Wayne State University Dissertations

January 2019

# A Qualitative Study Of Reflective Supervision From The Supervisee Perspective: An Ecological View

Carla Caringi Barron
*Wayne State University*, ccbarron88@gmail.com

# A QUALITATIVE STUDY OF REFLECTIVE SUPERVISION FROM THE SUPERVISEE PERSPECTIVE: AN ECOLOGICAL VIEW

by

**CARLA CARINGI BARRON**

**DISSERTATION**

Submitted to the Graduate School

of Wayne State University

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

**DOCTOR OF PHILOSOPHY**

2019

MAJOR: SOCIAL WORK

Approved By:

_____

Advisor                                    Date

_____

_____

_____

www.manaraa.com

## DEDICATION

This dissertation is dedicated to all infant mental health professionals

who are committed to

supporting relationships between infants and families.

# ACKNOWLEDGEMENTS

When people say that it takes a village to make things happen, and this project is a prime example. My village is full of people who have supported and helped me over the course of this program. First, my husband, John, for without him none of this would have been possible. His support and encouragement during this time have been major confidence boosters, and his understanding when it came to my (lack of) time and availability at home was greatly appreciated. My children, Anthony and Olivia, have grown so much and I thank them for teaching me how to be a mom and allowing me to grow right alongside them. I especially want to thank Olivia for helping me to find the right words to use and giving me advice on how to push through writing blocks. Also, my parents, Augie & Betty, my sisters, Paula & Dina, and cousins and friends who have been my cheering section and always there with an encouraging word or a glass of wine.

My advisor, colleague, and friend, Carolyn Dayton, once said to me, "when it feels like you are not doing a good job, know that I believe that you are." Her support of me during these last few years has been unwavering. She has been an essential part of this project and has provided me with a safe haven when I needed to regroup, and a secure base from which I have grown in more ways than I ever thought I would. Thank you for helping me to identify, and for tolerating, my process. Thank you to Ann Stacks, my director and friend, who has always had faith in me, even during times when I didn't have it in myself.

My infant mental health colleagues have been equally supportive. My teacher and mentor, Deborah Weatherston, put me on this path. She is my reflective supervisor and helped me to find the motivation I needed to grow in my career and tackle this incredibly challenging task. My exceptional friend, Nichole Paradis has been with me throughout my infant mental health journey. Along with being one of the consultants for this dissertation, she has been my personal and

# TABLE OF CONTENTS

# LIST OF TABLES

# LIST OF FIGURES

**INTRODUCTION**

This dissertation investigates the experiences of infant mental health (IMH) professionals who are receiving reflective supervision and is informed by theories that examine the critical nature of relationships in human development. Attachment theory (Bowlby, 1969/1988), a foundational theory of IMH, posits that through a trusting relationship with a primary caregiver, a child develops a felt sense of safety and security which allows them to explore and learn from the world around them. Attachment theory's view of how relationships support learning also informs an understanding of how learning happens across the life course. Even as adults, the capacity to actively reflect and think critically about one's actions is facilitated by engagement with a trusted other.

As social workers we use ourselves as agents of change. Social workers enter into relationships with clients that can feel deeply personal (Munro, 2012; Ringel, 2003; Shirilla & Weatherston, 2002; Weatherston, 2000b). They are often one of the only consistent, dependable people in the lives of individuals and families who may be experiencing a range of adverse events including poverty, isolation, and trauma.

IMH professionals often work with families in their homes and communities and are referred when barriers or risks to the developing parent-infant relationship have been identified (Harden, 2010; Weatherston, 2000b). This work exposes the IMH professional directly to the contextual adversity that families face on a daily basis. Navigating these complex risks and ecological influences on the development of early relationships can sometimes be overwhelming (Harden, 2010) and put the professional at risk for empathic strain (Osofsky, 2009), compassion fatigue, and burnout (Simpson, Robinson, & Brown, 2018). Engaging in a supervisory relationship that provides the opportunity to explore and reflect on their experiences may mitigate the stress

involved in working with very high risk families (Stroud, 2010; Shahmoon-Shanok, Gilkerson, Eggbeer, & Fenichel, 1995). Clinical and theoretical work within the IMH literature argues that the IMH professional's capacity to provide effective treatment is supported by their ability to reflect on their experiences within the supervisor-supervisee relationship. This dissertation study examines this hypothesis directly.

