designed as a large loop, and we circle it many times an afternoon. The work is recursive, involving a process repeated again and again—moving forward, stepping aside, keeping our eye and ear on an issue, entering in and knitting the issues into the larger framework of the unit and each family's life. It demands an activity and assertion and an emotional presence, which we achieve with varying degrees of satisfaction.

## Putting It All Together

At interdisciplinary rounds, the attending is concerned about the intrusiveness of Mr. and Mrs. L into the medical care of their now 6-month-old baby boy, R. "They are telling the staff what to do and calling specialists on their own. They can't manage the medical care of R."

I (ZS) offer to speak with the parents and the nurse. We have heard these concerns before about other families. In particular, educated parents with babies who suffer complicated long-term hospitalizations are prone to be seen as overbearing and intrusive. This baby, born full-term and at first doing quite well, has now been in two different hospitals for a total of 7 months. He has been on and off life-saving equipment, near death more than once. He has recently had a tracheotomy, a surgical procedure that involves making an incision through the neck into the trachea to open up the airway.



**Intense feelings of shame in both health professionals and parents can collide and result in anger and misunderstanding.**

Parents are on high alert, worried sick that the next time R turns blue will signal his last breath. They are a good team, seemingly supportive and connected to each other. R is having a good day; parents are as well. But yesterday was not a good day. The tracheotomy tube had fallen out in the morning right before the parents arrived. The nurse was new to R, hadn't known how irritable he was the day before, and was unprepared for how fussy he would be during her early AM care. The parents were agitated, but by the afternoon they were more relieved than upset, and they were grateful that the staff replaced the tracheotomy tube as efficiently as they did. But they suspected that their questions and observations were taxing for the nurses and doctors.

While I reviewed the roller coaster they have been on, I realized how collapsed time was for R's parents, that each event threatened to bring them directly back to the worst traumatic moments. I describe the telescoping of thought that happens when people have been traumatized previously by something similar, and remark that his parents have seen R so close to death—what could be more traumatic? This telescoping can be adaptive, alerting one to oncoming danger, but it can also preclude seeing distinctions. R's parents ask questions, expanding the conversation to include the mom's mother's death just months before R was born. They want to know how they can let the changing staff know what they know about R, his likes and preferences. I give them suggestions about how they can pass on these vital observations without sounding challenging, and we also talk about letting new staff know the snapshot of their experience. "They may not be holding that in mind," I say. "They know what the plan of care is for today, but not what you have emotionally absorbed over these many months. Putting your comments in context will make a difference," I assure them.

After meeting with the parents, one of their primary nurses asks to speak with me. I suggest we find a private space. Donna says she wants "off the case," that she can't stand Dad's medical management. I ask her what happened recently to tip her like this. "Dad somehow knows that I'm upset, and he asked if we could speak to clear the air. I don't want to do this." "Have you always found him difficult?" I inquire. "No, the funny thing is I really love R—he's such an interactive, alert baby, and I like Dad. I imagine what I'd be like if R were my child and I'd be just as questioning and anxious." "Hmm. It is interesting that you like them so much and empathize with them. Can you find a way to let him know that he needs to

back off at times, that his scrutiny can be too difficult?" "I generally don't have a problem saying something to parents. I can be gently assertive, but I don't know why, I can't do this with them." "Donna, you know when I feel confused like that I try to think about what this person or situation reminds me of—what might be on my mind though I'm not fully aware of the thoughts." Donna looks up at me with wide eyes, "I think R will die. He's like four of my last cases, and they died. I fear he's on a downhill course and I don't want to be there when that happens, and Dad saw my face today. I don't want to have a conversation with him."

We talk about the impact of these deaths, the feelings about the grieving parents ("I don't know why they thank me when they go home with no baby."), what is provided for relatively new nurses to help them cope. So, I wonder, "It sounds like the dad's management is difficult, but the harder issue is the management of your own feelings of loss, helplessness, and ineffectiveness." Donna nods in agreement. I then ask how she would feel if she removed herself from the case. She says that she would feel terrible. "I'd sneak around trying to avoid the parents." I ask if she might find it helpful to talk regularly, to see if she could find a new way of handling her deep and caring feelings so that she can continue to be of value to the family. She likes that idea, and we exchange contact information.

Later, I write a short follow-up to the attending, who says that he met with the parents after I did and that it went well. They told him about the previous times their baby decompensated, and he responded by saying that he thought R "would be a survivor." He also says that he will try to support Donna whenever she is working. I also "loop in" one of the charge nurses who is interested to learn that the common accusation of "parents managing" may, at times, be a way for nurses and doctors to move away from their own hopelessness, helplessness, and frustration. There is one significant detour: when I write the attending, I fear that I have overstepped my role, and when she doesn't acknowledge quickly, I write Susan to anchor myself, as we so often need to do with each other.

It might appear from this vignette that more support should be offered to nurses. It is interesting that the hospital offers a support group that is facilitated by a skilled and responsive veteran nurse, yet very few nurses take advantage of it. Donna knew about the group, yet she had never gone. Nurses may feel a sense of shame when they cannot handle their intense feelings on

their own, and they do not want to expose themselves to their colleagues, just as parents feel shame about the birth of a fragile baby. These intense feelings of shame in both health professionals and parents can collide and result in anger and misunderstanding. We have found that individual, well-timed, recursive, and nonconfrontational conversations that nurture reflection can make a significant difference.

Early in our NICU work, the nurse manager said that we were "the glue" for the unit. It took us a while to understand what she might have meant. Now we realize that as we immerse ourselves in this intense, fragmented technological world, where at every moment all stand at the threshold of life and death, that "glue" is found in our efforts to link, track, reframe, and make meaning of the staff members' and parents' experiences. Creating the moments for staff members to think deeply about themselves and their work generates cohesion, tolerance, and respect for the reflective process, and enriches both the staff members and the families with whom they work. §

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# Reflective Supervision

## *Supporting Reflection as a Cornerstone for Competency*

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Reflective supervision has now become well established in the infant–family field as an essential tool for supporting effective work with very young children and their families (Eggbeer, Mann, & Seibel, 2007). The capacity for reflection is widely recognized as essential to professional competence in the infant–family field. In this article, we present our views on the nature and importance of reflective supervision and describe the ongoing efforts of a unique multistate collaboration to expand and deepen our understanding of a reflective process that is critically important to professional competence for all who work with infants, toddlers, very young children, and their families. We invite you to consider the following as an introduction to our shared commitment to a powerful rationale for reflective practice:

*Melissa, a home visitor, began her morning with a visit to 24-year-old Mona and her two young children, ages 2½ years and 6 months. The referral came from a public health nurse who was worried about Mona's depression and the children's apparent developmental delays. During the visit, Mona described feeling deeply sad and morose following her husband's job loss and the subsequent foreclosure and loss of their home. She was very resentful of now having to live with her parents. "I can't stand living like this! It wasn't supposed to be this way." Her daughter played quietly in a corner of the room, occasionally toddling over with a toy to show her mother, but she quickly retreated each time as Mona ignored her bid. The baby lay on a blanket on the floor, halfheartedly sucking from a bottle propped by his side. He whimpered when the nipple slipped from his mouth, but Mona seemed to pay no attention. When Melissa asked about the baby, Mona began to*

*sob. "The timing wasn't right for this one. He came too soon. I just don't have the energy for all of this!" she cried, waving her hand in the direction of her two children. After attempting to comfort and reassure Mona and scheduling a second home visit, Melissa left feeling distressed and overwhelmed by Mona's sadness and her apparent lack of attention to and affection for her children.*

*Melissa's second home visit of the day was with June and her 20-month-old son, Jordan. They had been referred when Jordan was released from the hospital following a 2-month stay in the NICU. Alone in the care of her baby, unprepared and overwhelmed by the multiple needs of this very fragile infant, 17-year-old June had needed months of intensive support from Melissa. During the past year and a half, Melissa had worked through many crises with the family and had come to care deeply for both Jordan and his mother. This morning, June*

*appeared very agitated and distressed. She complained that Jordan was becoming really difficult to feed. "I hate it when he's like this! I can't get him to eat! He fusses and fusses at me. I can't do this anymore! He won't listen to me and makes me so angry!" She was uncharacteristically rough with Jordan who began to throw himself around in a rage. Melissa felt confused, frustrated, and angry herself, and very disappointed in herself for feeling this way. Although she offered some supportive comments to Melissa and suggested some strategies for helping Jordan during*

### Abstract

Reflective practice and reflective supervision have been the focus of a collaboration among representatives from 14 state infant mental health associations working to enhance competence among infant–family professionals. In particular, this group has worked to examine the fundamental nature of reflective practice, to deepen the understanding of reflective supervision, and to create strategies to support the development of critically important professional capacity. The authors summarize some of the key issues that are being addressed by this group and describe their views on reflective supervision as they have emerged through this collaboration.

mealtimes, she left feeling ineffective and guilty for not doing more.

An hour later, Melissa arrived at Sunny Days Child Care for a scheduled consultation and training. As she walked through the infant room, she saw three babies in their cribs, sucking on their blankets or their fingers and staring quietly at the mobiles dangling above them. Two other babies were crying. Strapped in their highchairs, three toddlers waited for lunch. Two of them were banging on their empty trays as a third began to wail. The caregiver nearby repeated, "I'll be there! I'll be there! Hold on. Don't yell so..." In the room next door, Melissa found Amy, the young director, filling in for a staff person who had called in sick. Amy looked tired and exasperated. "Here, you can help me by taking care of him! Change his diaper, please." She held out a very smelly toddler! Melissa had planned to offer a brief training on early literacy for a few child care staff and then meet with Amy to discuss future consulting activities for the center. She had prepared hand-outs and had purchased some new picture books for the center. Two hours later, she left with all of these materials still in her bag, frustrated about the time she had wasted preparing for the training, very worried about the care the children seemed to be getting, and wishing she would never again have to visit this center.

How does one witness such painful moments as these without experiencing strong emotions—even to the point of becoming overwhelmed? How does any infant–family professional, regardless of her specific role, purpose, or professional training, manage these feelings so that they don't result in comments that are dismissive or sharply critical, or in an emotional disengagement from a mother, her children, or a child care professional? How does an early intervention professional manage her feelings and behavior without a hint of disapproval or disgust? How does the professional use those feelings to inform rather than interfere with her work in face of overwhelming needs? We believe that reflective supervision supports reflection as a crucial component of competency for all professionals working with young children and their families.

## Exploring the Meaning of Reflective Supervision

GIVEN THE EMOTIONALLY EVOCATIVE nature and complexity of work with very young children and families who are vulnerable, it is imperative that practitioners across disciplines have time to pause and reflect. They need a time and place to contemplate what they are experiencing in the presence of a family and to share their personal responses to this very difficult work. They need to feel replenished and fortified.



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**Reflection is a crucial component of competency for all professionals working with young children and their families.**

Practitioners cannot do this in isolation. They need and are entitled to the support and insight that comes from discussing with another or others what they observed, what they thought, what feelings were aroused, and what they did with an infant or young child and his caregivers. Doing so within the context of a safe and trusting professional relationship may help professionals feel “accompanied” as they prepare to go forth and continue their efforts with, and on behalf of, the family.

A belief in the importance of this process is the cornerstone of the *Michigan Association for Infant Mental Health (MI-AIMH) Competency Guidelines* (Michigan Association for Infant Mental Health [MI-AIMH], 2002a). (See box The Development of the MI-AIMH *Competency Guidelines* and Endorsement System.)

Since the completion of the *MI-AIMH Competency Guidelines* in 2002, leaders in the infant and family field have continued to refine and clarify the nature and meaning of reflection in work with families with young children. Definitions, guidelines, and directions have been developed to support both supervisees and supervisors as they engage in reflective practice. (See box Best Practice Guidelines for Reflective Supervision/Consultation.) Fundamental elements and specific components of reflective practice and reflective supervision that are rooted in the *Competency Guidelines* now guide reflective practice in 14 states that have licensed the guidelines for use in their states (Weatherston, Kaplan-Estrin, & Goldberg, 2009).

First, although reflective supervision may accompany and supplement administrative

oversight, casework reviews, teaching, and directions for addressing a specific problem or family (Schafer, 2007b), the primary focus of reflective supervision is “the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners” (Weatherston & Barron, 2009, p. 63). This focus calls for a partnership between supervisor and supervisee that develops into a secure and trusting relationship. This relationship allows the supervisor and supervisee to explore what the supervisee has experienced with infants and families, the thoughts and feelings awakened in the presence of families, and responses, both personal and professional, to the work and to oneself. Safety, consistency, dependability, respect, confidentiality, and honesty are attributes that support the development of a strong and stable reflective supervisory relationship (Weatherston & Barron). That is, reflective supervision/consultation contributes to professional and personal development within one’s discipline by attending to the emotional content of the work and how reactions to this content affect interactions with the children and their caregivers.

Second, a distinguishing feature of reflective supervision/consultation is an exploration of the *parallel process*. That is, attention to all of the relationships is important: those between practitioner and supervisor, between practitioner and parent, and between parent and child. It is critical to understand how each of these relationships affects the others. Finally, there is an

## THE DEVELOPMENT OF THE MI-AIMH COMPETENCY GUIDELINES AND ENDORSEMENT SYSTEM

Beginning in the 1980s, in an effort to guide the training of infant mental health specialists at pre-service, graduate, and in-service programs in Michigan, the Michigan Association for Infant Mental Health (MI-AIMH) Board of Directors developed and published the *MI-AIMH Training Guidelines* (1986) that provided standards for training in the field. By the early 1990s and as the infant-family field grew, others, most notably the National Center for Clinical Infant Programs (NCCIP), known now as ZERO TO THREE, identified areas of importance to training and to competent service provision: specialized knowledge, direct service experiences, and regular, collaborative, reflective supervision. By the mid-1990s, federal legislation encouraged states to develop core competencies to promote family-centered practice for all professionals working with infants and toddlers with special needs. By the late 1990s, a 12-member group in Michigan, made up of experts in the infant mental health field, seasoned practitioners, university faculty, and policy experts, in partnership with many MI-AIMH members through focus groups and committee work, agreed upon a set of competencies that the MI-AIMH Board of Directors accepted and published as the *MI-AIMH Competency Guidelines* (2002a). These guidelines reflected the early *MI-AIMH Training Guidelines*, publications by NCCIP, and the core competencies developed by the Michigan Department of Education in response to federal legislation, specifically Public Law 99-457 and Part H.

The framework presented in the *MI-AIMH Competency Guidelines* addressed competency at four levels of experience and expertise: infant family associate, infant family specialist, infant mental health specialist, and infant mental health mentor. Each level of competency is organized around eight core areas: theoretical foundations; law, regulation, and agency policy; systems expertise; direct service skills; working with others; communicating; thinking; and reflection. Each component is integral to the set of standards for competency; none stands alone. Progressively more complex from level to level, the competencies address practice across disciplines and in many service settings, across a service continuum (promotion, prevention, intervention, treatment). Reflection is a competency that is linked to best practice as agreed upon by experts in the field and the hundreds who helped to develop the systematic workforce plan.

MI-AIMH first developed the standards in response to an urgent need to identify competencies linked to best practice with infants, toddlers, and families and a particular need to heighten awareness of the social and emotional needs in infancy and toddlerhood. Research in the fields of both child development and mental health underscored the importance of the earliest years and of infant-caregiver relationships in particular. The aim was to focus attention on developing professional competence and a system for recognizing competence for practitioners whose work focused on families with very young children. The increasing recognition of the importance of social and emotional development, coupled with the emergence of concern for, and increasing understanding of, the mental health needs of preschool-age children, has greatly expanded the concerns for children birth to 5 years old and their families. When completed, the *MI-AIMH Competency Guidelines* formed the basis for a systematic workforce development plan, the *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health* (MI-AIMH, 2002b; Weatherston, Kaplan-Estrin, & Goldberg, 2009).

It is important to recognize that MI-AIMH is not alone in the effort to define competency, but joined by other leaders across the country who are developing and promoting infant and early childhood standards and work force plans. (See "Field Notes" by Mathur this issue, p. 64, featuring a plan for professional development in California.)

### Beyond Birth to 3

The recognition of early childhood mental health concerns for children has prompted leaders in Michigan and other states to ask whether the *Competency Guidelines* could be used as standards for professionals working with children older than 3 years or in preschool or child care settings. Careful review suggests that no major additions or changes to the current *Competency Guidelines* would be needed. As written, the *Competency Guidelines* are appropriate for professionals working with children from birth to 5 years old and their families; each core domain is extraordinarily relevant for best practices within the infant and early childhood community.

emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts, and perceptions on his own without interruption from the supervisor/consultant.

### A Core Area of Expertise

The *MI-AIMH Competency Guidelines* detail the specific components of reflection as a core area of expertise (MI-AIMH, 2002a). The specifics include: Contemplation, Self-Awareness, Curiosity, Professional/Personal Development, Parallel Process, and Emotional Response. More specifically, a person who demonstrates competency in reflection:

- Regularly examines own thoughts, feelings, strengths, and growth areas
- Seeks or consults regularly with supervisor, consultant, peers to understand own capacities and needs, as well as the capacities and needs of families
- Seeks a high degree of agreement between self-perceptions and the way others perceive him/her
- Remains open and curious
- Identifies and participates in learning activities related to the promotion of infant mental health
- Keeps up to date on current and future trends in child development and relationship-based practice
- Uses reflective practice throughout work with infants/young children and families to understand own emotional response to infant/family work and to recognize areas for professional and/or personal development (MI-AIMH, 2002a, p.18)

To meet competency, as it is defined by the *MI-AIMH Competency Guidelines*, an Infant Mental Health Specialist or Infant Mental Health Mentor is expected to be reflective and to nurture reflective capacities in others. It is a deeply significant responsibility, one that is at the heart of effective practice with infants and families.

### A Multistate Collaboration to Build Capacity

LEADERS FROM THE 14 state infant mental health associations who are using the *Competency Guidelines* have established a forum through a League of States to regularly examine and discuss issues and questions related to the use of these guidelines. Key representatives from each of the participating states have met annually, beginning in 2007, working collaboratively to support capacity building and professional development to promote infant mental health. Although members of this working group recognize that there is a broad knowl-



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## BEST PRACTICE GUIDELINES FOR REFLECTIVE SUPERVISION/CONSULTATION

The invitation to reflect together—one talking, the other listening—is a remarkable one. It is within this listening context that a new thought might come to mind or a feeling might be experienced that leads to a shift in understanding. These key concepts are embedded in the *Best Practice Guidelines for Reflective Supervision/Consultation* (Michigan Association for Infant Mental Health, 2004). In sum, the following principles are integral to the League's present beliefs about reflective supervision: wondering, responding with empathy yet sharing knowledge if a crisis arises, inviting contemplation rather than imposing solutions, recognizing parallel process, supporting curiosity, remaining open, and recognizing the power of relationship as it affects health and growth.

The primary objectives of reflective supervision/consultation include the following:

Form a trusting relationship between supervisor and practitioner

- Establish consistent and predictable meetings and times
- Ask questions that encourage details about the infant, parent, and emerging relationship
- Listen
- Remain emotionally present
- Teach/guide
- Nurture/support
- Apply the integration of emotion and reason
- Foster the reflective process to be internalized by the supervisee
- Explore the parallel process and allow time for personal reflection
- Attend to how reactions to the content affect the process

In the work of infant mental health, some say that it is the relationship that promotes therapeutic change (Boston Change Process Study Group, 2010). From the perspective of the League of States, relationship is the context in which professional development and personal change takes place as well.

**Safety, consistency, dependability, respect, confidentiality and honesty are attributes that support the development of a strong and stable reflective supervisory relationship.**

edge base and many skills that are critical for successful work with families with infants and very young children, it is not surprising, given the centrality of reflection to the *Competency Guidelines*, that League members have identified reflective practice and reflective supervision as central and therefore worthy of special attention. For professionals at all levels, this refers specifically to competence in using supervision as a tool to become more reflective, and therefore more self-aware, when working with very young children and families. For professionals who supervise others, this also means using supervision to help other professionals become more reflective and self-aware as they supervise and mentor front-line staff.

