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 2 ½ 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 handouts 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

G IVEN 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.

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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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; Shamoon-Shanok, 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 lead 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 memberse 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

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.

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

Connecticut Association for Infant Mental Health
www.ct-aimh.org

Colorado Association for Infant Mental Health
www.co-aimh.org

Idaho Association for Infant Mental Health
www.aimearlyidaho.org

Indiana Association for Infant and Toddler Mental Health
www.mentalhealthassociation.com/iaitmh.htm

Kansas Association for Infant and Early Childhood Mental Health
www.kaimh.org

Michigan Association for Infant Mental Health
www.mi-aimh.org

Minnesota Association for Infant & Early Childhood Mental Health
www.macmh.org

New Mexico Association for Infant Mental Health
www.nmaimh.org

Oklahoma Association for Infant Mental Health
www.ok-aimh.org

Texas Association for Infant Mental Health
www.taimh.org

Wisconsin Alliance for Infant Mental Health
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?

HOW 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

DYNAMIC 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

WE 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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Acknowledgments

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