Broadly defined as the capacity for self-awareness, curiosity, and critical thinking (Knott & Scragg, 2013; Ringel, 2003; Ruch, 2000, 2007) *reflective practice* is an integral part of social work training, education, and supervision (Chow, Lam, Leung, Wong, & Chan, 2011; Davys & Beddoe, 2009; Knott & Scragg, 2016). Reflective practice strategies include the opportunity for evaluation of personal beliefs, assumptions, ideas, and emotional responses that can surface when working with multi risk families. Consistent with social work values and approaches, IMH treatment is based on the idea that the relationship that develops between the professional and the family is the instrument of change (Pawl, 1994). However, this assumption hinges upon the professional's capacity to reflect upon their experience and to use that reflection to deepen their understanding of the clinical situation. This is accomplished through the provision of *reflective supervision*, defined as the provision of support and guidance that is designed to help the clinician become aware of their own feelings, attitudes, and responses and connect these to their relationships with their clients so that they can provide effective early intervention services to the family (Heller, 2012; Shahmoon-Shanok, 2009).

In infant mental health, there is a body of literature that advocates for the infusion of reflection and reflective practice strategies within the supervisory relationship (Weatherston, 2000b). However, despite the fact that reflective supervision is considered to be an essential practice within the IMH field, the core elements that are key to effective supervision have not been

empirically identified. Many elements have been proposed and described within the clinical supervision literature; however, even these are derived only from the supervisor's perspective (Greacen et al., 2017; Tomlin, Weatherston, & Pavkov, 2014). Very little is known, even within the clinical literature, about the factors that supervisees themselves, view as important. In addition, there is limited empirical evidence of the effectiveness of reflective supervision and its impact on professional and clinical practice outcomes.

**Overview of Methodological Approach**

To address these research gaps, this study used qualitative methodology by sampling practicing IMH professionals who were currently receiving reflective supervision (individual and/or group). This study was implemented in two phases. Phase 1 tapped supervisees' perspectives regarding the essential components of RS and associated professional satisfaction and practice behavior outcomes using *focus group methodology*. Phase 2 involved the use of *individual interviews* to further investigate themes generated by the focus groups. Qualitative data analysis was conducted to determine the elements and outcomes associated with RS that are most salient and meaningful to supervisees. Grounded Theory analysis informed the development of a model of reflective supervision from the supervisee perspective that includes the process in which supervisees engage in RS over time, variables that can impact engagement in RS, and outcomes that are influenced by this engagement. In sum, this study addresses the gap in understanding of the supervisee's perspective of RS and identifies professional satisfaction and practice behavior outcomes that are associated with receiving RS. Results from this study will inform and improve future RS training, provision, and access through advocacy and policy change.

**My Own Professional Journey to the Development of this Dissertation**

This dissertation is a culmination of my 20 years of experience in the IMH field. Throughout these years, I have participated in RS as both a supervisee and supervisor. As a supervisee, I experienced first-hand how my home-based, clinical practice with vulnerable infants and families was enhanced by my participation in RS; and I also experienced how my clinical practice suffered and stagnated when I was struggling with my own emotional response and did not have a trusted and safe supervisory relationship to rely upon. As a supervisor, I have been witness to the professional development and personal growth of brave supervisees who allowed themselves to reveal profound emotional responses evoked by their therapeutic work. Unfortunately, I have also been a partner in difficult supervisory relationships where I was unable to be fully present with a supervisee's experience and added to the disruption of our developing supervisory relationship. My clinical experience has demonstrated that RS is an important part of IMH intervention and the professional growth of supervisees.

Furthermore, as an active member of the Michigan Association for Infant Mental Health (MI-AIMH), I have been a part of planning, providing, and attending training sessions for IMH clinicians, as well as supervisors. Often, trainings for clinicians underscore the importance of obtaining RS as an essential part of their work. More often than not, clinicians raise their hands to note that they are not receiving effective RS, nor do they feel able to seek it out due to systemic barriers to access or confusion or misunderstanding about the supervisee role within the RS relationship. As an outside consultant to IMH programs around the state, I have come to understand that the quality and access to RS varies greatly. Thus, supervisees are being told that RS is essential to their work, but feel helpless in obtaining it. Along with this, supervisees are often left out of the training and education related to the implementation of RS. Training opportunities are often aimed at the supervisor and focused upon *how to provide* RS. The data

presented in this dissertation suggest that providing training opportunities for supervisees related to *how to participate in* RS may also be important.