The specific parameters and qualities that define reflective supervision and the features that distinguish reflective supervision from other forms of supervision continue to be examined and discussed by leaders in the infant-family field (Gilkerson, 2004; Heffron, 2005; Schafer, 2007b; Shamooshanok, 2009; Weigand, 2007). Although much has been said and written, there remain sometimes subtle, sometimes significant differences in the definition, defining characteristics, and qualitative dimensions of its practice. Both “at home” with colleagues in their individual state infant mental health associations, during monthly League leadership conference calls throughout several years, and together during annual League retreats, League representatives who have

embraced the *Competency Guidelines* as their own have continued to explore and study the nature, function, and importance of reflective supervision.

### *League of States Accomplishments*

The efforts of the League of States have led to three outcomes. First, although League members agree on the common guidelines to help define and identify competence and all League members use these in their individual states, they have come to recognize that *reflective practice* and *reflective supervision* remain emerging constructs. Variation among definitions and core elements of their practice requires ongoing examination and discussion of just what these key professional competencies involve. League members are interested in the intra- and interpersonal processes that distinguish reflective supervision from other approaches to supervision and professional development. Second, they have become intrigued by one important feature of reflective supervision: the supervisor or consultant's ability to be “present.” League members have come to especially value attending fully to the supervisee's “agenda”: the story she needs to tell and the feelings, thoughts, and intentions imbedded within this narrative. League representatives have been examining this capacity in their own states and in “retreats” together, using “fishbowl” group and individual supervisions, guided discussions, and reflective exercises. Finally, they have begun to ask



**Time spent in the presence of very young children and their families often awakens powerful feelings and memories of one's own childhood experiences.**

questions concerning the worth, or effectiveness, of reflective supervision and strategies for attempting to answer these questions. The League has established a subcommittee within its leadership to seek funding for this work. What follows suggests how the League leaders are working together to understand processes in reflective supervision.

### ***Intra- and Interpersonal Processes in Reflective Supervision***

As the infant and early childhood field continues to grapple with defining reflective supervision, one question is of particular importance to the League of States: "What intra- and interpersonal processes promote reflective practice and reflective supervision?" While there has emerged a general consensus among many leaders in the field concerning the *process* of reflection and reflective supervision, further examination of the most useful intra- and interpersonal elements and qualities of reflective supervision has become a key focus of League members' work together. Exploration of these elements is a challenging one, in part because of the unique characteristics of infant–family work.

For one thing, infant mental health is a multidisciplinary and interdisciplinary field. Some in the field are mental health professionals, trained to engage with mothers, fathers, and infants or very young children to support the relationship, the child's development, or both. Others are early childhood specialists, trained as educators or developmental specialists to work with children. Still others are health care professionals working with adults in hospital, clinic, or public health

settings. It is important to keep in mind that the work of infant mental health is carried out in a wide variety of contexts and settings: a traditional office or clinic where the professional has control over the setting, or in someone's home, around a kitchen table or on the couch or on the floor with the baby and parent together. Furthermore, the work is not always about some specific problem the parent or infant is facing for which the practitioner might have professional insight or solution. Rather, the work is more likely to be about the infant or toddler's development within the context of the developing parent–child relationship, requiring careful observation as the practitioner watches a relationship unfold. It might be witnessing the baby turn away from his mother who already feels rejected or watching the father misread his toddler's bids for attention time and time again or listening to a mother describe her sorrow regarding her young child's significant developmental delays.

What infant and family professionals share is time spent in the presence of very young children and their families, moments that are evocative and that often awaken powerful feelings and memories of their own childhood experiences. Some of these are explicit and conscious, others are temporarily suppressed or even unconscious.

### ***A Holding Environment and Being Fully Present***

Leaders in the infant–family field have long recognized the importance of creating and providing an environment for the professional where feelings evoked by this work can be

expressed, contained and, as appropriate, explored within the context of a safe and secure supervisory relationship (Eggbeer et al., 2007; Weatherston, 2007). For many League members this is the fundamental purpose of reflective supervision: to provide a *holding environment*—not an attempt to help the worker figure what to do or how to fix (although that may be part of a supervisory conversation, especially in the event of a crisis), but to create an interpersonal space where the professional can think and give voice to the powerful emotions that are often aroused by this work, trusting that these thoughts and feelings will be held and affirmed rather than judged, reframed, criticized, or corrected.

Establishing and maintaining this holding environment requires supervisors to be fully present to their supervisees' internal experience during their work together. Supervisors should set aside a predetermined administrative or clinical agenda in order to allow the supervisee to identify and pursue what he wants to talk about during the time they have together. Although supervisors value the idea of presence when working with a parent and an infant or very young child, they often struggle to be present when supervising another or others. To be witness or simply hold does not seem like enough. Instead, supervisors want to teach, provide insight, or find the "moment of meaning" that will help their staff or supervisee help the infant or toddler and the family.

*The minute we begin to work in this way, we have imposed our own agenda and interrupted our capacity to create a space for another to explore. When individuals are allowed to continue thinking about and exploring their own ideas without interference from another or the imposition of another agenda, the knowledge gained is their own. It comes from within. It is implicitly rather than explicitly derived. This is the same kind of active learning we so advocate for in young children. ...In the case of a supervisee, the active pursuit of knowledge is toward a deeper understanding of her own inner world. Who am I? What do I think? What do I feel about that? How did I come to feel this way? What are the implications of those feelings for others? These personally valid answers cannot come from external sources. They must be discovered by the individual. They lie within. (Wightman et al., 2007, p. 32, quoting B. Weigand)*

Key to supporting this process is the supervisor's capacity to recognize and affirm that each individual's professional experience of a family is unique, relevant, and often deeply personal, as the following example illustrates.

During a reflective supervision group consisting of several infant–family professionals who have been meeting together for 3 years, the facilitator planned a session in which they were going to explore the idea of parallel process. She read the first page of a case study that described a depressed mother with a history of past abuse, loss, and abandonment, who was now parenting three very young children. After reading the initial history, the facilitator stopped and asked what emotions were evoked in each member as they listened to the mother’s story. Each member was given a chance to respond. The first member said that listening to the case made her feel overwhelmed with emotion and helpless. The second reported feelings of anger, bordering on rage. The third said she was identifying with a feeling that the mother had no voice, has never had a voice. The fourth said she felt very agitated and that she wanted to get active on the case. The fifth member agreed, saying she did not really feel anything other than a sense of, “Let’s get something done here.” The sixth said she felt the opposite in that the case made her feel paralyzed with helplessness and grief for the mother and she did not know where to start. A seventh member said the case just made her tired because so many of her cases had the same history. It made her feel like quitting.

All members of this group supervision were open in sharing what they thought and how they felt in response to this family. There was not one correct feeling important to the parallel process. There were many relevant and therefore potentially clinically important parallels. The challenge for the supervisor was to remain witness to each, present, accepting and affirming as she listened. This is how a reflective supervisor is challenged to “be,” to bear witness to the uniquely personal experience with which each practitioner enters into a relationship with a parent or parents on behalf of an infant, toddler, or very young child. In his description of a “mindfulness” model of supervision William Schafer (2007b) emphasized the importance of the supervisor’s capacity for presence and described it this way:

*Presence is the experience of being internally still without resistance or judgment and, hence, completely accepting and open, regardless of the experience. . . . It requires that one surrender the natural impulse to do and instead to maintain a stance of compassionate awareness for what is (p. 14).*

The following example from a reflective supervision training conducted by Schafer, a clinical psychologist, and Alice Mixer, a clinical social worker, illustrates this idea.

*At a recent reflective supervision training session for supervisors and experienced clinicians, two cases were presented for “fishbowl” supervisions. Both cases had several features in common. First, both supervisees were very invested in the cases and had given great deal of professional expertise, time, and emotional energy to their attempts to provide a positive outcome for the families. So much had they given to date that they “felt drained” by the intensity and sadness of the cases and by their strong and seemingly endless but futile efforts to change the outcomes. Secondly, many elements of the case were “out of their hands” and beyond their control. In the first case, the therapist had been working tirelessly to try to improve the circumstances of a child placed with insensitive and hostile foster parents as she watched him “regress,” showing signs of greater and greater distress. Sadly, the court was categorically unwilling to place the child in a more positive setting. In the second case, the supervisee was a neonatologist who had worked tirelessly for months to save the life of a premature infant who was all but certain to die. She knew that the baby could not live and felt as though keeping her alive was causing the baby great pain. She desperately wanted peace for the infant, but the parents were not yet able to give up hope, so she was forced to continue attempting extraordinary life-saving procedures.*

In cases such as these what can be offered? What truly helps? In neither case could the supervisor offer any suggestion that might save the case. The task facing the supervisors and the group was to be able to offer “the experience of being internally still without resistance or judgment and, hence, completely accepting and open, regardless of the experience. . . . (to) surrender the natural impulse to do and instead to maintain a stance of compassionate awareness for what is” (Schafer, 2007b, p. 14). The presence of the group, offered as the supervisees expressed and felt the legitimacy of the full range and depth of their emotional experience of these painful cases, fortified the supervisees as they came to recognize the appropriateness of their emotions and felt accompanied in their struggle. They had to return to these cases. They had to continue. Now they were less alone.

Participation in a supervisory experience of this kind made the group acutely aware of just how difficult it is to maintain stillness and presence—how hard it is to not do. Yet that might be the most valuable element of our efforts: to learn to be with.

As League members continue their work together, they hope to continue to examine more closely these intra- and interpersonal processes that are essential to effective reflective supervision. They

hope to deepen their understanding of those processes that specifically contribute to the supervisor’s ability to remain fully present and to understand the parallels that are the supervisee’s awareness of what is, the supervisor’s awareness of what is, and ultimately the child’s and the parent’s experience of what is. As they learn increasingly more helpful and effective strategies for ensuring that supervisees feel held, they expect to more effectively support reflection both in those they supervise and in themselves as supervisors and consultants.

### ***The Effectiveness and Value of Reflective Supervision***

Another important, equally complex, question that the infant–family field and League members are exploring is, “How do we know that reflective supervision contributes to competence in infant–family practitioners?” If reflective practice and reflective supervision are central to infant–family work, then competence in this realm should contribute to some positive outcomes for infants and their parents, and for practitioners. That is, some measurable or observable intra- and interpersonal changes must surely occur. League representatives collectively wonder most generally, “How do we know whether or not reflective supervision works, and, if so, when?” They ask, “Does *good* supervision *always* produce immediately observable change?” In short, they want to know if at all, and when, participation in reflective supervision contributes something meaningful and positive to the professional and the families they serve.

These are very tricky questions to try to answer! At first look, one would think that a simple strategy for observing and evaluating competency (or some other outcome) before and after the intervention would yield a compelling answer one way or another. The infant–family field (and those related to it) has a long history, a rich tradition, and a wealth of empirical tools for attempting to answer such questions. However, intra- and interpersonal relationships are dynamic systems involving complex relationships. Examining how such systems behave and change requires an understanding of the essential characteristics of complex systems, as well as the development of strategies for observing how these systems change and the consequences of the changes practitioners observe.

A simple, linear view of change applied to reflective supervision would lead its participants to expect that each session would indeed be incrementally more reflective and more therapeutically insightful and useful than those previous. Is this what

## Learn More

### Books

#### A PRACTICAL GUIDE TO REFLECTIVE SUPERVISION

Scott Heller, S., & Gilkerson, L. (Eds.) (2009) Washington, DC: ZERO TO THREE

Heller and Gilkerson offer an edited collection of chapters in which authors from across the country translate theories about reflective supervision into practice for professionals working in a variety of ways with infants, toddlers, very young children, and families.

#### THE PRESENT MOMENT IN PSYCHOTHERAPY AND EVERYDAY LIFE

D. Stern (2004) New York: W. W. Norton

Stern provides a compelling and useful look into the subjective experience of daily events. He explains how our subjective experience of these moment-by-moment events, whether we attend to them consciously or not, influences our thoughts, feelings, intentions, and actions. His work in this volume helps to understand what it means to be fully present.

### Article

#### WORKING WITHIN THE CONTEXT OF RELATIONSHIPS: MULTIDISCIPLINARY, RELATIONAL, AND REFLECTIVE PRACTICE, TRAINING, AND SUPERVISION

D. Weatherston, & J. Osofsky (2009). *Infant Mental Health Journal*, 30(6), 573–578.

### Web Sites

The following League affiliates have Web sites of interest to this article:

#### ARIZONA: INFANT TODDLER CHILDREN'S MENTAL HEALTH COALITION OF ARIZONA

[www.itmhca.org](http://www.itmhca.org)

#### CONNECTICUT ASSOCIATION FOR INFANT MENTAL HEALTH

[www.ct-aimh.org](http://www.ct-aimh.org)

#### COLORADO ASSOCIATION FOR INFANT MENTAL HEALTH

[www.co-aimh.org](http://www.co-aimh.org)

#### IDAHO ASSOCIATION FOR INFANT MENTAL HEALTH

[www.aimearlyidaho.org](http://www.aimearlyidaho.org)

#### INDIANA ASSOCIATION FOR INFANT AND TODDLER MENTAL HEALTH

[www.mentalhealthassociation.com/jiaitmh.htm](http://www.mentalhealthassociation.com/jiaitmh.htm)

#### KANSAS ASSOCIATION FOR INFANT AND EARLY CHILDHOOD MENTAL HEALTH

[www.kaimh.org](http://www.kaimh.org)

#### MICHIGAN ASSOCIATION FOR INFANT MENTAL HEALTH

[www.mi-aimh.org](http://www.mi-aimh.org)

#### MINNESOTA ASSOCIATION FOR INFANT & EARLY CHILDHOOD MENTAL HEALTH

[www.macmh.org](http://www.macmh.org)

#### NEW MEXICO ASSOCIATION FOR INFANT MENTAL HEALTH

[www.nmaimh.org](http://www.nmaimh.org)

#### OKLAHOMA ASSOCIATION FOR INFANT MENTAL HEALTH

[www.ok-aimh.org](http://www.ok-aimh.org)

#### TEXAS ASSOCIATION FOR INFANT MENTAL HEALTH

[www.taimh.org](http://www.taimh.org)

#### WISCONSIN ALLIANCE FOR INFANT MENTAL HEALTH

[www.wiimh.org](http://www.wiimh.org)

can be expected of both supervisor and supervisee? For many practitioners the answer is likely, “Yes,” if not in how they think theoretically about reflective supervision, then certainly in how they feel at the end of a session and, more generally, about their effectiveness in this work. Subscribing to this view means that most practitioners are not faring especially well in this work, or at least that they often are left to feel frustrated and inadequate.

It is becoming increasingly apparent in infant–family work that as practitioners observe and discuss samples of reflective supervision, that either few, if any, of them are at good at reflective work, or that linear models of change are inappropriate for use in gauging the worth and effectiveness of the intra- and interpersonal change that they hope to achieve. Some are beginning to question whether the dynamic models of change described by systems theorists (Boston Change Process Study Group, 2005; Thelen, 1990) more accurately characterize the nature and processes of change that typically occur as a consequence of reflective work.

Specifically, these dynamic models of change identify and explain several phenomena that seem to be characteristic of reflective work. First, dynamic systems theorists would recognize the inherent variability or heterogeneity and indeterminate quality typical of the thoughts, feelings, and behaviors that occur during supervision (Fogel, 2011; Granic & Hollenstein, 2003; Thelen & Smith, 1998). *Sloppiness* is the term used by the Boston Change Process Study Group (2005) for the “indeterminate, untidy, or approximate qualities” inherent in the “co-creative process between minds” (p. 694). Because such qualities are inherent in complex dynamic relationships, we would expect that the “degree” of reflection in a supervisee would legitimately vary from session to session, and from family to family, and that the degree or depth of reflection a supervisor accomplishes with supervisees would vary from session to session. Learning how to recognize and evaluate change over time while accepting heterogeneity in reflective capacity and the sloppiness of the process remains an important consideration.

## How Does Change Happen?

**H**OW CHANGE HAPPENS during reflective supervision and what it looks like when it does can also be examined from a dynamic systems perspective. Dynamic views of change recognize that, whereas some developmental changes are linear and incremental, many are transformational or, as Emde (1989)

has suggested, epigenetic. Often-cited examples from infant development include the emergence of such motor patterns as rolling over and walking. In these cases, babies are not doing something better or incrementally more efficiently; they have learned to do something entirely new. Often such changes—which also include that first delightful social smile or the less delightful, first definitive “NO!”—occur relatively suddenly in developmental time; they seem to erupt spontaneously with little warning (unless the adults have been watching *very* carefully for their often subtle and elusive precursors). Is this more likely to be the nature of the changes that supervisors expect and hopefully experience in a supervisee’s capacity for reflection? Might this be a more useful and accurate model of change for evaluating progress toward competence in reflective practice and in their ability to provide reflective supervision? That is, rather than continuous incremental growth, might change be characterized by sporadic “Aha!” moments that transform practitioners’ work? Much as Stern (1995) suggested in his description of brief serial approaches to parent–infant psychotherapy, might brief moments of significant growth be interspersed with extended periods of relative stability? As practitioners consider learning about and possibly embracing a more dynamic model of change they must learn to recognize and provide support for these moments of transformational change.

## Measuring Success

**D**YNAMIC VIEWS OF development also suggest that recently achieved abilities or milestones often appear fragile or unreliable, especially when coupled with other newly emerging skills or when applied to novel and challenging circumstances. This view also suggests that major changes or shifts—leaps forward, so to speak—are preceded and forecast by periods of disorganization, even apparent regression. How then might the disorganization that precedes substantive change during supervision look? What might this mean for what practitioners look for as success, and how they look for it, in reflective supervision? If supervisors are to consider a supervision successful, must there be a moment of reflective insight? If nothing happens, or if one or both parties feel lost or disorganized, is this an indication of failure or impending growth? What is happening if supervisor and supervisee together wonder and struggle to find a sense of direction? Do periods of disorientation or uncertainty indicate problems or potential failure, or might they be precursors to significant professional growth or insight?

## A Community of Reflective Practice

**W**E ARE NOT suggesting that League representatives have answers to any of these questions or that they have begun to apply dynamic systems principles to their considerations of whether or not and how reflective supervision works. In fact, they have not even clearly identified the questions that are most crucial to learning how to use, provide, or evaluate reflective supervision. As a “community of practice,” they are striving to chart a course of study together that will help to identify the most relevant issues to examine, consider strategies for improving their understanding of reflective supervision, and develop and practice activities for improving their ability to use and provide reflective supervision.

### Training to be Reflective

League members continue to grapple with the question, “How do we effectively train for reflective practice and reflective supervision?” Inviting reflection and promoting both the disposition to be reflective and competence in the use of reflective supervision is challenging, especially for professionals whose prior training or professional discipline has not included or promoted the practice as a worthwhile skill (Emde, 2009; Gilkerson, 2004). The League members have tackled this head on: Few leaders across the many states were experienced in reflective supervision, so those in states that had this expertise were invited to provide intensive training over many months. This has served to build a cadre of professionals from different disciplines and in a variety of services who are more confident about their reflective practice skills.

In addition to training, all League states have designed reflective supervision experiences for practitioners and supervisors, offering opportunities for personal and professional exploration within the context of groups for a minimum of 1 year, many for several years. These reflective supervision groups have varied depending on the needs and resources of individual states. Some have organized reflective supervision meetings monthly for practitioners on the front line to engage in conversations about their work and responses to their work for a minimum of 1 year. Others have organized reflective supervision groups for supervisors, offering opportunities for live or fishbowl supervisions followed by thoughtful discussions with all of the supervisors about their roles, responsibilities, and experiences supervising others in reflective work. Still others met face-to-face initially for small group discussions with an expert facilitator and have continued with monthly phone

consultations, using new technologies such as Skype. What all have valued is the commitment to working together, over time, allowing trusting relationships to deepen and for each to experience the meaning of reflection in their work and for themselves.

### Systems Changes

As a result, systems have changed in many states. Some now require reflective supervision for Medicaid-funded services (Michigan); others require reflective supervision for early childhood mental health consultation projects (Kansas and Minnesota); still others have instituted reflective supervision in home visiting programs (New Mexico) and child care programs (Texas) in their states; and still others have embedded reflective supervision in university programs (Arizona) and certificate programs (Minnesota) to promote competency at the pre-service and postgraduate levels. In sum, the adoption of the *MI-AIMH Competency Guidelines* and the *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health* (MI-AIMH, 2002b), the full plan for workforce development, has called attention to reflection as the basis for competency in the promotion of infant mental health. This has stimulated the development of collaboration among professionals from 14 states who are now working together to expand and deepen their understanding of the nature and value of reflective supervision. Together, they have created opportunities for regular reflection within the League and, along the way, have nurtured the capacity to be reflective in their professional and personal lives. ♣

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# Enhancing Discipline-Specific Training Across Allied Health Professions Through Reflective Supervision

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Consider the following questions one might typically hear from a concerned parent:

- When will my child talk?
- When will she use sentences?
- When will my child walk?
- Is my child ever going to have good health?
- Am I always going to see all of these professionals?
- Will my child always be like this?
- Will my child get better?
- When is my child going to die?
- Will my child function like a “normal” child?
- Will he be able to keep up with his friends?
- Why does she have low tone?
- What can I do to help?
- Was it my fault?

In working with young children with developmental disabilities and their families, we have often been faced with these and other questions that challenged us and left us feeling unprepared, and unsure, as to how to respond. These actual questions have been raised within our respective practice experiences within speech–language pathology, occupational therapy, and physical therapy. Most allied

health professionals have been well trained to assess and treat a broad range of developmental disorders in young children. Acquisition of a strong knowledge base—such as anatomy and physiology of the human body, neuro-anatomy, typical developmental processes, and assessment and treatment of pediatric and adult disordered processes—is viewed as essential to the course of study. Understanding the psychological underpinnings of the child’s social–emotional development or the parent–child, or provider–family, relationship is minimally studied, if at all.

In this article, we discuss the established parameters of professional preparation common to our disciplines; describe aspects of professional training that have been neglected, or minimized, in the applied non-mental health disciplines; illustrate how relational and reflective supervision is necessary for best clinical practice; share how we made transformations in our own clinical work through the use of reflective supervision; and detail the benefits, possibilities, and challenges in using a broader and more integrative model of intervention in allied health disciplines. This article is a call for allied health professions to incorporate relational and reflective principles into graduate and postdegree training programs. Although it is beyond the scope

of this article, it is equally true that mental health practitioners can benefit from using the developmental knowledge and domain-specific expertise of allied health practitioners to broaden their own scope of practice.

## Abstract

The professional preparation of allied health professionals typically focuses on the acquisition of knowledge in a particular area of expertise with less consideration of training on social–emotional development and on how to engage parents in the clinical process, parent–child relationships, or principles of mental health. The authors explore how their respective training in speech–language pathology, occupational therapy, and physical therapy was enhanced by integrating principles of infant mental health intervention through reflective supervision and practice. The article highlights the benefits, possibilities, and challenges in incorporating relational and reflective principles into the training of allied health professionals.



**Therapeutic intervention across all allied health disciplines involves relational work with clients and families.**

## Professional Preparation in Allied Health Professions

**E**ARLY IN THE history of allied health disciplines, the therapeutic relationship was regarded as an important element in intervention. In these early paradigms, the practitioner served as the expert in the therapeutic enterprise. As Taylor (2008) noted, “The [occupational] therapist served [sic] as a kind of master of ceremonies who orchestrated the environment and the unfolding process of occupational engagement” (p. 5). Similar patterns are evident in speech–language pathology and physical therapy. Over time, a paradigm shift resulted in a more mechanistic focus on the intervention, emphasizing the therapist’s role in identifying the client’s core impairments and reducing the effects of the underlying pathology. This model of intervention continues to dominate discipline-specific approaches today, in which “the problem is located in a specific body part or domain of functioning within the ‘patient’ and the burden of fixing the problem is laid solely on the practitioner/helper” (Moss & Wightman, 1993, p. 6).

### *Established Parameters of Professional Preparation Across Allied Health Disciplines*

Education and training for allied health professionals focus on the acquisition of a broad base of theoretical, analytical, and technical knowledge as the basis of intervention with young children with varying developmental disabilities. Discipline-specific knowledge is emphasized in graduate training programs because practitioners need

to acquire an enormous amount of information in their content area. For all allied health professions, entry-level practice is based on attaining basic competencies in specific knowledge and skill areas (Council for Clinical Certification, 2005).

Although the acquisition of discipline-specific expertise is imperative, therapeutic intervention across all allied health disciplines involves relational work with clients and families. Interpersonal and intrapsychic dynamics form the basis of all clinical relationships whether we acknowledge this aspect of our work or not. Discipline-specific training often focuses on observable aspects of the delay or disability with little attention paid to the latent or underlying forces that impact our work, and relationship-based principles have been neglected within discipline-specific education (Geller & Foley, 2009a, 2009b; Norman-Murch, 1996; Shahmoon-Shanok & Geller, 2009). As Moss and Wightman (1993) noted, “Most preservice professional training is not designed to help practitioners learn to establish, maintain, and strengthen relationships that are collaborative, respectful, and rewarding to all participants” (p. 1). Furthermore, they noted that “current training practices all too often perpetuate models of relationships characterized by dependency and an inequality of power” (p. 1). Although these comments were written more than a decade ago, this way of working remains evident in the applied disciplines. Many allied health practitioners continue to provide services to children in isolation from important people in the child’s life,

minimizing the power of relationships and its influence for good or ill on treatment outcomes and actually, though inadvertently, undermining relationships between parents and their young children. The challenge for allied health professions is to integrate analytical, technical, and theoretical knowledge with broader constructs of how individuals operate during moment-to-moment interpersonal and experiential situations (Geller & Foley, 2009a).

### *Limitations and Opportunities in Discipline-Specific Training*

Discipline-specific training can lead to a lack of ability to see the full context of the child’s development or the broader environmental influences in which therapeutic work evolves: that is, the family and cultural context of the child’s life. Over the past 30 years, infancy researchers and practitioners have demonstrated the essential role that early infant–parent relationships play in the healthy development of young children. This research has established how early relationships between the infant and parent support, or hinder, the continued growth of the young child (Beebe, 2005; Fraiberg, Adelson, & Shapiro, 1980; Sameroff & Fiese, 2000; Stern, 1985). From this perspective, relationships are viewed as the central organizing feature of early development and are the foundation for developmental change and growth in young children and their families. An understanding of the bidirectional, or back and forth, nature of relationships changes the basic structure, or organization, underlying clinical work and highlights the importance of integrating parents/caregivers into contemporary early intervention programs (Geller, 2010).

The questions posed to us by parents at the beginning of this article reveal several themes about our professional training. First, we were not prepared to handle parents’ distress, feelings of grief and loss, and their own emotional reactions to the intervention we or our students offered. Second, we were equally unprepared to work with our own reactions and feelings toward each young child’s profound developmental challenges and struggles. Third, we were not prepared to address the child’s internal feeling or affective states at the moment of our intervention. Finally, we felt uncomfortable and, more often, inadequate in our attempts to know how to respond in ways that would be helpful. What is evident is that we have been well trained to relate to the problem, impairment, or mechanism of the injury but not to the child. We often ignored the child’s moment-to-moment influence on our treatment and often failed to effectively engage parents in the process. As a result, we applied techniques irrespective of the mood or

preparedness of the child, or family, at the time of the intervention.

Professionals in the allied health disciplines have rarely been trained to enter the realm of feelings of their clients, families, and themselves. Clinical distance is the norm as is avoidance of the complication the family brings into the therapy room. Thus, practitioners generally perceive as “not my role” anything other than the specific goals and objectives of their discipline. When professionals receive minimal training in working from a relationship-based perspective, it clearly makes sense that they may become anxious, avoidant, fearful, resistant, and reluctant to address issues beyond discipline-specific content. At best, allied health professionals have been trained to be instructional, directive, informative, and somewhat prescriptive in their work with families. However, any work with young children with developmental challenges requires the establishment of positive, sensitive, and thoughtful long-term relationships with parents on behalf of their children. Therefore, professionals need to learn how to (a) develop these strong alliances with families; (b) work collaboratively in co-constructing goals and deciding on desired outcomes; (c) understand the latent content or dynamics of clinical relationships; (d) work from a strengths perspective in contrast to a deficit model; (e) develop more empathic, trusting, and authentic relationships with clients and families; and (f) understand how the professional use of self informs their work. Although many of these constructs have yet to be addressed in most graduate training programs and clinical training practice across allied health professions, some have already been implemented (Geller & Foley, 2009a, 2009b; Norman-Murch, 1996; Shahmoon-Shanok & Geller, 2009.)

### Traditional Versus Reflective Supervision

**R**ELECTIVE SUPERVISION HAS BEEN defined as the “process of examining, with someone else, the thoughts, feelings, actions, and reactions evoked in the course of working closely with young children and their families” (Eggbeer, Mann, & Seibel, 2007, p. 5). Reflective supervision involves a twofold process of engaging in a dialogue of words and actions in which there is integration of (a) substantive knowledge of a discipline (e.g., exploring learning theories, facts, procedures, techniques) with (b) application of theoretical constructs to ongoing moment-to-moment clinical experiences (Schon, 1987). Ultimately, the supervisee must be willing to engage non-defensively with the reflective supervisor as well as be able to attribute meaning to the feelings of self and others. The critical step to

a nondefensive position is facilitated by the development of security in the relationship and trust by the supervisees that their reflective supervisor is on their side and will value and validate the supervisee’s strengths while understanding and supporting their vulnerabilities (Shahmoon-Shanok, 1992).

The process of reflective supervision is quite different from traditional supervision practices across many allied health disciplines. In traditional supervision, supervisors are often described as instructional, didactic, directive, and prescriptive. Traditionally, the role of the supervisor has been to transform the behaviors of the supervisee and do something “to the other.” This is a rather unidirectional model in which the supervisor’s goal is to impart knowledge and technical expertise onto the supervisee. Supervision across most allied health professions involves “some form of presentation of work examples by the supervisee, followed by review, discussion, clarification, and feedback from the supervisor” (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001, p. 138). The supervisor may provide training to the supervisee about particular skills in the form of instruction or modeling. In this paradigm, the supervisee becomes a somewhat inactive and passive participant in this process, which is not unlike what often happens to the child and parent in a therapy session. Of further note, supervisors often focus on the supervisee’s developmental challenges and struggles, which parallels medical models and deficit-oriented approaches to intervention. Thus, most allied health professionals rarely receive regular, collaborative, and reflective supervision even when addressing straightforward therapy processes. As Geller and Foley (2009a, 2009b) noted, this way of working involves “doing something to” the supervisee, client, or family rather than “being with” or “doing something with” the supervisee, client, or family.

Traditional supervision practice relates to only one aspect of reflective supervision; namely, a focus on substantive knowledge. In contrast, reflective supervision usually occurs with an experienced mentor or supervisor within, or outside of, one’s particular discipline. Reflective supervision can be the means in which practitioners integrate new competencies—such as those to do with social-emotional development of the child, the parent, and the dyad—within their specific-discipline specialization.

Schafer (2007) articulated and prioritized the dimensions of relationship-based, reflective supervision models elaborating on the idea of intersubjectivity between self and other, for example, between supervisor-supervisee/provider; supervisee/provider-parent; or supervisee-provider-



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**Many allied health practitioners continue to provide services to children in isolation from important people in the child’s life.**

parent-child (Siegel & Shahmoon-Shanok, this issue, p. 6). Intersubjectivity involves shared implicit relational knowledge and experiences they have of and with each other: They know and “read” (or sometimes misread) each other. Schafer further noted that in relationship-based models, a “developmental space” is created to allow growth and exploration for all participants. The parallel process of relationships between supervisor-supervisee, between supervisee/provider-client, and so on, becomes intersubjective contexts within which to develop the exploration and investigation called “introspection.” These reflective partnerships become agents of change (Schafer, 2007). A shift in supervision essentially holds a place that allows the therapist to integrate content with the process underlying clinical activities, including the feelings evoked by both content and process (Heffron, 2005). That is, the intersubjective experience that evolves between the supervisor and supervisee emerges as a parallel process that similarly affects the supervisee’s relationships with her clients: The essence of what is experienced in one relationship transfers outward to other helping relationships.

### Integrating Reflective Supervision Into Practice

**S**OME (NOT ALL) mental health professionals receive supervision over the course of their professional prac-

tice. In contrast, most (non-mental health) practitioners do not receive supervision beyond their formal graduate education. For example, in speech-language pathology, supervision occurs during graduate school and 1 year post-master's degree. Beyond that time, most allied health professionals are not mandated or even encouraged to receive supervision. Indeed, graduates are expected to be full-fledged professionals with their studies behind them. At that point in their professional training, supervision in the work setting is most often for administrative purposes and typically only occurs during the employee's annual performance evaluation.

It is alarming that allied health professionals are not compelled to receive ongoing supervision to deepen their understanding of their work with children and families, let alone cultivate self-awareness, self-reflection, and understanding of the complexities involved in clinical work. The challenges of clinical intervention across all disciplines are such that ongoing supervision should be considered a necessity. We became aware of the constraints of our professional training at different points in our professional careers.

### Embedding Mental Health Principles in Our Work

IT WAS QUITE challenging for each of us to embrace ideas beyond our specific disciplines. A shift in therapeutic practice and use of broader relational and reflective paradigms led to feeling frightened, anxious, resistant, confused, ambivalent, awkward, and uncomfortable about how to incorporate new constructs into our established ways of

working. When faced with children and parents who were often anxious, emotionally fragile or reactive, grieving, or pressuring us for answers and “magical cures,” we each had a choice: to avoid these issues (continue to maintain a distant, professional, and objective stance) or learn how to embed mental health principles within our particular area of specialization. Each of us began to realize that the traditional stance of our particular therapy was not adequate in our interactions with families in some unarticulated way. In the sections that follow, we share our experiences and the transformations that have occurred in our work when we realized the value of reflective supervision and practice within our own disciplines.

#### **Elaine Geller, Speech-Pathologist**

*I observed a graduate student telling the mother of a young child on the autism spectrum how she, the student, was able to engage the child and make him giggle. I was struck with the expression on the mother's face, which looked—and seemed as though it felt—like sadness, defeat, and, perhaps, jealousy, regarding what this young student could do and perhaps, she, the mother, could not do with her son. This sensitivity to a somewhat innocent event which frequently occurs in speech-language pathology training clinics (reporting a clinical session to a parent sitting in the waiting room) resounded for a long time and heightened my urgency to educate graduate students to understand the power of their actions, behaviors, and words on families. As Costa (2006) has often noted, “Those helpers who*

*have the most impact on supporting capacities and reducing risks in families—the basis of good mental health in infants and families—are often not mental health practitioners” (p. 136), and, equally important, the emotional well-being of our clients and families, and ourselves, is clearly in the realm of all applied disciplines—not just mental health professionals.*

#### **Barbara Wightman, Occupational Therapist**

*I remember watching a videotaped feeding episode between a mother and child while sitting in training with professionals from varied disciplines. I was confidently taking mental notes of the feeding assessment, looking for lip closure, amount and type of food offered, size of the spoon, child's interest in eating, sensitivities, jaw control, and so on. When the videotape ended, several social workers stood up with a definite degree of anger and asked, “Was that child removed from the home?” During the uproar, it became clear that I had missed something important! This event, which was one of many, led to a profound personal and professional journey through the support of reflective inquiry over time to comprehend, integrate, and fundamentally alter the way I think about and work with children and their parents.*

*I began to understand through reflective supervision that something very important was occurring when I quietly listened, observed, and repeated back what I understood the parent or child was trying to share. For a while I struggled, and still do, with doing and fixing, and therein lies the rub. I eventually began to discover that being with and being fully present resulted in professional relationships that fully support the child and family when engaged in services. I eventually began to grasp that aspects of the work that are often not openly expressed have everything to do with therapy and how we are with children and their families. This means addressing the underlying worries about having a disability, understanding the fears related to upcoming surgeries, staying with parents and children as they face the helplessness of ongoing degeneration, altering intervention strategies to help families understand that we are present and that we can tolerate their anguish. Consequently, another purpose of reflective supervision: to hold us as we hold our clients.*

#### **Harold Rosenthal, Physical Therapist**

*A mother brought her child, Don, to a clinic for a neurological evaluation in preparation for his going to a school for children with visual difficulties. As she was leaving the neurologist's office, she met another mother whose daughter had similar difficulties as Don. They talked*



PHOTO: ©STOCKPHOTO.COM/NORIKO COOPER

**Relationships are the central organizing feature of early development and are the foundation for developmental change.**

*a little about their children, and both mothers wondered together “what they had done to have a child so disabled.” Later, while telling me the story, the mother began to cry. I was on the floor with Don while his mother sat on the couch. I listened to her crying for a while and didn’t interrupt her, make any comments, or change the subject. I didn’t hand her a tissue because she might have interpreted the gesture to mean that she was doing something that I wanted her to stop. I quietly listened. Several minutes later, Don’s mother thanked me for being supportive to her and for working with Don. My silence was an acknowledgment that Don’s mother needed time to share her feelings and reactions; my silence and resonance reflected that I was available to the mother for that purpose and I could recognize, understand, bear, and accept her grief.*

From our shared perspectives, we were not equipped to embrace parents and their experiences. In fact, parents were often judged as troublesome, difficult, reactive, and, if possible, to be avoided. As previously stated, most clinical interventions with which we were familiar have focused on working with children in isolation from their parents. Parental deficits or struggles were often highlighted in our work rather than the ability to balance between parental competences and vulnerabilities. Medical models or deficit-oriented perspectives were generalized to seeing deficits across clients and families. Learning how to form alliances with parents and embrace each parent’s challenges and vulnerabilities became an area of interest and study.

We were all quite struck with the unfamiliar notion that developing alliances with families involved not having some preset agenda or plan but instead that the work evolved in relation to each particular family and its unique needs. We had to learn to tolerate not being in control of what would happen next. Integrating parents into all aspects of clinical intervention was also a new endeavor. Working jointly to establish shared goals and desired outcomes was not part of our graduate education. Moreover, avoiding the latent content of relationships and the feelings triggered during clinical interactions did not solve any problems as these dynamic forces influenced all aspects of the intervention. Of course, we ignored or minimized not only the parents’ feelings and reactions to the intervention but also our own feelings and reactions to their struggles, pain, and grief. Finally, we sometimes became uneasily aware of the burdensome knowledge that some of the children we treated would not make significant changes in their growth and development. Although we were sure that our work was important to the day-to-day well-being of the child, we were unsure how the child’s

parents were processing the permanence of their child’s delays.

To work in this broader and more integrative model, we each received (and continue to receive) reflective supervision. This was how we learned to integrate our specialization, or expertise, with these psychological constructs. We used reflective supervision to transform slowly our clinical work and to embrace families in our intervention. We were committed to understanding the child’s and parent’s perspectives on the intervention, which then allowed us to work with families in a different way. We moved from doing something to the child and parent to doing something with the child and parent, thus giving parents the opportunity to be hands-on while we became more hands-off. Instead of compartmentalizing the particular disorder as within the child, we challenged ourselves to be more holistic and embrace all dimensions of the parent–child relationship.

Our experiences of reflective supervision became the means of allowing us deeper insights into our clinical work and a safe place to be supported in that work. This ongoing process is an opportunity to reflect on the stresses of working with families of disabled children, and to make sense of the conflicts that occur in such a sustained relationship. The opportunity to engage in ongoing reflective dialogue in supervision deepens our capacity for more empathic interactions with others (Siegel & Shahmoon-Shanok, this issue, p. 6).

### **Benefits, Possibilities, and Challenges**

**A**LTHOUGH WE DO clearly recognize that, at this point, this broader way of working is not of interest to all allied health professionals, the opportunity to step back and reflect on our professional practice has been invaluable to our supervisors, to us as supervisees, and to the children and families with whom we work. Having a therapeutic context within which to explore the witnessed interactions between a parent and child, along with our own reaction to the event, takes us into unknown territory. Learning to tolerate ambiguity can ultimately have a substantial impact on our work and results in discovery and enhanced effectiveness. To value and affirm the parent’s participation and perspective invites the parent to value and affirm the child’s experience. When we allow ourselves to take in and connect to our understanding of the family’s worries, anxieties, and fears, we create a place of safety to express all of the unspoken, powerful issues that can get in the way and affect the outcomes of our efforts to habilitate the child’s functions and capacities. We gradually learned that if we

continued to work from only our particular area of specialization, and focused solely on observable behaviors to minimize deficits or impairment, then we missed essential opportunities to help our clients and their families. We learned that addressing social and emotional areas also strengthened our abilities to be successful in the specific developmental domain of our discipline.