Throughout the implementation of this study I have continued to engage in reflective supervision as a supervisor, a supervisee, a learner, a teacher, and a trainer. I have continued my relationships with my colleagues who also provide and receive reflective supervision. I have maintained active involvement in MI-AIMH and the local chapter, and have had countless discussions with colleagues, mentors, students, and supervisees about IMH work, RS, education, and training of students and professionals. At times it has felt as though I was conducting an ethnographic study, as I remained fully immersed in the IMH community and in the implementation of RS throughout this process. Although this immersion was a benefit and helped me to decipher the ideas and results obtained from my data, it has also been a barrier, or at the very least a disruptor, of my capacity to fully ground myself in my participant's words and ideas. Often, when working on data analysis, I found myself thinking about the RS group I had just facilitated or an IMH professional's experience of a case; and often during facilitation of RS or during my own RS sessions, I thought of my participant's words and my ideas for analysis. In this process, there was a danger that I might use my participants' words to conform to my own perspective of what RS is, or should be. Therefore, throughout data collection and analysis, qualitative memo writing and ongoing peer debriefing was essential in helping me to fully rely on the data and be less inclined to convolute their words with my own pre-existing ideas.

**Summary**

The clinical and theoretical literature in infant mental health argue that reflection and reflective practice are important for IMH professionals who work directly with high risk infants and families (Fenichel, 1992; Heller, 2012; Weatherston, Weigand, & Weigand, 2010). RS offers

an opportunity for these professionals to partner with a supervisor who can provide the time and space for this reflection to take place. RS is described as a collaborative, co-created experience between supervisor and supervisee (Fenichel, 1992; Parlakian, 2001; Shahmoon-Shanok, 2009), yet, the vast majority of work in this area highlights the supervisor's perspective and his/her responsibility in creating opportunities for reflection. Placing the impetus solely on the supervisor neglects not only the supervisee's perspective of what they might benefit from, but it also takes away the responsibility of the supervisee as co-contributor to the development of the reflective environment.

Therefore, this dissertation investigates supervisee perspectives on RS. The goals of this dissertation project were to: 1) identify the components of RS that IMH professionals find most important and impactful to their work; 2) Identify the professional satisfaction outcomes (e.g., job satisfaction, burnout, etc.) that are associated with RS; and 3) Identify practice behavior outcomes (e.g. capacity for reflection and insight) that are associated with RS. Due to the paucity of RS research, there is not sufficient *empirical* evidence to support the argument that RS is an essential component of IMH practice. This dissertation project utilized the perspective of the supervisee to hone in on the components of RS that are most meaningful and impactful upon their work and identified potential outcomes of RS that can be used to further investigate its role in the provision of IMH services.

**CHAPTER ONE – ATTACHMENT AND INFANT MENTAL HEALTH**

**ATTACHMENT IS THE WHY AND INFANT MENTAL HEALTH PRACTICE IS THE HOW: IMH AS A FIELD OF STUDY AND AN INTERVENTION STRATEGY**

"Love as powerful as your mother's for you leaves its own mark…to have been loved so deeply, even though the person who loved us is gone, will give us some protection forever" –

Albus Dumbledore

This chapter will review attachment theory which is foundational to infant mental health (IMH) practice. In addition, the critical nature of early development, the importance of sensitive caregiving, and the practice of infant mental health intervention to support parents and their infants will be described.

**The Critical Nature of Early Development**

The first three years of life are critical in establishing a foundation for later development across multiple life domains including physical, social, emotional and behavioral (Sroufe, 2005; Sroufe, Egeland, Carlson, & Collins, 2009; Sroufe & Waters, 1977; Zeanah & Zeanah, 2009). The prenatal period through the first three years of life is a critical time for infant brain development, and a time when the infant brain is highly sensitive to environmental input (Sheridan & Nelson, 2009; Davies, 1999). An infant's early experiences are impacted by a variety of factors, including biological, environmental, and societal. For example, family stressors such as poverty may impact the infant's access to quality child care and community violence may impact the parent's capacity to provide safe opportunities for play. Importantly, for the infant, all of these early experiences are filtered through their primary care relationships (Cassidy, 2008; Sroufe, 2005; Zeanah & Zeanah, 2009); the infant is fundamentally dependent upon these relationships to shape the environment within which they grow.

Attachment theory (Bowlby, 1969/1988) contributes to our understanding of the organization and structure of the infant-parent relationship. This relationship consists of multiple interactions that start with the infant's need (which may be related to distress or a desire to explore their environment) and behavior that conveys the need (such as crying or pointing and vocalizing toward an object). The parent's interpretation of what that behavior means (does the infant need comfort or help) will then inform their response to it (such as picking them up and talking in a comforting way or helping them to reach an object to explore). IMH interventions are designed to assist parents in identifying, interpreting and responding to their infant's needs. As an example, Figure 1 is a graphic developed as a component of an empirically supported IMH intervention (Hoffman, Marvin, Cooper, & Powell, 2006; Marvin, Cooper, Hoffman, & Powell, 2002) to help parents understand attachment in ways that can promote their understanding of their infant's behavior and emotions, in order to better respond in ways that are sensitive to their infant's emotional needs. Over time, these infant-parent transactions build a foundation for development across the lifespan (Sameroff, 1993; Sroufe & Waters, 1977; Sroufe et al., 2009).