In all health care professions, there is a strong pressure to relate to our clients in technical terms. We hear many clinicians talk about their clients in terms of their disability or diagnosis (e.g., “I saw several autistic children today”). There is also a push to use technology to assess and treat our clients with instruments that provide us with data, yet these often diminish our innate and intuitive perceptions of the needs of the individual who has come to us for care. Clients are hurried through clinics to maximize the number of patients per unit time. Although these ways of relating are justified in terms of economic efficiency, and possibly scientific rigor, they often work against a relationship-based practice that values the thoughts and feelings as well as the technical expertise in the therapeutic relationship. Some might consider relationship-based practice an attempt to return to an earlier time—one in which clinicians had more time to spend with their clients. In contrast, we see this way of working as an advance in the care of children and families because all participants are respected, supported, and heard in the process of intervention.

We each experienced changes in our approach to clinical intervention regardless of our particular expertise or port of entry. These transformations included the following: (a) working dyadically with parents and seeing parents—along with the provider—as primary agents of change; (b) highlighting each parent’s capacities and strengths in being with the child; (c) providing a safe space in which parents felt free to share the gamut of their feelings without being told what to do or how to do it, and often letting them teach us; (d) collaborating with parents to develop shared goals that are appropriate to their child’s developmental level and capacities; (e) embracing parents rather than avoiding, ignoring, or minimizing their influence on their child and on our treatment; (f) appreciating the powerful underlying psychological forces that influenced all of our clinical relationships; and (g) paying attention to the ongoing alliance that needed to be nurtured so that we could provide families with a secure place as they came to understand their child’s developmental challenges and struggles. (For a more detailed discussion of the differences between traditional and relational–reflective clinical practice in

speech-language pathology, see Geller, 2010; Geller & Foley, 2009a; Shahmoon-Shanok & Geller, 2009.)

From our shared perspectives, our traditional ways of working with children in isolation from their families no longer make sense. Once we shifted away from this viewpoint, there was no turning back. Each allied health practitioner is faced with a clear challenge: to continue to work within one's specialization or to augment one's discipline-specific knowledge with relational and reflective principles. On a much larger scale, each discipline has a similar choice in the development of its professional organizations and its graduate schools.

From the perspective of families, "When children are the recipients of therapy, the intimacy of this relationship is intensified and extends directly to and impacts the child's parents or guardians" (Hjorngaard & Sieck Taylor, 2010, p. 79). We came to understand that our most effective work occurred when there was a greater degree of trust, closeness, and connection with our families on behalf of their children. Returning to the penetrating questions posed by parents at the opening of this article, relational and reflective supervision gave us the tools to listen deeply with humility and empathy to their fluctuating feelings, struggles, and reactions without minimizing their feelings; avoiding these painful moments; offering formulaic responses; and/or becoming more instructional, informative, or prescriptive. Embracing an expanded perspective within

our discipline-specific practices—enhanced by the insights and knowledge engendered in the process of reflective supervision—leads to more effective, holistic, and comprehensive understanding of our clients and families, which, in turn, leads to more optimal clinical outcomes. ♪

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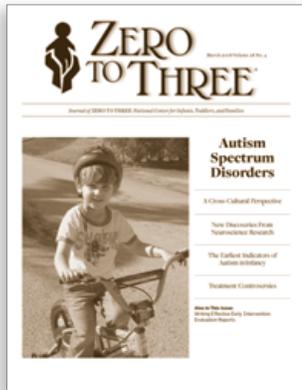
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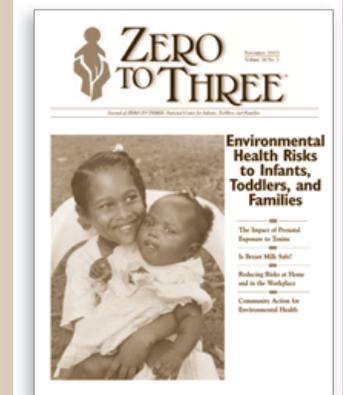
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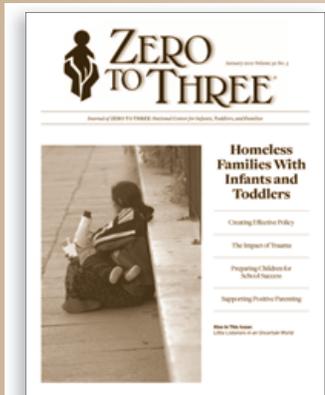
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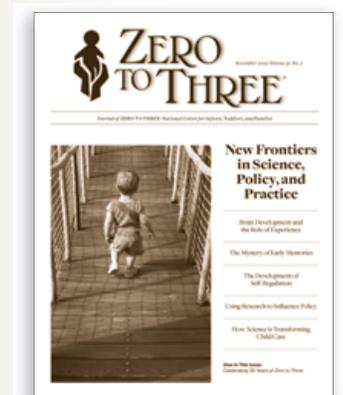
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# Reaching Toward an Evidence Base for Reflective Supervision

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A number of publications have been written about reflective supervision, but, to date, only a handful of studies actually have attempted to demonstrate its effectiveness (Gordon, 2004; Tomlin, Sturm, & Koch, 2009; Virmani & Ontai, 2010). Yet, despite the relative absence of research to support it, professionals in the early childhood field are nevertheless actively teaching about and practicing reflective supervision. Given the fact that “evidence-based” has become a virtual requirement for funding programs and for training, reflective supervision has not yet garnered the necessary attention by professional organizations, nor has the practice or study of it received adequate funding. Reflective supervision has, however, begun to be required by some statewide credentialing systems (Weatherston, Wiegand, & Wiegand, this issue, p. 22).

Researchers and clinicians alike must begin to aggregate and establish a foundation of evidence for reflective supervision and reflective practice before such practices can become seamlessly integrated in all disciplines, systems, and programs serving small children and their families. If a central goal of the infant–family field is to develop a strong, relationally competent corps of leaders, supervisors, and direct service workers within each discipline—professionals who possess an integrated multidisciplinary knowledge base to lead and work in comprehensive, universally available services for babies and young children—then developing a solid body of evidence for reflective supervision is nothing short of a necessity.

Given our hope, and that of ZERO TO THREE, to inspire more research on reflective supervision, this article explores that imperative, beginning with a brief description

of how reflective supervision has become such a central tenet of the infant–family field. It discusses recent attempts to begin creating an evidence base to establish reflective supervision’s efficacy and identifies next steps the field can take to draw attention to and make the case for its funding and use across all settings for infants, toddlers, and families.

## The History of Reflective Supervision and of the Field

IN THE 1970s when ZERO TO THREE (the organization) was born, the “nature–nurture” controversy was alive and well. At that time, the field did not possess sufficient research to support what its members believed: that relationship is at the center of healthy development and, thus, of effective practice, no matter the discipline. Back then, many thought that IQ was inborn and that at birth an infant was a passive,

sympiotic creature without sight or the capacity for memory, for interaction, or for having a differential effect on close caregivers (Shahmoon-Shanok, 2009). We now know that much of precious brain development occurs after birth, through nurture, and that babies are born with many capacities that predispose them to relational learning including certain types of memory, imitation, and interaction. Indeed, what professionals in the field (that was not yet a field) believed before, they now incontrovertibly know: that babies—and their brains and central nervous

## Abstract

Over the more than 3 decades that it has taken “zero to three” to become a field—actually the coming together of many fields—reflective supervision has evolved as the centerpiece in the attainment of high-quality, effective practice. However, there is little research evidence to support reflective supervision or practice as being central to the field’s worldview. Despite the relative absence of research to support it, the field is nevertheless actively teaching about and practicing reflective supervision. This article provides a brief history of reflective supervision in the early childhood field and shares ideas to begin building an evidence base for reflective supervision.



**We now know that much of precious brain development occurs after birth, through nurture.**

systems—are deeply affected by the care they receive day-to-day. They also know that children affect their caregivers deeply, having an effect on their development as well. There is now solid evidence for the relationship centeredness that ZERO TO THREE (then the National Center for Clinical Infant Programs) held as its central commitment. That evidence includes the corpus of attachment and transactional research with their lifespan implications, other experimental and longitudinal research, and neurobiological studies that have spurred a brand new variation on the theme of relationship, variously called *interpersonal neurobiology* or *neurorelational psychology* (Siegel & Shahmoon-Shanok, this issue, p. 6).

### **Clinical and Reflective Supervision**

So where and when did reflective supervision intersect with these emerging ideas about the essence of infant–family work? And how did what was known as clinical supervision in mental health fields become reflective supervision?

In the late 1980s, ZERO TO THREE convened a national multidisciplinary group to identify the key knowledge and skills necessary for those working with the youngest children and families. This group—which included an occupational therapist, a pediatrician–psychoanalyst, a social worker, a psychologist, a parent, a foundation representative, a nurse, a special educator, and a leader of family-centered outreach and work with very young children and their at-risk families—met for a couple of years, after which it issued

related documents for four audiences about preparing practitioners to work with infants, toddlers, and their families. Published in 1990, these TASK (Training Approaches for Skills and Knowledge) publications called for the inclusion of four important and interrelated elements of training:

- Knowledge based on concepts common to all disciplines;
- Opportunities for direct observation and interaction;
- Individualized, clinical-like supervision, differentiated from administrative supervision, that encourages reflection; and
- Collegial support (Fenichel & Eggbeer, 1991, p. 1).

This was a rather audacious position to take then—and it still is. If reflection is essential to all practice with very young children and their families across all human service professions, it implies significant alterations to the ways in which professional training takes place across each of many professions (Geller, Wightman, & Rosenthal, this issue, p. 31). The term *reflective supervision* is deeply linked to the clinical supervision that mental health professionals (e.g., social workers, psychologists, psychotherapists, psychoanalysts, psychiatrists, arts therapists, marriage and family therapists, psychiatric nurses) experience in their predegree training and then within their workplace over many years.

Soon after these documents were published, ZERO TO THREE secured funding to train teams of trainers from across the country on these training elements. As the trainers (including authors Linda Eggbeer and Rebecca Shahmoon-Shanok) prepared to teach the participants about supervision in each of the week-long intensive training events, it became clear that virtually nothing had yet been published about the supervision of cases where the focus is on an intimate relationship in which one of the members is barely verbal. The planning committee realized that they needed to differentiate the supervision they would teach from administrative supervision—the kind that tracks levels of service, paperwork, and other information of that nature—in contrast with the partnering, looking together, supporting, and guiding they were advocating. So, the model of clinical supervision used in mental health training was adapted, and through case studies and role plays, it addressed the unique and challenging issues involved in supervising professionals working with the very youngest children and families. With no model yet for a mentoring supervision, the model that was illustrated through role plays and taught in all of the trainings was clinical supervision used in mental health training.

The participants responded so strongly to the parts of the week focusing on supervision that an issue of the *Zero to Three* journal, “Supervision and Mentorship in Support of the Development of Infants, Toddlers, and their Families” (Fenichel, 1991) was dedicated entirely to the topic. By 1992, ZERO TO THREE published a groundbreaking book (often referred to as “The Yellow Book”) titled *Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers and their Families: A Source Book* (Fenichel, 1992). Between the mid-1990s and today, interest and activity surrounding reflective supervision has blossomed. It has moved beyond mental health settings into child care, early intervention, home visiting, Early Head Start, and other arenas where very young children and families are served. More and more training programs for infant–family professionals are including it in their scope. (Several useful materials have been published and are listed in the Learn More box.)

### **Research Is Beginning to Stir**

**I**N EARLY 2009, ZERO TO THREE was invited by the National Professional Development Center on Inclusion at the Frank Porter Graham Center at the University of North Carolina at Chapel Hill to host an online discussion on reflective supervision. The topic was chosen both to build on a National Training Institute (NTI) session the previous year and to serve as a planning tool for a full-day Pre-Institute on the topic for the 2009 NTI. ZERO TO THREE staff alerted a group of individuals across the country who were actively engaged in studying and using reflective supervision. They also sent notice of the opportunity to ZERO TO THREE’s extensive e-mail list to try to reach new audiences of professionals interested in the topic. The discussion began with a brief definition of reflective supervision and an invitation to respond to a few questions, among them: what steps, large or small, were people taking to help infant–family professionals think more deeply and reflect on their work; what settings were they working in; and how were they going about building organizational support for reflective supervision.

The very rich online conversation that unfolded over the 2-week “live” discussion was both fascinating and edifying. Professionals providing services in child care, Early Head Start, home visiting, Part C, mental health, and child abuse programs were eager to share their experiences and questions. Several provided descriptions of preservice and in-service training programs across the country. Many shared their thoughts about the influence of reflective supervision on their (and others’) practice. What stood out was that no one was aware of an empirical body of evidence about the effect

## REFLECTIVE SUPERVISION: DEFINING THE PROCESS

The process of reflective supervision has been defined and described in a variety of ways, with some common themes: Trust, safety, security, respect, patience, confidentiality, thoughtfulness, presence, commitment, respect, engaged listening, being nonjudgmental, relationship for learning, refueling, mutuality, reciprocity, observation, self-awareness, deeper exploration of feelings, and parallel process. Below are a variety of definitions for reflective supervision:

*Reflective supervision is the process of examining, with someone else, the thoughts, feelings, actions, and reactions evoked in the course of working closely with infants, young children and their families (Eggbeer, Mann, & Seibel, 2007, p. 5).*

*The essential features of this supervisory relationship are reflection, collaboration, and regularity of occurrence (Eggbeer et al., p. 5).*

*Reflective supervision is a set of caring conversations co-constructed over time by supervisee and supervisor, improvised or created in the moment, yet deepening their connection as together they develop their history and knowledge of one another and of the children and families in their conjoined care (Shahmoon-Shanok, 2009, p. 12).*

*Although reflective supervision may incorporate administrative and clinical tasks, and include attention to collaboration within learning relationships, its primary focus is the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners (Weatherston & Barron, 2009, p. 63).*

*Reflective supervision provides “a practice arena that can shape and strengthen the intervener’s knowledge of self in regard to relationships, empathy for others, and skills in perspective taking” (Heffron, 2005, p. 118).*

*Reflection . . . is an attitude of mind cultivated in relational exchange that enables people to see several levels of interchange from many angles (Shahmoon-Shanok, Lapidus, Grant, Halpern, & Lamb-Parker 2005, p. 462).*

*[Reflective supervision is a] shared process in which [the supervisor] provided a safe and compassionate kind of mirroring.... [Three core reflective tasks include] relating and re-experiencing emotionally significant events...; examining and evaluating the meaning of the feelings, thoughts, intentions, actions evoked during those events; and considering how [to] use this understanding for...professional [and personal] growth ... (Weigand, 2007, p. 18).*

of reflective supervision on professionals and practice, let alone on client children and families. Several participants identified studies that looked at the effect of mental health consultation in early childhood programs or at the addition of reflection and other mental health concepts to training programs for different professional disciplines. Other participants noted that the fields of social work, psychology, psychoanalysis, counseling, and education are the most likely disciplines to have explored supervision and its effect on practice.

As the online discussion concluded, several members of the NTI Work Group decided to build on the obvious interest of this online discussion and bring together in person a multidisciplinary group of professionals and a group of researchers interested in thinking together about useful strategies for researching the benefits and effect of reflective supervision. The 2009 NTI seemed the logical venue to try something new: a symposium entirely devoted to brainstorming. A few known researchers were invited to

the session, and, fortunately, the participants who signed up turned out to be a good mix of researchers, educators, supervisors, and providers. With a standing-room-only group of almost 120 participants, researcher Walter Gilliam of Yale University facilitated an energetic, compelling discussion with the help of Rebecca Shahmoon-Shanok.

To set the stage, Rebecca Shahmoon-Shanok summarized the history of reflective supervision and distributed a handout with several definitions of reflective supervision and related ideas (see box Reflective Supervision: Defining the Process). Walter Gilliam then briefly discussed a study he had recently conducted looking at mental health consultation in child care programs. He described how he went about identifying the characteristics of a “mentally healthy” classroom. The conversation went on quickly from there as participants shared their perspectives about reflective supervision and what might be studied; they kept building on one another’s comments with the intention of stimulating

readers to think creatively and possibly pursue them (see box Reflections on Building an Evidence Base for some of the many insightful ideas and questions that were raised).

## Finding Pearls at the New Frontier

THE IDEAS GENERATED and summarized from the NTI discussion underscore the importance of taking guidance both from the evidence emerging from recent studies on reflective supervision (Gordon, 2004; Tomlin et al., 2009; Virmani & Ontai, 2010) and from other related fields of theory and research including infant observation (Sternberg, 2005); mentalization and reflective functioning (Fonagy, Steele, Steele, Morse, & Higgins, 1991; Slade, Grienberger, Bernbach, Levy, & Locker, 2005; Steele & Steele, 2008; Toth, Rogasch, & Cicchetti, 2008); and psychotherapy research on clinical supervision (Sutton, Townend, & Wright, 2007; Wampold & Hallway, 1997). In what follows, we offer suggestions about research and training that could be fruitful to future research efforts on reflective supervision. Some of these ideas were raised in, and follow from, the 2009 NTI Symposium.

The field of infant observation (IO) in training psychotherapists was developed in the 1940s at the Tavistock Clinic in London (Bick, 1964). The training involves regular trainee visits to family homes to observe a developing infant within the context of his primary relationships—simply observing and becoming aware, not “doing” anything. At the center of the experience is post-observation, reflective writing by trainees about both their observations and their emotions and other responses to what is observed and heard, and reflective discussion with a seminar leader who serves to “hold” the trainees as they become aware of difficult feeling states that emerge at any point in the process. Leaders are encouraged to help trainees wonder, notice, articulate, and examine the range of their reactions that have emerged during the observation sessions or in the reflective writing process (Sternberg, 2005).

Sternberg’s elegantly designed study of this aspect of psychotherapy training is an example of a type of inquiry that could provide a model for research on the process of reflective supervision. Using Grounded Theory approach (Strauss & Corbin, 1990), Sternberg illustrated the thoughtful use of this qualitative research methodology in which themes are noted by documenting the frequency of trainee comments relating to relevant capacities and skills such as the following:

- “Registering feelings,” “picking up projections”
- “Tolerating feelings and holding onto painful feelings”

## REFLECTIONS ON BUILDING AN EVIDENCE BASE

The following ideas, questions, and suggestions were generated by participants in the 2009 ZERO TO THREE National Training Institute conference symposium, "Beginning to Build an Evidence Base for Reflective Supervision."

- We have to be able to study and measure the process or construct of reflective supervision (the independent variable). How does it work? What are its core features?
- How can we measure someone's ability to be reflective? What evidence would we look for to establish that someone is a reflective supervisor or supervisee?
- What do "good" reflective supervisors actually do?
- A national survey being conducted at the Institute for Social and Policy Research at Purdue University will define key elements of reflective supervision; perhaps researchers and clinicians together could use these data to develop an observational measure (in real time or through videotape) to determine whether these elements are present in a reflective supervision session.
- It's important to be able to understand and measure the internal processes in both supervisee and supervisor. What's going on in their minds or in their relationship that isn't necessarily visible from behaviors alone?
- We probably want to be able to measure a number of supports that need to be present (investment of program leadership to dedicated time for reflective supervision, etc.) to enable it to work in an organization.
- We need to learn how to measure the things that we hope reflective supervision will change—in the supervisees, their practice, and in the children and families with whom they work.
- How do we begin to think about measuring something that is often a long, slow process? Multiple measures over time?
- How can we best measure something that is transactional?
- How should we take into account the fact that the attempt to measure something in and of itself often changes it?
- Scott Miller's work in psychotherapy research (Miller, Duncan, Brown, Sparks, & Claud, 2003) with the Session Rating Scale and Outcome Rating Scale may be helpful (e.g., use a few short questions that clients—in our case here, reflective supervisees—answer immediately after a therapy—a supervisory—session).
- How can we go about rating reflective supervision sessions? What would we use as a measure? Do we know good reflective supervision when we see it?
- How about coding the dialogue between the supervisor and supervisee to study the shift in the supervisee's ability to look at the baby and the relationship and her own emotional responses (and other important aspects) as one way of measuring reflective supervision?
- Maybe we could code language in terms of categories of verbs—I think, I know, I wonder about . . .
- Perhaps a content analysis of case records and process notes could help us look at change in language and thinking over time, ultimately examining the language and thinking of parent-clients, as well.
- Over time, does the supervisee's conversation move from what happened in a home visit to what is currently happening in the reflective supervision session?
- We could look at Peter Fonagy's measure of reflective functioning (Fonagy, Target, Steele, & Steele, 1998), in which parents are scored on how reflective their description of their child is to see if it could be adapted for reflective supervision.
- Can the Theory of Mind literature be helpful?
- How could we look at the developmental progression of the reflective supervision relationship?
- It's important to try to tease out and understand the choices the supervisor and supervisee make to go in one direction or another.
- Might it be useful to try to define points on the reflective supervision continuum to look at the developmental trajectory?
- If supervisor and supervisee have a contract and set specific goals, we could measure whether they've accomplished them.
- Once we're able to figure out that something works, we have to figure out who it works for and under what conditions (second-generation research).
- We need to explore not only what the supervisor is doing but also the effect of the reflective supervision relationship on the supervisor.
- Possibly, the neurobiological and experimental lines of evidence already attained for relationship centrality in the development of young children and their parents could become pathways through which aspects of reflective practice can be studied.
- Could we demonstrate the importance of reflective supervision in recruiting and retaining staff members and reducing and burnout? If we could show these Human Resource implications, that would provide another rationale for investing in reflective supervision.

- “Recognizing the usefulness of own feelings as information”
- “Process, think about what is happening inside oneself”
- “Use of theory to help understanding”
- “Awareness of the importance of maintaining boundaries” and
- “Awareness of what is not noticed” and the like (Sternberg, 2005, p. 186).

In addition, the growth from pre- to post-IO experience in the trainee’s capacities and skills and what s/he felt s/he was able to bring to the infant observation is noted in interviews and includes the increased capacity for tolerance of anxiety and uncertainty, waiting for meaning to emerge, empathy, close attention, listening and skill in communication with parents, and the like (Sternberg, 2005).

Over several decades, much theory and research has been generated that examines the process of clinical supervision in the training of counselors and psychotherapists (Wampold & Halloway, 1997), including studies that examine the use of reflective space (Gordon, 2004) and reflective journaling (Sutton et al., 2007). For example, Gordon (2004) also used a grounded theory analysis (Strauss & Corbin, 1990), as well as physiological measures to document that assisted reflection helped to uncover the discrepancy between the counselor’s espoused theory and beliefs and what actually occurred in his practice and that counselors use a range of strategies when reflecting on their practice that include both cognitive and affective levels of reflection. The level of reflection was captured in physiological measures of calmness and slowed heart rate. Through the use of focus groups, prompt questions, and interpretive phenomenological analysis, Sutton et al. (2007) documented the value of reflective learning journals in a postgraduate psychotherapy training program, finding that increased self-awareness of personal thoughts and beliefs, cathartic experiences, improved reflection through discovery, and exploration of thoughts and feelings were reported by the postgraduate trainees. The infant-family field can learn much from these studies that used varying research designs and methods to investigate aspects of supervision and reflective process and be carefully guided in the further development and refinement of research questions, research design, and methodology (including the selection and/or development of measures, quantitative and qualitative methods of data collection, and data-analytic approaches), as well as in the interpretation of findings that are grounded in related theory and empirical research.

Quite recently, the study of *mentalization*—the capacity for reflective functioning that



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**Research is finding that caregiver insightfulness about the motives underlying children’s behavior is associated with having experienced reflective supervision.**

allows the caregiver to hold the infant or child and her mental states in mind (Fonagy et al., 1998)—and the study of insightfulness—the “ability to understand the motives underlying the child’s behavior in a complete, open and accepting way” (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002, p. 539)—have been used in the development of measures. These include scoring of reflective functioning capacity in the Adult Attachment Interview (Fonagy et al., 1998; Steele & Steele, 2008; Toth et al., 2008), the Parenting Development Interview (Hill, Levy, Meehan, & Reynoso, 2007; Slade et al., 2005), and the Insightfulness Assessment (Koren-Karie & Oppenheim, 2004) for the study of these capacities, previously investigated in parents to study the development of these capacities in psychotherapists and child care providers. These measures lend themselves to studies of reflective supervision and have already been used in such a way in at least one instance: in a study conducted at the University of California–Davis by Virmani and Ontai (2010). This small yet well-designed study, conducted at two university child care centers, compared the effect of reflective supervision and training with that of traditional supervision and training on the capacity for insightfulness in caregivers when they first began in their positions and again at a second time 2.5 months later. They found that components of caregiver insightfulness, including complexity, insight, openness, acceptance, richness, and coherence were associated with having experienced reflective supervision. In another recently reported preliminary study, Tomlin et al. (2009) provided additional examples

of methods to explore providers’ self-report of the importance of reflective practice skills in their work with parents of young children and whether provider valuing of reflective functioning skills is associated with reported practice using hypothetical vignettes drawn from common home-visiting scenarios.

For further investigation of the affective experience of each participant—in this case, supervisor and supervisee in the process—there are several other promising approaches from other areas of our own field, including videotaped, frame-by-frame observational studies (cf., Beebe, Jaffe, Feldstein, Mays, & Alson, 1985; Stern, 1971; Tronick & Cohen, 1989) and physiologically based ones, such as those involving the lowering of cortisol (Gunnar, Mangelsdorf, Larson, & Hertsgaard, 1989), vagal tone (Porges, 1995) and other stress-level studies; those using brain imaging of parents to assess activation of emotion control centers in the brain in response to baby cries (Mayes, Swain, & Leckman, 2005); and, from other interpersonal neurobiology, experimental approaches such as those used in the study of mirror neurons (Iacoboni et al., 1999; Rizzolatti, Fadiga, Gallese, & Fogassi, 1996).

By now, immeasurable clinical experience has made it evident to many in the infant-family field that the audacious ideas conceived in the late 1980s are valid: Reflective supervision exerts a generative effect both on providers and on the quality of the services they are able to offer to very young children and their families. The insightful ideas, abundant energy, curiosity, goodwill, solidarity, and commitment evident in the mood of participants at the

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PHOTO: ©STOCKPHOTO.COM/TOMASZ LEWYTEK

**Reflective supervision exerts a generative effect on both providers and the quality of the services they are able to offer to very young children and their families.**

2009 NTI brainstorming session are a testament to—and also fuel a deep and abiding interest in—moving forward with a research agenda devoted to learning all that is possible to discover about how reflective supervision works and the effect it can have on services. 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, with its 2009 NTI Symposium ideas, brief reviews of and suggestions for research angles, and the Learn More resources, 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. ♪

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# Honoring Diversity Through a Deeper Reflection

## *Increasing Cultural Understanding Within the Reflective Supervision Process*

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Where each of us comes from is important to who we are. Where I come from is essential to this article and the reader's deeper understanding of my perspective. My lens of experience is that of a clinical psychologist, an infant mental health specialist, an African American woman, a supervisor/mentor, and a trainer of reflective supervision concepts. It is my goal in this article to create a shared journey of learning with the reader. As I discuss the process elements of the reflective supervision model, readers are invited to reflect on their personal supervision journey, as supervisors or providers, and then to seek opportunities to reflect more frequently on issues of difference. Each reader's unique lens will help shape how she interprets the content provided and applies it to her individual experiences.

I will explore diversity from a wide lens, considering the perspectives of families, providers, and supervisors. For the purpose of this discussion, the term *diversity* is used as an all-inclusive descriptor of issues of difference across race/ethnicity, gender, individuals with disabilities, sexual orientation, religious belief, class, and educational status, as well as professional culture. The term *supervisor* refers to anyone who manages, oversees, provides clinical hours, directs staff, or provides administrative leadership. At this point in the development of our field, supervisors providing reflective supervision exist across many disciplines, including mental health, early care and education, early intervention, special education, child welfare, and nursing. The

receiver of reflective supervision is referred to in this article as a *provider* or a *supervisee*.

### Foundations of Understanding

RESEARCH ON REFLECTIVE supervision—and specifically on issues of diversity in reflective supervision—is scarce. However, a recent study of the supervisory dyad that examined racial microaggressions specific to Black supervisees and White supervisors revealed that Black supervisees experienced their White supervisors as minimizing, dismissing, or avoiding the discussion of racial issues in supervision (Constantine & Sue, 2007). Furthermore, supervisees indicated that their supervisors demonstrated stereotyped assumptions

about clients of color, blamed clients of color for their problems, and offered culturally insensitive treatment recommendations. Although such findings may be shocking to some, it is important to remember that the responses from the supervisors in question were well-meaning and meant to be color-blind in nature. Often a supervisor, in an

### Abstract

At the heart of the reflective supervision relationship is a shared journey of self-discovery for the individual staff member as mentored by a supervisor. In this journey, it is the relationship that serves as a trusted guide. This article examines the many lenses of culture that shape self-understanding. In the reflective supervision relationship, the challenges of exploring culture often go unexplored. How can professionals seek to build a deeper understanding of cultural differences, create opportunities for safe discussions regarding cultural differences, and prepare staff members to openly explore, with grace and honest inquiry, the multifaceted elements of diversity that shape every relationship?

effort not to appear motivated by racial issues or cultural difference, will ignore the topic of culture altogether. Research such as Constantine and Sue's study serves to underscore the importance of open discussions of diversity and difference in the supervision relationship.

In their 2007 article "Exploring Diversity in Supervision and Practice," Heffron, Grunstein, and Tilmon provided a list of the possible barriers to open and honest discussions of diversity within the supervision dyad, such as the fear of misunderstanding others, fear of doing or saying the wrong thing, or feeling ignorant about other cultures. The barriers to attaining a deep level of understanding and reflection are as varied and individualized as the families we serve. Given the growing diversity of both the workforce and the general population, it is the obligation of supervisors to initiate discussions with their supervisees related to diversity and ensure that the providers are equipped to bring awareness and open communication regarding diversity into their relationships with their client families.

### **Relationships Matter**

Relationships of support are the foundation for successfully overcoming life stressors. It has been well established that responsive caregiving creates the foundation for a secure attachment, instills feelings of nurturance and support, and facilitates healthy social-emotional development. When individuals are faced with stressful life events, relationships of support serve to mitigate negative outcomes.

Engaging in a discussion about diversity with a family can produce anxiety, and service providers may be hesitant to begin the discussion. Together, the provider and the supervisor must face the discomfort, the challenges, and the tension of the unknown in the process of reflective supervision. Exploring issues of diversity strengthens the supervisor-provider relationship and reveals the provider's personal beliefs, attitudes, and fears related to the service population or the supervisor-provider relationship; this, in turn, leads to a deeper level of understanding.

### **Examining Biases**

We cannot ignore the presence of inequity, prejudice, and stereotyping in our society, particularly as they affect our relationships. Research has demonstrated that unconscious negative stereotypes toward persons of color are present in many well-meaning Whites (Dovidio, Gaertner, Kawakami, & Hodson, 2002, as cited in Constantine & Sue, 2007). It is important to note that stereotyped views are held not only by Whites; people of all backgrounds must find the time and seek

support for self-examination of underlying internal prejudices. This is a question many professionals do not wish to face. All people, including those of color, have internal biases. The first step toward greater understanding is personal awareness. Supervisors must value personal examination of biases and beliefs if they expect supervisees to risk the vulnerability of opening their personal Pandora's box related to issues of diversity, inclusive of race, culture, gender, religion, sexual orientation, physical disability, and class. For example, as a clinical supervisor, I experienced a situation in which one of my supervisees had observed less than culturally sensitive practice in an allied professional. In this situation, my supervisee had taken a family to visit a consultant. During the consultation session, the consultant indicated that the family should look on the Internet to find more information available in their primary language about the diagnosis they had received and possible treatments, including medication and possible side effects of the medications. Although assisting the family to locate information in their own language was beneficial, the consulting professional assumed that the family had access to and knowledge related to the use of the Internet. My supervisee was very upset by the consultant's assumption that everyone had a computer in the home or regularly made use of the Internet. As a point of reference, the service agency was in an inner-city community, with low-socioeconomic-status families and many bilingual families; many

of the parents had limited formal education. I first worked with my supervisee on her emotional response to the situation and the feelings related to insensitive practice. We then directed our discussion to supporting the family and assisting them in getting the information they needed. Finally, I explored with the supervisee regarding addressing this situation with the consultant professional to help improve his awareness.

### **Reflection and the Parallel Process**

**I**N THEIR EFFORTS to create a deeper understanding of diversity as providers and supervisors, all professionals must start with a deeper understanding of themselves. This begins with self-reflection. Providers who remain aware of their personal triggers and internal stressors, and who actively use self-care techniques, are more emotionally available to support families. Moreover, when providers can be mindful of their own emotional experience, they have a greater capacity for empathy and can assist others in building self-understanding (Siegel & Hartzell, 2003). Furthermore, parents with a deeper understanding of their stress responses, personal triggers, and parenting history can be less reactive and more emotionally available to their child.

The parallel process of how supervisors support providers, and providers support parents, which, in turn, enables parents to best support their children, is a powerful and highly valuable aspect of reflective supervision. The parallel process of reflective



**Relationships of support are the foundation for successfully overcoming life stressors.**

PHOTO: ©ISTOCKPHOTO.COM/ROBERT TEAVICK



## REFLECTING ON DIVERSITY CHECKLIST FOR SUPERVISORS

The following issues should be raised over time within reflective supervision:

- The unspoken power differential of the supervisor–provider relationship
- Issues of difference or sameness related to culture, gender, religion, language, and any diversity issue within the supervisor–provider relationship
- How issues of power and prejudice have influenced the interpersonal development of the provider
- How issues of power and privilege are addressed within the relationship between the provider and the family
- Does the provider feel comfortable bringing up issues of sameness and difference within the context of the provider–family relationship?
- How issues of power and prejudice have shaped the family (or families) with whom the provider is currently working

### Exploring issues of diversity strengthens the supervisor—provider relationship.

supervision dictates that supervision should be a model for how we treat families. As defined by Shahmoon-Shanok (1992), “supervision parallels good work with families, the place for parents and children to feel safe enough to recognize the worst and best of their feelings” (p. 37). It is through the examination of parallel process that providers should feel emotionally held, safe to explore their feelings, accepted where they are in their professional developmental path, and supported as they flourish in self-exploration. Likewise, providers should be creating a space where families can feel heard and valued at that moment in their personal journey toward good parenting.

Another valuable aspect of reflective supervision is allowing providers to tease out where their implicit memories may be influencing their understanding of the work and their objective assessment of the family system. The ever-changing family dynamic is highly complex. Parenting is an interactive process in which parents are guided by their own histories of being parented as well as societal pressures and unspoken family values. It is the role of the provider to uncover the possible elements underlying parental behaviors in support of greater parenting success. Time, objectivity, and rethinking about the family dynamic with a reflective guide (e.g., a supervisor) can help providers discern all the powerful elements that influence a single parenting response. Continued opportunities for reflective supervision can serve to decrease providers’ anxiety in the field while increasing their capacity to manage their own emotions in a stressful situation and give them greater professional confidence. Within the shared collaborative and nurturing environment of reflective supervision, the supervisor can provide a listening ear from a

nonjudgmental perspective to assist the provider in understanding the uniqueness of each family system. Such supports allow providers to build their clinical skills and the competencies necessary to support vulnerable children and families. Supervisors and providers need dedicated time for reflective opportunities.

The parallel nature of the reflective supervision model requires that supervisors also receive the opportunity for nurturing, self-understanding, and reflection. Supervisors also need to reflect on their internal processes and develop self-understanding (e.g., Who am I in this relationship? What do I bring to the supervisory dyad? What beliefs shape my understanding of this provider or this family system?). Knowing oneself as a supervisor is vital in the relationships one develops with supervisees. Supervisors working within the context of an increasingly diverse workforce need to examine the strategies they are using to address issues of diversity within the supervisory relationships (for suggestions, see the box Reflecting on Diversity Checklist for Supervisors).

### Shared Language and Meaning

Building a shared language is an element of the parallel process and is important in working with providers and families to ensure that all parties are clear on the context and meaning. For example, when someone uses the term *people of color*, do you immediately know the group of “people” to whom she is referring? Furthermore, providers need to ensure that language issues and communication across diverse groups of family systems are clear. For example, when the family says that they use “time-outs,” what does a time-out mean to this family? The issue of shared language and shared

meaning reminds supervisors to check in with providers and families. Do they have a full picture of what is being communicated from the perspective of the other person? Building an understanding of shared meaning prompts them to ask many questions and to seek clarity from the others in the relationship. Holding the concept of shared meaning in mind, they are further mindful that diversity means they can assume that everyone sees the world in different ways, depending on their formative experiences. Providers and supervisors alike need to inquire rather than assume.

### Power in Relationships

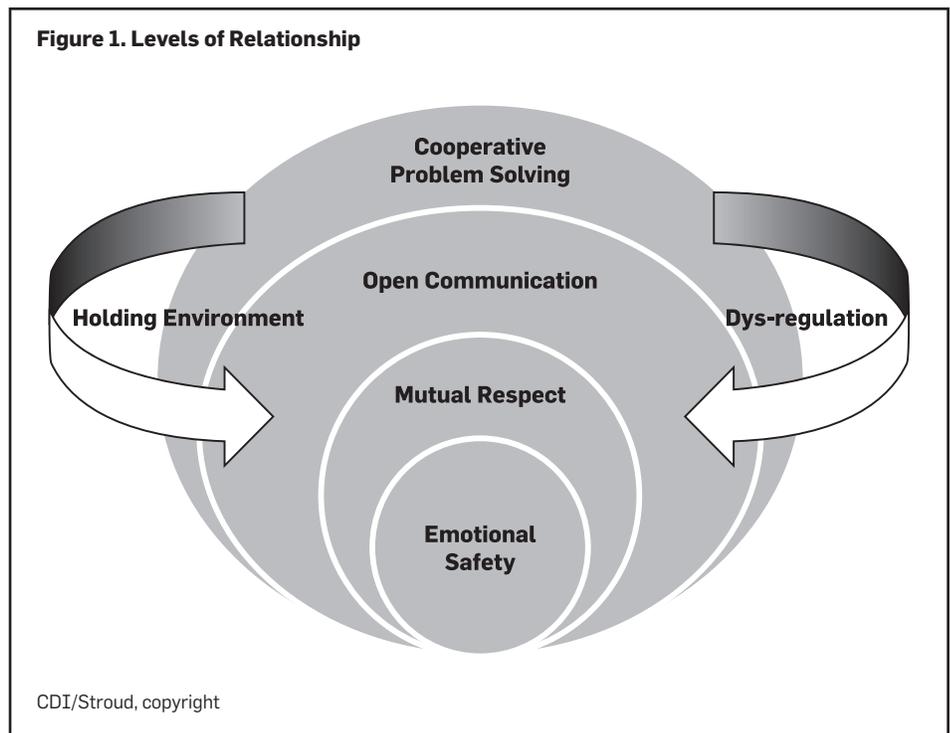
Supervisors hold power in the supervision relationship. It is important to remember that different roles come with differences in power. Providers are fully aware of the power supervisors have over them, and such power difference can create anxiety (Shahmoon-Shanok, 1992). As Mann, Steward, and Eggbeer (2007) pointed out, providers hold power in relationships with families and must maintain time for reflection and examination of their personal values and beliefs. The holder of the power in the relationship (in this case, the supervisor) should open the door to discussions of power, privilege, and prejudice. Individuals with limited power and privilege in the community (e.g., individuals from diverse backgrounds) often feel that their views of prejudice and discrimination are minimized by others or seen as irrational. As an example, in the vignette above demonstrating culturally insensitive clinical practice, the primary therapist was a bilingual

Latina professional. The consultant was a White male professional. The woman, from a more diverse background, initially felt unwilling to address the issue of insensitive practice with the dominant-culture man because she believed that he would minimize her concern or call her “too sensitive.”

Inequity within a professional relationship creates meaning for the individual with less power. When the supervisor does not address issues of difference, then the supervisee may believe that “if my supervisor is not going to talk about diversity, then it must not be important.” In the parent-provider relationship, the same parallel process develops. Remember that in the relationship between provider and parents, the service provider is the holder of power due to his role as a professional. Therefore, the hidden message becomes: “If my service provider does not think issues of diversity, privilege, and prejudice are important to discuss, then I (as the parent) should not bring them to the table.” When the supervisor is able to explore issues related to diversity with the service provider during reflective supervision, despite the uncomfortable feelings it may evoke, it provides a template for the providers to explore areas of diversity with their families. As a supervisor for many years, I observed that when providing background information on children, my supervisees would offer age, diagnosis, and family constellation but rarely ethnicity data or cultural background. When I began to ask for the cultural makeup of the family, including the traditions and rituals practiced, providers began to ask the families about such issues and bring more culturally rich information to supervision. If I had not asked about issues of culture and ethnicity, providers might have thought the issues were not important to treatment. In my role as a supervisor, I thought it was essential to assist providers to inquire and develop an understanding about the unspoken messages embedded in a family’s traditions and how they shape the developing child.