Figure 1

The Circle of Security Graphic



CIRCLE OF SECURITY
PARENT ATTENDING TO THE CHILD'S NEEDS

I need you to...

SECURE BASE

Support My Exploration

- Watch over me
- Delight in me
- Help me
- Enjoy with me

SAFE HAVEN

- Protect me
- Comfort me
- Delight in me
- Organize my feelings

I need you to...

Welcome My Coming To You

*Always:* be BIGGER, STRONGER, WISER, and KIND.
*Whenever possible:* follow my child's need.
*Whenever necessary:* take charge.

© 1998 Cooper, Hoffman, Marvin, & Powell
circleofsecurity.org

Attachment theory rests on the premise that infants are biologically wired to seek proximity to their primary caregiver during times of threat (Bowlby, 1969). Termed the *attachment system*, the goal of this system is to return to a state of comfort and feeling of safety when the infant is exposed to danger or threat. Assisting the infant in returning to a sense of safety and organizing their emotional response is an essential role of the *attachment figure* (e.g., the parent or caregiver; Ainsworth & Bell, 1970). These caretaking responses to infant distress or fear, can promote or inhibit the development of a *safe haven*, defined as a relationship wherein the infant seeks refuge in times of danger or when they need help regulating their emotions (Rosenblum, Dayton, & Muzik, 2008). Parents and caretakers who are sensitive, nurturing, and predictable in their responses to infant distress provide their infants with a caregiving environment that feels safe, warm, and consistent. Further, the infant's early experiences within their primary relationships form the foundation of their thoughts, behaviors and expectations within subsequent relationships later in development (Fonagy, 2002; Sroufe et al., 2009). Therefore, when the development of the safe haven is compromised in infancy, this can inhibit the child's ability to connect with and trust others later in development (Sroufe & Waters, 1977).

Very early in their life, infants signal their need for proximity to their caregivers through attachment behaviors such as crying (Ainsworth & Bell, 1970). As they grow, especially in their first year of life, their ability to achieve proximity to their parent increases. For example, a newborn infant may need to rely on crying and body movements to signal their distress while a seven-month old infant may be able to physically move their own body closer to their parent to gain a sense of safety and security. Further, an older infant may already have learned which behaviors are more effective in reaching the goal of proximity to the parent (Cassidy, 2008). For instance, in cases where the parent-infant relationship is compromised, perhaps due to

environmental stressors such as violence or poverty exposure, the infant may learn that if they frown and cry when they are in need, they are ignored, whereas, if they smile and coo their parent becomes available and responsive. Bowlby (1969), the father of attachment theory, considered conditions of the child, such as hunger, illness, fatigue or pain and conditions of the environment, such as presence of a physical threat, as factors that would activate the child's attachment system. Under ideal circumstances, the infant's attachment signal (e.g., crying) activates the caretaking behaviors of the parent and thereby increases the infant's proximity to the parent (Cassidy, 2008).

In addition to the attachment system, attachment theory also postulates the existence of an *exploratory system*. The goal of the infant's exploratory system is to promote development through motivation to seek out novel experiences and explore the environment (Sroufe & Waters, 1977). However, the infant's level of exploration is dependent upon whether they can trust that their caregiver will support them and continue to be available when they move away (Bowlby, 1988; Rosenblum et al., 2008). Therefore, in order to explore, infants need to feel secure and to trust that if they feel threatened or become distressed, they can return to their parent for help. Termed the *secure base*, the infant's trust in their parent's availability allows for exploration of the environment in important ways that promote early learning (Davies, 1999; Sroufe & Waters, 1977). If their caregiver is typically unavailable or inconsistent in their response to their distress, the infant will learn to maintain proximity to their parent in ways that may inhibit their exploration. That is, when the infant does not feel safe, the attachment system is activated and the infant limits exploration and plays or explores less; when the attachment system is deactivated, the infant feels safe to move away from the attachment figure and explore their environment (Powell, Cooper, Hoffman & Martin, 2013; Sroufe, 2005).