## Levels of the Supervision Relationship

HELPING SUPERVISEES to dive into the content area of diversity and face their fears of the unknown requires a specific type of relational support. Figure 1 illustrates four levels of support within a supervisory relationship: emotional safety, mutual respect, open communication, and cooperative problem solving. In Figure 1, the levels of supervision are reflected in expanding circles to demonstrate that each level builds on the next. It is illustrated that emotional support serves as the starting place for relationship building. As the parties move through the levels, respect and communica-



tion are established, and the opportunity for cooperative problem solving is created. It is in the area of cooperative problem solving where supervisors and providers can successfully share power in the relationship.

### Emotional Safety

Emotional safety can be found when the supervisor (or holder of power in the relationship) provides nonjudgmental feedback, offers understanding from a strength-based perspective, and provides clarity of expectations for the relationship. When supervisors observe less than optimal performance in providers, do we seek to scold or to support, understand, and, if needed, offer training? As a supervisor, can you openly accept feedback from supervisees? If you are a member of the dominant culture, can you accept that you may not fully understand the nuances of what it means to experience the world as a person of color, an immigrant, a Muslim, or a gay parent? When supervisors can demonstrate in our relationships with providers the emotional safety that allows for honest discussions of diversity, the providers have a model for how to bring such topics to the service delivery relationship.

For services provided to young children and their families, reflective supervisors want providers to approach parents and families from a strength-based and nonjudgmental stance. Providers should be able to initiate honest conversations with families about issues of difference such as religion, race, or issues of discrimination for same-sex parents. Even in the most challenging of circumstances, providers should see the best in

the families they are serving. But can supervisors see the best in providers even when faced with faults in their performance? It is vital that families trust that their service providers see all their strengths, challenges, loving relationships, and diversity.

### Learn More

RACISM AND RACIAL IDENTITY: REFLECTIONS ON URBAN PRACTICE IN MENTAL HEALTH AND SOCIAL SERVICES

L. V. Blitz & M. Pender Greene. (Eds.) (2006)  
New York: Haworth Press

REFLECTIVE SUPERVISION AND LEADERSHIP IN INFANT AND EARLY CHILDHOOD PROGRAMS

M. C. Heffron & T. Murch (2010)  
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RE-VISIONING FAMILY THERAPY: RACE, CULTURE, AND GENDER IN CLINICAL PRACTICE (2ND ED.)

M. McGoldrick & K. V. Hardy. (Eds.) (2008)  
New York: Guilford Press

REACHING OUT IN FAMILY THERAPY: HOME-BASED, SCHOOL, AND COMMUNITY INTERVENTIONS

N. Boyd-Franklin & Brenna Hafer Bry. (2001)  
New York: Guilford Press

EXPLORING DIVERSITY.

Zero to Three Journal, 27(5).  
Edited by S. Powers

## Mutual Respect

Mutual respect is present in the relationship when each member feels she has something of value to bring to the relationship. For the supervision relationship or the treatment relationship, mutual respect is evident in building collaborative teams with providers, and partnerships with parents, and moving away from the role of expert to the role of knowledgeable facilitator. Supervisors must ask themselves whether they are celebrating the talents that their providers bring to the supervision relationship. Can they be humble and support providers as they build their skill set and expertise in working with families? For the supervisor, this respectful supervisory stance requires patience and trust in the emerging skills of the provider. The supervisor's ability to trust the growing capacity of the provider creates the parallel for the provider as she works to nurture the new skills of the parent. Providers can show respect for families by seeking to build an understanding of the family's diversity issues, empowering the family as the expert on their individual experiences of power, privilege, and prejudice while supporting the family in finding the strengths embedded in differences. In creating respect and a deeper understanding of diversity, providers and supervisors must embrace an acceptance of the perceived truth as experienced by the other and withhold interpretations of the lived experience of the other. By honoring the real differences as experienced by diverse populations (without minimizing), providers and supervisors truly grow and build understanding.

## Open Communication

Open and honest communication emerges when a relationship is firmly rooted in emotional safety and mutual respect. Issues of diversity in supervision can be addressed only from a perspective of open, authentic communication. Both the fear of not understanding a provider from a different background and the experience of not being fully seen and

understood as a person from a diverse group have to be given voice. Open communication leads to shared meaning. Within the supervision relationship, providers need to experience open and honest communication so that they can begin to build a similar dynamic process with families. Indeed, many parents seeking infant mental health services also need to feel emotional safety, mutual respect, and open communication before they are able to offer this to their young children. Remember that people cannot give what they do not have. At the level of creating healthy relationships of support, you cannot give one until you have one.

## Cooperative Problem Solving

A relationship firmly established on a foundation of emotional safety, mutual respect, and open communication is well positioned to address any challenge. With a strong relationship in place, problem solving can be more productive and take into account the various dimensions embedded in diversity. Once providers feel safe that their experiences will be respected as legitimate and that they will be valued for their unique perspective, they can openly celebrate multiple possibilities for change and growth with the reflective supervisor. When families feel empowered by the experience of mutual respect and validation for their genuine experiences of discrimination or prejudice, they can explore innovative solutions. Only after providers can engage in open communication related to issues of diversity within the supervision relationship can supervisors and providers move to an authentic place of shared meaning related to diversity and truly understand the experience of living outside of the majority culture's point of view.

## Journey Toward Understanding Diversity Issues

**S**UPERVISORS ARE CHARGED with supporting the development of competent professionals who engage in ethically sound practice on the basis of best-practice research. Failure to address diversity and give this topic the full extent

of their open and honest exploration is an obstacle to their ultimate task as trainers of a new generation of professionals. In the goal to support professional competence, reflective supervisors must remember the powerful duo of relationship and reflection. Relationships of support make all the difference, and this is true in all things. Reflection at the level of the self, within the supervision dyad, and in the relationship with the family is always necessary. Supervisors must be prepared to set the tone in supervision to respectfully explore issues of diversity. This begins with educating staff members regarding the importance of self-reflection and providing the environment to examine deeply felt beliefs. Supervisors must be prepared to hold the emotional tension that is present when diversity issues are explored. Furthermore, supervisors must be prepared to accept what they do not understand from lack of experience with a particular culture or life choice. Exploring diversity requires the bold steps of speaking about social taboos and about discrimination, prejudice, and power differentials. The challenge for supervisors and providers is to find the courage to initiate such discussions, create the opportunities to reflect on the responses, and build relationships of support and understanding for themselves and the families they serve. ❧

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# The Reflective Supervisor's Role as Team Leader and Group Supervisor

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*Editor's Note:* This article is an excerpt from *Reflective Supervision and Leadership in Infant and Early Childhood Programs* (2010, ZERO TO THREE).

In this article, the authors provide a brief overview of several group leadership roles, a discussion of the skills and strategies central to such roles, and vignettes of supervisory discussions using language infused with reflective principles.

## The Supervisor as Team Leader

*Julie has recently been promoted to the position of child development manager for the Healthy Families program where she has worked as a home visitor for many years. The previous manager had a reputation for being quite disorganized, and staff members had been frustrated by her apparent lack of preparation for their team meetings. It was generally felt that the meetings were a waste of time.*

*As Julie prepares for the first meeting with her staff members, she realizes that she is quite anxious. The previous supervisor also tended to dominate the conversation and to allow for relatively little collaborative problem solving or open-ended discussion. Julie is determined to try to make it a more meaningful experience and wants to provide an opportunity for everyone to participate. But she feels overwhelmed by the number of administrative tasks and issues that have to be addressed. She knows that somehow she is going to have to find a balance between time spent on these duties and time for team members to help each other think about their work with individual children and families. She is not at all sure how to present herself. Should she sit at the head of the table? Should she come in with a prepared agenda? What role should she play in structuring the meeting?*

Julie is wise to be giving some careful thought to her role as a team leader and to be thinking about the many competing priorities. She is perceptive in her awareness of the possible effect of the team's previous experiences and the need for striking a balance between providing structure and guidance and protecting opportunities for reflection and open-ended exploration about the work with children and families.

Supervisors like Julie are likely to be involved with various types of teams and groups with different purposes. These include, for example, ad hoc teams that come together to support a particular child or family, teams that represent programmatic or administrative entities such as an Early Head Start or IDEA Part C, early intervention teams working with families in a defined geographic area and providing a prescribed set of services, and supervisory or consultation groups of many kinds.

Team-based work is part of a growing shift to coordinated care methods in the management of medical conditions. Coordination maximizes efficient use of both expertise and financial resources by drawing on multidisciplinary staff members and eliminating duplication of effort. These same benefits also apply to the complex work

with multistressed, high-risk children and families.

Ideally, every individual practitioner will take personal responsibility for seeking out the other professionals working with a family to initiate and sustain communication, to collaborate, and to integrate information gathered and intervention provided. The special role of the supervisor in coordinated care is to make sure that the staff members make such efforts and follow through over time. The supervisor will also provide guidance and support for these coordination responsibilities.

Work with young children and families is often accomplished through a team-based approach. Staff members can learn a great deal from one another, and no one individual, profession, or discipline is likely to have all the knowledge, skills, or expertise needed to provide holistic and comprehensive services. Best practice dictates a multidisciplinary team assessment, coordinated intervention planning, and integrated service delivery. In some cases, one professional is the primary service provider and the one who carries the relationship with the child or family. The primary provider can then be supported by a number of other professionals, some providing direct service and others in a consultative position. One important function of these kinds of multidisciplinary teams is to build a coherent understanding and intervention approach from the varied assessments and input offered by team members. This can then be communicated clearly to families seeking help and



**Work with young children and families is often accomplished through a team-based approach.**

support for their child. Supervisors play a central role in bringing team members together and helping them collaborate to be as effective as possible in supporting child and family health and well-being. The supervisor creates an environment for the professionals on the team to work together.

### Group Reflective Supervision

**R**ELECTIVE SUPERVISION CAN be provided in a group setting, and in some cases group supervision can be a valuable adjunct to individual supervisory work. In other cases, it will be the main source of reflective supervision. Some programs have the resources to support separate supervision meetings solely devoted to discussions of children and families; others need to manage team meetings so that administrative issues can be discussed along with consideration of the team's clinical work. Some agencies create leadership or supervisory groups that bring together supervisors from a wide variety of programs. They offer opportunities for professional development and skill building in a specific area (e.g., learning about a particular strategy or content area). They also can be used as a way of providing that leadership group with their own supervisory support.

### Embracing the Leadership Role Inherent in Supervision

**T**HE FIRST STEP for any supervisor, manager, or leader is to acknowledge that she has an important and complex responsibility. The supervisor needs to be comfortable in accepting this leadership position and to understand that in doing so she can be very helpful to a team or group. It is

important not to be dismissive of the role or give mixed signals about it. This might happen when a supervisor one day acts as a leader and the next day acts as part of a group of peers.

This uneven acceptance of a leadership role can happen when a supervisor is first promoted to the position, especially if she is now responsible for the work of former peers and feels that she might lose important relationships with them if she appears to take her role too seriously.

Underlying an acceptance of the leadership role should be an understanding that the leader's job involves engagement with others, drawing out the talents and different perspectives of group members, embracing diversity of all kinds, creating a safe atmosphere, and communicating a sense of the whole so that the group has a feeling of unity and purpose. In an odd way, the supervisor must truly step up and assume her leadership role in order to step back and create the desired opportunities for reflection.

There are many ways to be an effective leader of a team or supervision group. Individuals with different temperaments will have unique challenges as they take on these roles and responsibilities. Some may need to cultivate the "taking charge" part of leadership, whereas others need to build their abilities to truly listen to others and engage them in the group process.

### Skills Supervisors Need for Facilitation of Team Meetings and Group Supervision

**F**OLLOWING IS A description of some of the key skills supervisors will need for effective team facilitation. The reader

will note that these closely parallel skills used in individual supervisory meetings.

### Contracting and Clarifying

When any team or supervisory group begins to work together, time is needed to contract and clarify the purposes and processes of the group. This needs to happen at an administrative level and with the group itself. Recontracting and reclarifying may be necessary when members join or leave a group or when a group has lost direction and needs to get back on track. The supervisor organizes and tracks the following steps:

#### **DOING THE GROUNDWORK WITH AGENCY MANAGERS AND ADMINISTRATORS TO DISCUSS THE SCOPE OF WORK, ROLES, EXPECTATIONS, AND PURPOSE**

What is this team or group supposed to do? What did it do before? How did it work? What can be improved? As conditions and needs of a group change, additional discussions at this level may be necessary.

#### **ORIENTING TEAM MEMBERS ABOUT THE MISSION OF THE TEAM OR SUPERVISORY GROUP**

How will the team use its time? What is the purpose of the team or supervision group? What can participants expect? What are their expressed needs and thoughts about the group?

#### **DEFINING PROCESSES FOR HOW THE GROUP WILL WORK TOGETHER**

For example, the supervisor may hold the overall responsibility for how the group runs, but individual team members may rotate the facilitation. Some groups may want notes or minutes to track the work in a way that can be shared.

#### **WORKING WITH THE TEAM OR GROUP TO CREATE A SET OF AGREEMENTS PARTICULAR TO THE TEAM OR GROUP**

Agreements about how the team or reflective supervision group will run are a basic need if it is to be productive. For example, group members should decide the beginning and ending times and how they will start their work. There should be an agreed-upon agenda, so that team members have a clear understanding of how the time will be spent. Some groups may choose to address administrative issues at the beginning of the meeting, and others may wish to save those for the end. Groups may want to develop rituals such as sharing of food, highlighting a recent success, or simply a reminder to come in the room and be present with one another. In some supervisory groups, members choose to start meetings by picking a red, yellow, or green card. A red card means that the member has

an urgent concern, yellow means that the person would like to talk if possible, and green means smooth sailing and no urgent needs.

Supervisors are encouraged to explore with the group how electronic downtime may enhance the group experience and figure out how to handle text and phone use. It is better if agreements are written. Some teams or groups may want to have agreements available on laminated cards or wall posters. Agreements about confidentiality are important in early discussions.

### **HIGHLIGHTING THE VALUE AND IMPORTANCE OF TEAMS AND GROUPS AND CREATING THE EXPECTATION THAT ALL MEMBERS WILL PROTECT AND RESPECT THE TIME TO PARTICIPATE**

Orientation for new staff members should include discussion of the ways in which group or team work is integral to their job.

### **ENSURING THAT STAFF MEMBERS ARE ACTUALLY AFFORDED ENOUGH TIME FOR TEAM MEETINGS AND GROUP SUPERVISION**

Supervisors may need to advocate for this time and should stand ready to explain ways that the groups support program quality and develop staff members' skills.

### **FRONT-LOADING THE PROCESS BY SPENDING EXTRA TIME WHEN A NEW TEAM OR GROUP IS JUST GETTING TOGETHER, IN ORDER TO LAY A SOLID FOUNDATION**

Front-loading should always include some training and practice on how to use reflective approaches in a group and how to work effectively as a team. Staff members will learn a great deal from the way the team leader or group supervisor works, but explicit training and guidelines will move the reflective skills of the team members along exponentially.

### **PLANNING FOR UPCOMING TIME TOGETHER**

Staff members are likely to be only as prepared and committed as the supervisor. The nature of this planning depends on the purpose of the group meeting, but all groups are enhanced by a review of what happened the last time the group was together before moving on to new topics or discussions. The supervisor should keep and review notes of issues discussed, past case presentations, agreed-upon action items, and questions raised for future discussions. She should be sure to follow through on any responsibilities she has assumed.

### *Containing and Organizing*

The supervisor has the task of promoting the well-being of the team or group as

a whole, while attending to the individuals within the group itself. Although each individual member also plays a part and can have an important role in supporting fellow team members, giving feedback to others, and helping the group stay focused and true to its mission, the team leader or group supervisor ultimately has responsibility for the team's operation. If she can avoid the temptation to jump to conclusions too quickly, but instead model a calm and reflective stance, it will be easier for the team members to contain their more reactive impulses. If the supervisor hears a remark that is potentially damaging to the group or far off the mark from the group's mission, her role is to notice and comment. She must work to make sure that all team members have a chance to participate and be heard. As team leader, she helps staff members use their time most productively, balancing the need for process and exploration with the need to come to a decision and make a plan. She can summarize a discussion to help the group move on. Above all, she should monitor the group to make sure that there are no invisible members or absent voices. All this should be done in a collaborative and collegial manner, as in the following examples:

- "How much time do you think we need for this discussion?"
- "Before we start figuring out what to do, are there other things we need to know about this situation?"
- "I know the question about whether we are going to expand the geographic boundaries of our service area is on everyone's mind, but could we start by taking some time to talk about some of the

recent trends with our families, so we can better forecast what our program capacity will be for next year?"

- "Christine, I appreciate your thoughts on this, but I'd like to hear from Jodi, too, and she has been wanting to say something for a few minutes."
- "It sounds like some of us felt quite upset with this parent for being so hostile in the parent group, but I wonder if there is another way to understand her anger? Do you think there is anything that happened while she was here that may have added to her distress?"
- "We have been discussing this situation with Alice's new foster mom for some time. I wonder if we can move on to the questions Peter wanted to discuss, or do you think you need a few more minutes?"

The supervisor helps the team or group members keep their purpose in mind and consider what is and is not within the scope of their work. She stays attuned to the tone and mood of the group as a whole, helping it to regulate strong emotions, to focus, and to avoid a hijacking by a single vocal member, issue, or point of view. She is vigilant about "group-think," or the tendency in groups to jump on a bandwagon without fully exploring all perspectives. Here are examples of how a supervisor can keep a group meeting productive and on track:

*Deadlines are killing everyone, and I am willing to help anyone who is struggling to meet a deadline on an individual basis, but I want to table this discussion now and return to our discussion about some of the difficulties we are having phasing new children into the center.*



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**Agreements about how the team or reflective supervision group will run are a basic need if it is to be productive.**



**The supervisor should keep and review notes of issues discussed, past case presentations, agreed-upon action items, and questions raised.**

\*\*\*

*It sounds like everyone is really upset about the changes in the Department of Health Services billing procedures. Unfortunately, there doesn't seem to be much we can do about it right away—so let's try to figure out how to minimize the effects on our program while we continue to advocate for change. If you can get me examples of how these changes are hurting children and families, I can bring this information to our meeting with the Department next month.*

In teams and group meetings, time is often needed for exploring fears, negative emotions, and concerns:

*Jackie has been pretty clear about her worries and feelings about safety concerns in this neighborhood where the family is now living. I sense it has been upsetting to hear some of the things that have happened. I'd also like to hear from anyone else who may have had similar concerns.*

\*\*\*

*We have spent a lot of time exploring how painful it is for Camille to cope with this mom's depression and to watch the effect on her baby's communication development. What do others think—is there anything else that Camille could explore?*

Team members get real support by being able to talk about these kinds of strong feelings and reactions with their team. The supervisor should help create an atmosphere that

supports this because so often what is shareable is bearable (Siegel, 2010). Ideally, the supervisor first gives time for the group to listen, respond, and help; however, if the mood seems to be escalating, or if staff members start “catastrophizing” (i.e., overreacting and appearing unable to pull themselves back together again), then the supervisor should step in to bring them back to a calm and constructive state. This kind of subtle pivot on the part of the reflective supervisor allows the team to reconnect, explore the situation in a more objective fashion, and, if warranted, come to a consensus and make a plan. The supervisor helps to keep the balance between the need for expression and recognizing when the team needs to move on. In making this kind of a pivot, it is crucial that the supervisor acknowledges the strong feelings and avoids giving the impression that she simply wants to avoid controversy:

*I think we are all in shock that Paula has suddenly decided to move to Los Angeles, where she doesn't seem to know anyone or to be connected with any of the services that she will need to care for her baby. It is particularly upsetting since you all have worked so hard to help her get a really good service team in place here, and things seemed to finally be turning around for both of them. But since it looks like she is pretty determined to follow through with this plan, let's do some brainstorming about how to help her find the resources she will need when she gets there. And we should remind ourselves that Paula's ability to make a move on her own is a testimony to how well you have helped her become more confident in her own abilities.*

### **Managing Change**

All the skills described will be important in helping the supervisor manage change effectively. This is an issue that arises frequently for infant–family service providers because of increases or decreases in funding levels, the effect of new developments in research or standards of best practice, changes in contracts, loss or addition of staff members, or new regulatory requirements.

### **Creating a Safe and Supportive Environment**

Teams and supervisory groups work well only when group members feel safe enough to both be themselves and be part of an endeavor shared by the team or group. To achieve this sense of safety and comfort, a supervisor must encourage expression and awareness of others and insist on a respectful stance. The supervisor should communicate that differences of opinion and perspective are an asset as long as there is a willingness to hear out differing views. Supervisors can also help create a

sense of safety by communicating the insight that one can be visible and included even if one's voice is not heard as often as some others. When these conditions are present, groups are more likely to be free to do their most creative thinking. They are also able to provide the highest level of support to one another.

Many of the same strategies for building a sense of safety and support in individual supervision apply to the team or group supervision setting. However, the task is more complex, because the supervisor must consider individual responses and needs as well as the team as a whole. The supervisor should start by monitoring her own behavior closely and avoiding being judgmental, critical, dismissive, or directive, or seeming to have favorites. Staff members need to trust that they will be respected and that the group will support them or at least that they will not be shamed or scolded. The supervisor should do everything possible to stay open-minded when listening to a discussion, thus encouraging the team as a whole to follow her lead. This atmosphere usually helps individual staff members feel comfortable enough to explore their own reactions, values, beliefs, and the effect these might have on their work, including situations where they may have done less than their best work.

**Sara:** *This is hard for me to admit—but this mom just doesn't seem to like me. I don't know why, but I am almost tongue-tied when I am with her, and I am sure she was wishing she still had Sarah as her home visitor.*

**Johan:** *I bet every one of us has felt that way from time to time. I am wondering how you would like the group to help you—would you like to share more details about this, or might it be helpful to hear how others have managed transfer cases?*

Supervisors can set the tone for openness and exploration by bringing up their own past mistakes and admitting to their own misgivings. With this kind of openness, team meetings and group supervision offer opportunities for learning and growth possible through sharing rough spots and mistakes.

It is critical to assure that confidentiality is maintained and that sensitive personal, client, or programmatic information shared during a team meeting stays within the group. Everyone on a team or in a supervisory group should have a chance to review and discuss the reasons why this is so important. The supervisor should clarify that if anything comes up that constitutes a danger to a child, family, team member, or the agency, then the information may need be discussed with her own supervisor or other appropriate program staff members. Team and supervisory group

members need to be informed regarding any particular exceptions to confidentiality that may arise so that they understand what the next steps will be.

If there are multiple lines of supervision in an agency, these issues can be complicated and deserve clarification in initial stages of group formation. The following is an example that illustrates this complexity:

*In her reflective supervision group, Tanya, a site supervisor for a Head Start program, asks her colleagues for help with one of her teachers, who is having trouble working with parents due to her extreme shyness. Tanya has been doing the required home visits for the teacher and finds herself feeling resentful but also pressured because of the upcoming federal review. She wants the site to do well and have all requirements met. Margit, the supervisor for the group, finds herself working hard to monitor her own feelings. She is aware that the education coordinator has been explicit that all teachers must do the home visits to go over the education plans. She wonders whether the education coordinator knows that Tanya is doing this. Rather than put herself in the middle of this situation, she asks Tanya if she has talked to the education coordinator. Tanya says she hasn't, and Margit asks her whether she thinks she might be able to ask that person for assistance in addressing the teacher. Margit adds: "I think that would really help. Hiding this from the education coordinator is keeping the teacher from building her skills, and you from getting your other work done."*

Supervisors may be tempted to transport issues from individual supervision sessions to the whole group because of the learning value of a particular example. Before doing so, they should first ask permission from the supervisee, thus respecting the confidentiality of those one-on-one conversations.

### **Addressing Difficulties and Conflict in Group Settings**

Even in well-functioning teams and groups, difficulties arise that should be addressed or responded to in some fashion. Comments are made that are hurtful, whether or not they are intentionally so, and team members behave or respond in ways that negatively affect their colleagues. A member of the team may express a prejudice toward a group or individual; another person may be tuned out throughout a meeting; a sarcastic remark or outburst of negative emotion directed at a team member may have a jarring effect. Typically, a supervisor is advised to address these situations in the moment, when they happen, but often there may need to be a fuller discussion in a private meeting later on. By engaging in a direct and respectful way, the supervisor demonstrates that difficult topics can be discussed and will not go underground.

*Valerie is a social worker who is assigned to help young children transition from foster care to permanent homes. In a recent meeting, she asks the team for help. She says that she feels it is wrong that the department is placing a little boy with two dads. She states that her religious beliefs hold that homosexuality is wrong. She says she feels she has no place to talk about this conflict. Valerie's supervisor Andi feels a surge of anger as she listens to Valerie. She then says: "This is tough. I appreciate your honesty about your beliefs. I think some of us see this differently, but I wonder if we could explore how these feelings are making it hard to help little Alex settle in to this family." Valerie says she wants to do the right thing, but it is hard to hold her beliefs separate. Some team members express that they had similar feelings in the past but think that it is important to look at the abilities of the new parents rather than their sexual orientation. This conversation seems to help Valerie relax in the team, and she asks her team members who had worked with same-sex couples for more specific ideas and help about her case.*

### **Finding the Teachable Moment**

As represented throughout this book, reflective supervision is seen as a primary vehicle for promoting staff members' development. Team meetings and group supervisions offer many opportunities to help staff members grow and learn as professionals. The supervisor can make a conscious effort to take advantage of these in a variety of ways. If, for example, the group has recently attended a workshop, the supervisor can watch for ways of applying the training content to a specific case discussion.

*Molly seems to be wondering whether this baby's refusal to try pureed foods might be related to some sensory problems. Thinking back on the training we had last week about the possible sensory basis of feeding disturbances, do you think this child fits the profile?*

The supervisor can identify trends or make connections among issues that have come up for several team members, to help the group think about the underlying concepts and try to see the "big picture."

*It seems as if the last few toddlers we discussed have teen moms who are struggling with their own independence from their mothers. Maybe we can understand their reactions to their toddlers' behavior in the context of their own challenges. Do you think this might be useful?*

The supervisor also functions as "team historian" and provides continuity for the discussions that take place from one week to the

next. She can be depended on to follow up on past conversations.

*Jorge, could you please give us an update on the Alfonso family? When we talked last week, you were just about to go with them to the school district transition meeting. We were all wondering whether the district would be receptive to our suggestions and what information would be important to them to help with the placement decision.*

These approaches will be useful only if the supervisor is authentic in asking her questions or making her observations. Staff members will be put off by comments that seem patronizing or have an obvious hidden agenda. All questions should be statements of honest inquiry rather than disguised efforts to elicit a desired response.

Finally, the supervisor can help staff members learn that part of their job is to seek information and input from others. She can create a space for collaboration and dialogue and help staff members learn how to learn from each other.

*In a group supervision, Elaine is discussing a toddler whose family is about to have a new baby. The supervisor asks, "Do any of you have good picture books that you would recommend to Elaine to give to this little boy? There are a lot of them out there, but it might be helpful to have some specific recommendations of ones you have found helpful."*

### **Summary**

**A**N EFFECTIVE TEAM OF supervisory group will ideally have these features:

- A clear vision, mission, guiding principles and communication guidelines
- Well-defined roles
- Effective leadership

### **Learn More**

RELATIONSHIP-BASED ORGANIZATIONS.

J. Bertacchi (1996)

*Zero to Three*, 17(2), 3-7

HOW DO I, AS A REFLECTIVE SUPERVISOR, REPAIR RUPTURES IN THE SUPERVISORY RELATIONSHIP?

A. W. Keyes, A. E. Cavanaugh, & S. Scott Heller (2009)

In S. Scott Heller & L. Gilkerson (Eds.)  
*A Practical Guide to Reflective Supervision*

(pp. 99-119)

Washington DC: ZERO TO THREE

- An atmosphere of trust, safety, and mutual respect
- Space for strong emotions and different points of view
- Open and direct communication
- Adequate resources such as time and space
- Well-defined outcomes and a means of evaluating them
- A shared dedication to high-quality services
- Synergy among the team members
- The ability of members to get their work done effectively and efficiently

If we are lucky and work hard enough, we will each have the pleasure of being part of a successful team or group. We can recognize it when it happens. Staff members come to the meetings fully prepared and ready to participate, having left other tasks behind. They come ready to approach problems in a collaborative and constructive manner, having already started to think about possible solutions. Everyone participates. The group members are able to take the time they need to reflect and explore broadly but are also able to come to decisions and make plans in a timely manner. They do not stay stuck in repetitive cycles of frustration and inaction. Members can tolerate the ambiguity of complex situations. There is an atmosphere

of calm but also an alertness and lively spirit within the group.

Team and group members know each other well and are supportive of each other. They are respectful and know how to help each other. There are no obvious zones of silence; difficult issues can be raised and discussed in a safe and respectful manner. Staff members take responsibility for their own actions and are self-reflective and able to accept and use constructive feedback. Team time is protected; everyone arrives on time and stays fully engaged.

All members take advantage of the opportunity to learn from each other. There is a creative energy that is focused appropriately on critical needs of the program. Ideas discussed in team and group meetings start to be discussed and referenced outside the meeting.

At these times, it feels like being a member of a gold-medal rowing team: Everyone is strong, they pull together, and the boat flies through the water. 🚣

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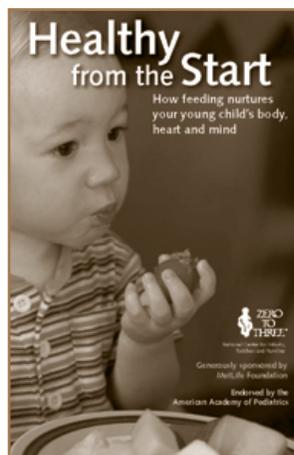
Program which provides relationship-based training to staff working across disciplines in a variety of service delivery settings. She also directs several other projects including the Fussy Baby Program. She has been involved for many years in providing reflective supervision and consulting with agencies on how to set up reflective supervision services.

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National Center for Infants, Toddlers, and Families

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# Recollection, “Reality,” and Reflective Supervision

## *A Novel Comparison Technique*

GILBERT M. FOLEY

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Reflective supervision is an act of shared mindfulness (Foley, 2009). It is a relationship for learning within which an intermediate space is created between didactic instruction and psychotherapy for the purpose of examining, deepening, expanding, and refining therapeutic consciousness, or the ability to be fully present, especially in mind and feeling with insight into both the self and the supervisee (Geller & Foley, 2009; Schon, 1987; Shahmoon-Shanok, 2006; see also Siegel & Shahmoon-Shanok, this issue, p. 6). An integral ingredient of therapeutic consciousness is for the therapist to perceive the internal experiences of another person and make sense of those imagined experiences through heightened affect attunement and contingent responding between therapist and client—critical capacities to be both used and refined through the supervisory partnership (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Siegel, 2001; Siegel & Hartzell, 2003).

The aim of this brief piece is to describe a technique which lends an insight and depth-oriented dimension to the broader aims of reflective supervision defined above. The strategy described below yields considerable richness in the production and processing of reflective material. The technique is embedded in the theoretical and research matrix of psychoanalysis

and projective methodology or transfer of unconscious content onto stimuli that may be ambiguous or shadowy to which I allude but do not delve, as it is beyond the scope of this article. The term *dynamically oriented* suggests one of the functions of reflective supervision is to mobilize the forces of the unconscious in the service of heightened and expanded awareness.

The technique consists of dividing the supervisory session into three parts or phases: the recollection phase, the “reality” phase, and the integrative phase.

### Recollection Phase

THE RECOLLECTION PHASE CONSISTS of the *recounting sub-phase* and the *association sub-phase*. In the recounting sub-phase, the therapist/supervisee is asked to recall and reconstruct from memory a particular interaction from her work with a child and family. The vignette is chosen by the supervisee to serve as the object of association, reflection, and examination. The practitioner is asked to reconstruct from memory as close as possible to what actually happened. Following the recounting of the vignette, in the association sub-phase, questions and probes are presented to the supervisee to evoke material related to the memory of the event for reflection examination and analysis and, often more important, to

make connections between the memory of the experience and her feelings about it.

To get at the heart of the supervisee’s experience, mind, feeling, and less-than-fully conscious content, I might ask such practical questions and pose probes as follows: Describe what happened? What did the child “tell” you? Where was the parent in this scenario? What was said? “Where” was the action? What were the patterns of movement, positions, and postures assumed by the players? Tell me about your role in the scene? What/who do you think you represented to the child and parent? Did parent or child remind you of anyone? Was the scene “familiar,” “alien”? What did it bring to mind? What was most charged about the session? What was the prevailing affective tone of the session? What emotions were stirred in you or in the players? Do you have any notable body memories? Were you bored? When? Why then? What did you love? What did you hate? What would your boredom, love, or hate speak? What subtexts might have been operating? What might this scene mean beyond the obvious? If the child could talk or elaborate, what might he have said? If for example, a particularly toy or object were at the center of a play scene, what might it say if it could talk? Does that toy bring anything to mind? What did you say or do when...? What was your line of clinical reasoning in arriving at a response

or intervention? Reflecting upon it as we did, would you say or do the same things now? If not, how might you alter your interventions and interpretations and why? What do you think you learned from and about the child and parents? What do you think you learned about yourself? Have your formulations changed? What working hypotheses might you generate? What next?

This process during the association sub-phase is kept sufficiently open-ended to promote a nonlinear unfolding of the material for reflection, examination, and analysis relative to the case content. A “what-comes-to-mind stimulus approach” is often used within a more logical line of inquiry. The line of questioning is peppered with calls to impressions, affect, divergences, bodily and sensory states, associative material, memories, and so on. All is permitted, indeed encouraged, within the association sub-phase and all is considered material for reflection and examination relative to the client, family, and therapist within the context of the treatment.

Although drawn from the technique of free association, the process I describe is intentionally kept “tighter.” Might I suggest a state in which consciousness is sufficiently permeable to allow for the magical intrusions and meanderings of the unconscious without being loosened to the degree of primary process (pre-logical) thought. Associative material is not analyzed with regard to its origins in the supervisee’s life history as it might in psychoanalysis but only with regard to its meaning within the context of the interaction chosen as the object of reflection. In contemporary conceptualizing, this associative sub-phase might be considered more consonant with right brain processing.

### “Reality” Phase

THE “REALITY” PHASE consists of two sub-phases as well: the *discrepancy* and the *interpretive sub-phases*. The discrepancy sub-phase consists of jointly viewing a videotaped segment of the same vignette just reconstructed and examined from memory. Together the supervisor and supervisee compare and contrast the remembered vignette and associations with the recorded event in terms of content, sequence, what was said by whom; who did what; who was where, when; what materials were used in what ways; positions and postures of the players, and so on. The goal is to identify the



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**Together the supervisor and supervisee compare and contrast the remembered vignette and associations with the recorded event.**

lapses, inconsistencies, transpositions, and notable discrepancies between the remembered and the recorded as well as when memory and recording were in congruence.

A line of inquiry might include some of the following: How did your recollection of the scene and the taped version compare? Where was there congruence; what was out-of-synch? What in your recounted version was forgotten altered, distorted, out of sequence? Did recognizing the inconsistency trigger any immediate feeling—can you elaborate? What might you make of these lapses in memory—any clues? What does each version evoke in terms of associations, feeling, comfort-level, and so on? How might the “misremembered” version have served you, the child, the parent, the process? If the “misremembered” version could elaborate, what might it say? Is there any word or action in the misconstrued version that stands out in your mind or triggers any memories about the treatment, other cases?

During the interpretive sub-phase, the supervisee is again asked to associate to, reflect upon, analyze, and make-connections among the discrepant material. The supervisor and supervisee look for clues as to possible hidden or shadowy meanings and function of the lapses in memory out of which unfold interpretations that hold the potential for a deepening

of understanding and insight relative to the work in question. The examination of material is not top-down but rather unfolds as a course of mutual exploration, inquiry, association, discovery, and hypothesis generation, drawing from the content, lapses, and associations offered by the supervisee and supervisor informed by theory, research, clinical experience, and the “third ear” (Reik, 1948) of both supervisor and supervisee. This sub-phase of supervision might bear some parallel to interhemispheric communication (exchange of material between the right and left hemispheres of the brain).

### The Integrative Phase

THE INTEGRATIVE PHASE represents an effort to summarize what was learned by the comparison of the memory and the videotaped event into a language-based, systematic, categorical, and cohesive understanding of the supervisee’s experience of the intervention with the family. This part of the work is apt to be more linear, logical, and organized. It may be a springboard for guiding the supervisee’s next step with the family, alerting the therapist to material, themes, and affects that might be particularly

charged; identifying underlying concerns about the parent, child, or process that might have heretofore been shadowy in consciousness but present in action; generating working hypotheses to guide treatment, maximize the use of self, and heighten consciousness. This sub-phase of supervision might bear some parallel to left brain processing.

I will offer an abbreviated but, I hope, tantalizing supervisory snapshot, to illustrate. In the vignette presented from memory, the therapist/supervisee recounted the child taking a stuffed alligator and pretending to gobble up Mother with playfully high affect. Mother seemed hesitant to expand the child's bid to play and reacted with soberness. The child then turned to therapist/supervisee who attempted to pick up the thread of content and elaborate the play, spinning off the child's comment that the alligator was "looking for water." The therapist/supervisee responded by saying the alligator wanted to "cool off" and attempted to engage the child in a pretend search for water but the play faltered at that point and failed to yield the potential richness suggested by the provocative prelude. The supervisee asked, "What might have blunted this interaction and potentially expansive play theme?" Although various hypotheses were formulated, interpretive inferences became clearer when the

therapist/supervisee and I viewed the video clip together to see what clues it might yield. In fact, the child said the alligator was looking for water to "swim", not cool off, as the therapist had recounted it. There was a mismatch in reading intent and motivation, and the child responded by looking confused and then confounded and the play foundered.

Was this simply a matter of the therapist not hearing correctly or not hearing correctly in addition to something else? A reflective examination suggested that in fact the therapist/supervisee may well, at some level, have perceived the emotional climate as "hot" and indeed in need of "cooling off." A central theme in the course of the treatment had been the mother's worry that the child was not attached and had, in fact, rejected her. The therapist/supervisee came to hypothesize that she may have been latently concerned about the mother's perception of the child's aggressive, albeit playfully affectionate, overture, a first in their sessions. The therapist came to further hypothesize that had she too successfully engaged and expanded the child's play the mother might have felt marginalized, possibly rejected and injured, and she might have exacerbated a competitive theme present all along but kept invisible. Indeed the misheard intent and aim of the child's search for water and the incongruent response on the part of the therapist/supervisee might have unconsciously served to abort a play

scenario that may in the end have served the therapist's needs more than those of the dyad and driven a wedge between them—possibly making a "hot" situation even "hotter." §

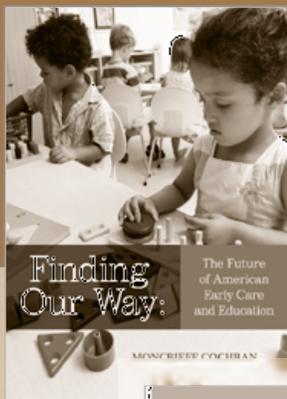
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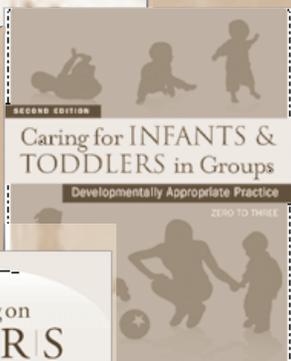
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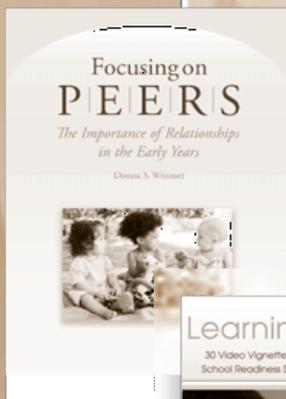
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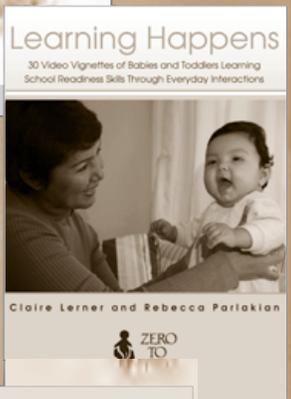
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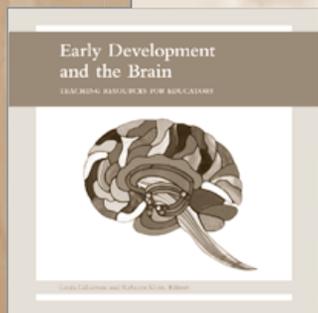
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# QUANTUM Supervision

## *Six Keys to Reflective Supervision*

WILLIAM M. SCHAFER

*Ann Arbor, MI*

I usually hate acronyms. So when one came to mind while I was putting this piece together, I winced. QUANTUM Supervision—it sounds like a new electronic game for a 10-year-old. (My next thought was even spookier: “Hey, that’s a cool name, maybe it will sell!”) On reflection, QUANTUM may not be a bad name. Quantum mechanics says that the universe is not totally determined, that the fundamental energy from which everything is made has a steady state of zero probability that it will be observed at any determined strength or position. It describes a world in which there is always room for something new and surprising. This is very different from the precisely and overdetermined universe most people were taught to expect in school. So here are six keys to reflective supervision, acronym and all. I hope you find them helpful.

### Key No. 1: QU

**QU** IET ATTENTION IS attention that is focused equally on everything that happens. It has no expectations and no preconceptions. It is an attitude of mind that is looking for the unexpected, unplanned, and underdetermined aspects of the conversation with your supervisee. In an odd way, this gets harder the better you get to know your supervisee. In the beginning, you are relatively open and have

fewer preconceptions. After a while, you tend to bring certain expectations to each conversation: “This is the supervisee who always . . .” “This is the one who needs to . . .” These expectations make it harder to stay open to what is new and surprising. Before each session, remind yourself to look for those things you have never heard and never felt before. If nothing else, it will keep your work more interesting and alive for you. So pay quiet attention to...

### Key No. 2: A

**A**LL SECTORS OF experience. There are three main sectors of human experience: concepts/ideas, feelings/emotions, and images/sensations. Most people are specialists in one sector and not so comfortable in the other two. Mental supervisors experience the world through concepts and ideas. Their waking consciousness is mostly filled with thoughts, expressed in their minds as words. Emotional supervisors experience the world through feelings. Their consciousness is aware of the mood, the atmosphere, and the aura that the supervisee brings to the conversation. Sensing supervisors live in a world of images and kinesthetic sensations. They quickly get global impressions of the kind of dance they are dancing with their

supervisee, and these impressions do not always quickly turn into words or feelings. All of us possess the ability to access each sector because we all have minds, hearts, and bodies, but most of us live mainly in one sector to the exclusion of the others. Get to know your own bias, and make an effort to grow more comfortable with the sectors you usually avoid. For example, if you are a mental person, you may be very good at observing another’s facial expressions and body language to get a reading of her emotions. However, if you never learn to actually *feel* them, your supervisee will not have the experience of feeling felt by you. You will know about her feelings, but you will not resonate to them—and she will know it. The same can be said for those supervisors who easily resonate to the emotional aspects of the case material but sometimes get so swept away by feelings that they cannot help their supervisees figure out how to manage the case. Finally, sensing supervisors can quickly get a holistic image or sense of a case but have trouble putting it into words with sufficient exactness to give the supervisee a practical direction to follow. Once you get to know your own bias toward ideas, feelings, or body images and become comfortable using the sectors you usually avoid, pay attention to how the

There is more to good supervision than just you and your supervisee. There is a third thing, called the Process. The Process is the mind's natural movement toward greater awareness.

sectors function for each supervisee you have. Learn how each one gravitates to one sector while avoiding the others. Then help them find greater balance as well.

#### Key No. 3: N

**N**OTICE YOUR OWN internal reactions. Some of them are obvious, but many of them are tiny enough to miss unless you maintain deep inner stillness. This is the real advantage of paying quiet attention to all sectors. You get to notice your own reactivity even when it is small. Notice also what set the reaction off. It may be the comment the supervisee just made, the metaphor he chose, a certain inflection he used, or a gesture. Whatever it was, if it caused even a small reaction in you, use your reaction to underline its cause as something that may be important. Put it on some little shelf in the back of your mind. Then resume paying quiet attention to all sectors. You will remember the reaction and what caused it when and if you need to. Why? Read the next key very carefully.

#### Key No. 4: T

**T**RUST THE PROCESS. This is already the fourth of six keys, and so far they all have been about what is going on inside of you, the supervisor. None of them has been about what you should be doing or saying, and that can be hard for some supervisors. They find it difficult to

just listen. There is something inside each supervisor that wants to explain what is going on, to offer a solution, or to fix it for the supervisee. If you just listen with quiet attention to all sectors while noticing your own reactions, you will probably find yourself getting impatient. You will be asking yourself, "When am I going to put all of this to use? When are these keys going to pay off?" Don't let yourself be rushed into action. You don't have to have it all figured out as soon as you think you do. Give yourself at least half the supervisory hour to just listen, and if you haven't yet figured out what the central point of this supervision is, don't panic. There is more to good supervision than just you and your supervisee. There is a third thing, called the Process. The Process is the mind's natural movement toward greater awareness. The mind, like the brain—the neurological functioning of which makes the mind possible, is a self-organizing system that seeks greater coherence and integration. Calm, accepting awareness, especially when shared by two people of good will, leads naturally to greater and greater integration. This is how the Process works. Trust it. It is wiser and more powerful than either of you. Of all the keys I am giving you, this is the hardest one to put into practice. It is also the most important.

#### Key No. 5: U

**U**NDERLINE THE SUPERVISEE'S shifts of energy. In every supervisory hour, there are one or two moments when the supervisee's inner state shifts. The shift can show up as a glistening tear, a flicker of tension around her mouth, a sigh of relief, a deep breath, a relaxation of her shoulders, and a hundred more ways. Whenever you notice something like this, underline it for yourself: "This may be important." At some later moment, you may want to ask your supervisee, "What happened there? You were talking about such and such and you seemed to relax just a bit. Do you remember that?" The reason you want to do this is that these energetic shifts are the signs that the supervisee has reached some inner threshold.

She is at the edge of what she knows and can articulate to herself. What lies just beyond is still inchoate in some way. The energy shift is her body's way of calling attention to the threshold. Don't lose the opportunity to explore it.

#### Key No. 6: M

**M**ILK THE METAPHORS. It is almost impossible for a supervisee to talk for 30 minutes without using metaphors. Pay attention to them, especially to those that cause some inner reaction in you. If you trust the Process and keep on paying quiet attention without forcing some premature conclusion or understanding of the material, the metaphors themselves will come back to you. When they do, be willing to play with them. Turn them every which way you can; invite your supervisee to play along with you. You will both be pleasantly surprised at how much deep understanding you can reach this way.

Try out these six keys. See if they help you find the freedom to discover something new and liberating in your supervision sessions. If you make them second nature to your practice, you can eventually forget the acronym.

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*WILLIAM M. SCHAFER, PhD, is a retired clinical psychologist who lives in Ann Arbor, Michigan. He began doctoral training in 1970 at the University of Michigan, spending 8 years with Selma Fraiberg at the Child Development Project. He is past president of the Michigan Association for Infant Mental Health, as well as past president of the Michigan Council for Maternal and Child Health. He has taught courses in infant and toddler development at both the University of Michigan and Wayne State University. For the past 18 years, he has been deeply interested in the interface between Eastern philosophy and Western psychology. He devotes much of his time to retreats, courses of development, and intensive training for psychotherapists and other healing professionals.*

# Field Notes

*ZERO TO THREE Fellows share news and information about research, policy, and practice innovations in their work with infants, toddlers, and families.*

## USING REFLECTIVE PRACTICE FACILITATION COMPETENCIES AND ENDORSEMENT IN INFANT–FAMILY EARLY CHILDHOOD MENTAL HEALTH

Monica Mathur, WestEd Center for Prevention and Early Intervention, Sacramento CA

**T**HE FIELD OF infant–family early childhood mental health is complex, including providers from diverse professional backgrounds working with children and families in a variety of settings.

At least two groups have analyzed the need for clear competency guidelines for the infant–family early childhood mental health field and have created guidelines that differentiate among the roles in this field and clarify and elaborate the knowledge, skills, and reflective supervision and facilitation practice important for each.

The Michigan Association for Infant Mental Health (2002) created competency guidelines that include four levels of competencies (Weatherston, Weigand, & Weigand, this issue, p. 22).

In California, the California Infant–Family and Early Childhood Mental Health Training Guidelines Workgroup has just released the *Revised Training Guidelines and Personnel Competencies for Infant–Family and Early Childhood Mental Health* (2009). These competencies provide a basis for in-service and pre-service training programs and provide a framework for individuals interested in obtaining specialized training in the area of infant–family and early childhood mental health. Competencies and guidelines are developed for three groups.

1. Core providers include professionals from multiple disciplines (e.g., early intervention, nursing, human development,

and social work) that have frequent contact with pregnant women, young children, and their families and are most likely to provide promotion and preventative mental health interventions.

2. Infant–family and early childhood mental health specialists that provide prenatal, infant–family, and early childhood mental health services within their scope of practice in the areas of promotion, preventive intervention, and treatment.

3. Reflective practice facilitators who have training and experience as infant mental health specialists or core providers as well as an additional set of trainings and competencies focusing on the reflective practice facilitation process. (California uses the term *reflective facilitation* for reflective supervision to make a distinction between the legal implications of the term *supervisors*.)

Reflective practice facilitation can be provided on an individual basis or in small groups of up to 8 participants to support practitioners to:

- Explore ways to apply relevant theories and knowledge bases to clinical situations;
- Model an appreciation of the importance of relationships that are at the core of infant–family and early childhood mental health;
- Reflect the experiences, thoughts, and feelings involved in doing this work;

- Understand the family’s culture and the parents’ and infants’ interpersonal perspective; and
- Explore possible approaches to working effectively with infants and families.

Both the Michigan and the California systems emphasize the need for reflective supervision (referred to as reflective practice facilitation in the California system) and highlight it in the endorsement process. This focus on reflective processes provides both those who are seeking training and those who are deepening their practice with appropriate reflective practice experiences needed to develop competency in infant–family and early childhood mental health service delivery.

CALIFORNIA INFANT–FAMILY AND EARLY CHILDHOOD MENTAL HEALTH TRAINING GUIDELINES WORKGROUP. (2009). Revised training guidelines and personnel competencies for infant–family and early childhood mental health. Retrieved October 12, 2010, from [www.ecmhtraining-ca.org/](http://www.ecmhtraining-ca.org/)

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## REDISCOVERING SUPERVISION

Linda Gilkerson, Erikson Institute

**F**OR THE PAST 3 years, I moved to the other side of the supervisory desk. As a returning graduate student in social work, I spent a year on a health outreach bus and then a year and a half in a

community mental health center doing individual and family therapy. Regular supervision was part of each of these experiences. So what did I learn anew about supervision?

First, I felt the vulnerability that a new learner experiences and the need for an attachment figure—a central part of the supervisory role. I stepped off the bus that first night into a gathering of persons who

were homeless or nearly so. My supervisor watched my tentative first steps and walked over to introduce me to one of the parishioners who had been close to the previous intern. “Zeke, you got to know Katie really well. You’ll like Linda too. This is her first day. How about telling her a little about yourself.” In that moment of my uncertainty, he stepped forward to build a bridge that I could cross, calming my fears and launching me into a year of discovery and growth.

The vulnerability returned as I entered my next placement and began interning as a therapist. The constancy and predictability of my supervisor—her rock-solid presence every Tuesday at 6 o’clock and her depth of experience—were anchors in this unknown sea. She was *my* go-to person—I could seek her out to share a moving experience from a session or collapse for a moment in her office when it all seemed to have fallen apart. Accepting, understanding, and using the feelings that were

so much a part of the therapeutic process became central to our work together. As the safety grew, there were times when we could use our own relationship as a mirror into the clinical process. In a supervision where my frustration leaked out about never filling out the mental health forms right—perhaps masking my feelings of inadequacy and wish for her to be the perfect supervisor, she said: “Linda, let’s step back a minute and talk about what’s happening—even what’s happening between us right now.” In the session with a young, volatile client that followed my own supervision session, I found myself more confidently using the here and now—acknowledging her growing frustration with me in the moment, exploring her distress, and, together, moving a little closer to understanding her inner world.

I was surprised by how flexible I needed my supervisor to be—sometimes I needed her to provide a patient, nonjudgmental holding environment where I could

explore feelings; other times, I needed her knowledge and teaching. And sometimes, I just wanted her to tell me what to do. Her unflinching understanding of the therapeutic process and her own authenticity—being confident in who she was and at the same time being clear that a therapist is always a learner—allowed me space to grow. As I write this, I look forward to meeting the new supervisor whom I will be with for the next year and a half, as I work toward the LCSW. I know in my bones what this relationship can offer and look forward to the journey that we will take together.

The experience as a supervisee deepened my commitment to the role that I have—and that you have—when we are on the supervisory side of the desk. There is no other professional relationship with the potential to mean more to the growth of the individuals involved and the parents and children they serve.

## MATERNAL RESOLUTION OF GRIEF AND PRETERM BIRTH: IMPLICATIONS FOR INFANT ATTACHMENT, AND NEONATAL FOLLOW-UP

Prachi Shah, University of Michigan at Ann Arbor

IT IS WELL described that the premature birth and hospitalization of an infant is often traumatic and a significant source of distress for parents which can persist long after the time of initial hospitalization and continue for many months after the infant is discharged home (Davis, Edwards, Mohay, & Wollin, 2003; Kersting et al., 2004; Poehlmann, Schwichtenberg, Bolt, & Dilworth-Bart, 2009). The degree to which the parents can resolve feelings of grief and loss surrounding the premature delivery is thought to affect the development of a healthy parent–child relationship and contribute to resilience processes in vulnerable infants.

In research done with preterm infants at the University of Wisconsin, Madison, my colleagues and I found that mothers who have unresolved grief regarding the premature birth of their infant were almost 3 times more likely to have infants who are insecurely attached (Shah, Clements, & Poehlmann, in press). These data suggest that a mother’s psychological adaptation to having a preterm infant has important implications for the preterm infant’s later social–emotional development. Currently,

the process by which parents resolve their grief following a preterm birth is not known. However, the pediatric visit provides a unique opportunity to explore the parent’s experience of having a baby born prematurely, identify risks to the early parent–child relationship, and provide support and encouragement in hopes of optimizing their adaptation following preterm birth.

In the Neonatal Follow-up Program at the University of Michigan at Ann Arbor, my colleagues and I see a high-risk population of preterm infants who were born typically less than 28 weeks gestation and weighing less than 1200 g at birth. In our clinical experience, we have found that the normal fears and vulnerabilities experienced in becoming a parent are intensified when becoming the parent of a premature infant. In presenting for developmental follow-up, most parents have moved beyond the crisis mode of the early NICU period, when faced with issues of life and death. In Neonatal Follow-up, we find that parents are concerned, not with “whether my child will live,” but rather, “what kind of life will my child live.” This understandable parental desire to

know definitively the prognosis of their infant is challenged by the very nature of Neonatal Follow-up: that development unfolds over time and that predicting later developmental outcomes, at best, has some degree of uncertainty.

To help parents of preterm infants in this period of ambiguity as development is unfolding, it is important that parents experience a supportive “holding environment” in which they experience a sense of safety to explore their fears, vulnerabilities, and challenges (Shah, 2007). My colleagues and I have found that this supportive space is best fostered when we incorporate the key features of *reflective practice* into the pediatric encounter. Central to the philosophy of reflective practice are the meaning of relationship to the development of a vulnerable but resilient infant and the importance of relationship to the discovery of the parent’s capacity to be a mother or father to the child (Weatherston, 2007).

In the context of the NICU Follow-up visit, the tenets of reflective practice are a helpful framework to explore with parents their experience of having a preterm infant while highlighting their infant’s

developmental strengths and capacities in the context of the caregiving relationship.

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# EXPERT ADVICE FOR HELPING TEEN PARENTS

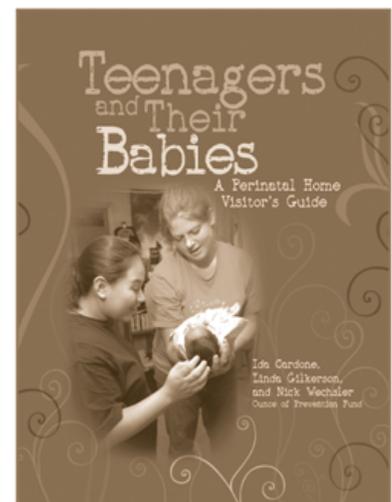
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# Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	What it means
<b>Cultures of Action</b>	This term describes the highly technological, acute, intense and intensive, high-risk medical setting where the environment is structured toward keeping relationships, communication, even knowledge and experience fragmented and dispersed (Gilkerson, L., 2004). (Find it in Steinberg & Kraemer, page 15).
<b>Dissociative Forces</b>	Dissociative forces refer to the “forgetting” of traumatic experience in the face of unbearable psychic realities, such as that of parents with severely ill children in the neonatal intensive care unit. (Find it in Steinberg & Kraemer, page 15).
<b>Group Reflective Supervision</b>	Reflective supervision provided in a group setting, either in separate supervision meetings solely devoted to discussions of children and families or in team meetings that also address other administrative issues. Some agencies create leadership or supervisory groups that bring together supervisors from a wide variety of programs which offer opportunities for professional development and skill building in a specific area or as a way of providing that leadership group with their own supervisory support. (Find it in Heffron & Murch, page 51)
<b>Intersubjectivity</b>	Intersubjectivity refers to the meeting of internal mental states, that is, the creation of a “we” state between individuals; it is the shared subjective world created between two or more people. A term with roots in European philosophy and more recently applied by innovative developmentalists such as Stern (1995) and Trevarthen (Trevarthen & Aitken, 2001), the concept is increasingly being used by a wide range of clinicians and researchers, especially contemporary psychoanalytic theoreticians. (Find it in Siegel & Shahmoon-Shanok, page 6)
<b>Mindsight</b>	The ability not only to see the mind and have insight and empathy for the mental experience of self and others, but to sense the patterns of shared communication of energy and information exchange within relationships; simultaneously, it refers to the neural mechanisms beneath mental and relational life (Siegel, 1999). (Find it in Siegel & Shahmoon-Shanok, page 6)
<b>Racial Microaggressions</b>	Microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color (Sue, et al., 2007, pg. 274). (Find it in Stroud, page 46)
<b>Therapeutic Consciousness</b>	Therapeutic consciousness in the context of reflective supervision refers to the ability to be fully present, especially in mind and feeling with insight into both the self and the supervisee. (Find it in Foley, page 58)
	<p>Siegel, D. J. (1999). <i>The developing mind: How relationships and the brain interact to shape who we are</i>. New York: Guilford Press.</p> <p>Stern, D. (1995). <i>The motherhood constellation</i>. New York: Basic Books.</p> <p>Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, M. B., Nadal, K. L. &amp; Esquilin, M. (2007). Racial microaggression in everyday life: Implications for clinical practice. <i>American Psychologist</i>, 62(4), 271–286.</p> <p>Trevarthen, C., &amp; Aitken, K. (2001). Infant intersubjectivity: Research, theory, and clinical applications. <i>Journal of Child Psychology and Psychiatry</i>, 42(1), 3–48.</p>

## UPCOMING ISSUES

January: Infants and Toddlers in Foster Care

March: Early Intervention for Infants and Toddlers With Disabilities

May: Family Child Care

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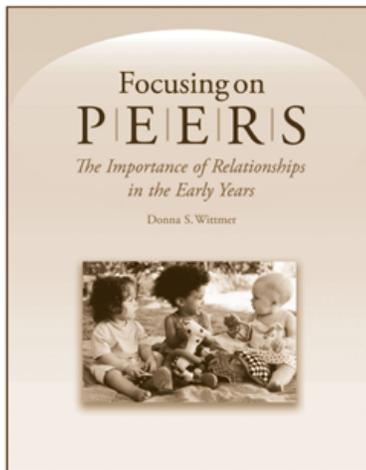
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DONNA S. WITTMER

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create environments that  
foster children's relationships  
with peers."*

—Carolee Howes, PhD  
Director, Center for Improving  
Child Care Quality,  
Dept. of Education, UCLA

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