In summary, across many domains of development (e.g., physical, emotional, social), the caregiver's responses to the infant teaches the infant about relationships, the world, and themselves. In a sensitive, responsive caregiving environment, infants learn that they are worthy of love and that relationships can help them to reach their goals. In a rejecting or unpredictable caregiving environment, infants learn that the world can be very scary, and that they can't count on others to meet their needs. Therefore, in view of the fact that the parent-infant relationship is the primary contributor to the infant's healthy, social-emotional growth and development, understanding and intervening with the factors that influence the parent's capacity to be available and responsive to their infant's needs is critical.

**The Case for Supporting Parents of Infants**

Recent empirical research related to brain development, the infant-caregiver relationship, and risk and protective factors within the early caregiving environment, emphasize the importance of intervening as early as possible with infants and their families who are considered at risk for poor developmental outcomes (Fraiberg, 1980; Lieberman & Van Horn, 2008; Phillips & Shonkoff, 2000; Ramey & Ramey, 1998; Schore, 2001; Shonkoff et al., 2012; Weatherston, 2001; Zeanah & Zeanah, 2009). Risks may be related to the parent, such as teenage pregnancy (Letourneau, Stewart, & Barnfather, 2004; Spieker & Bensley, 1994), mental illness (Goodman & Brand, 2008; Van Doesum, Hosman, & Riksen-Walraven, 2005), and substance abuse (Nair, Schuler, Black, Kettinger, & Harrington, 2003; Suchman et al., 2010). Further, a psychodynamic perspective highlights the importance of understanding the influence of past experiences upon present interactions (Fraiberg, 1980; Fraiberg, Adelson, & Shapiro, 1975; Furman, 1982; Slade et al., 2005; Weatherston, 2001), thus emphasizing the parent's own attachment history, experiences of trauma, and history of separation and loss as important variables that can influence the parent-

infant relationship. Risks may also be related to the infant such as low-birth weight, medical concerns, developmental delays and disabilities (Benoit & Coolbear, 1998; Dunst, 2007). Other influences on the developing parent-infant relationship may include the influence of culture and race on child rearing practices; the experience of ecological stressors such as poverty and violence exposure; and community and societal stressors that may include exposure to systemic oppression such as racism and sexism (Lewis, Rosa Noroña, McConnico, & Thomas, 2013; Harden, 2010; Ghosh Ippen, Rosa Noroña, & Thomas, 2012).

These risk factors can set the parent-infant relationship on a negative trajectory that can be detrimental to the health and development of the infant. In contrast, when it is going well, the parent-infant relationship can be a buffer for the infant in the experience of both risk and protective factors. Qualities of parenting such as sensitivity, warmth, and responsiveness have been connected to optimal infant social, emotional, and cognitive development even in the presence of contextual risk (Zeanah & Zeanah, 2009). Therefore, a primary goal of IMH programming is to support parents in providing the best possible emotional environment for their infant's development (Weatherston, 2000b; Weatherston, 2001).

**IMH Intervention Supports Parents and Infants**

Therapeutic and supportive relationships between parents and IMH professionals have the potential to influence the parent-infant relationship and buffer the effects of contextual and other risks (Johnston & Brinamen, 2012; Emde, 1991). Therapeutic relationships that embody warmth, empathy, sensitivity, and kindness are typically well received by at-risk parents and support the development of professional-parent relationships that support parent competencies and increase parental capacities to be emotionally and physically responsive to their infants in ways that support early development (Weatherston, 2000b/2010). By providing reliable, nurturing, and empathic

responses, the IMH professional strives to develop a therapeutic alliance that can support the parent's psychosocial growth and thereby improve their sensitivity toward their infant (Brandell & Ringel, 2004; Weatherston, 2001). Thus, just as the parent supports the development of the infant, the primary aim of the IMH professional is to support the development and healthy functioning of the parent.

IMH professionals are social workers, psychologists, educators, and nurses; each of whom hold unique perspectives important to the development of early relationships. Disciplinary perspectives converge into an integrated, multi-disciplinary IMH practice approach, which holds in mind certain tenets including: 1) a focus upon strengths without ignoring or minimizing liabilities or challenges; 2) a prevention orientation that keeps the future developmental growth of the child in mind; and 3) a relational framework that guides assessment and intervention (Zeanah & Zeanah, 2009). IMH professionals utilize relationship-focused strategies such as identifying and enhancing the capacities of the parent, helping the parent find pleasure in their relationship with their infant, and providing emotional support and developmental guidance. These are coupled with concrete strategies such as helping families access community resources in order to support parents in providing rich, positive experiences for their infants (Weatherston, 2000b).

**Home-based intervention.** Many IMH professionals provide services to infants and families in their homes. In Michigan, the community mental health (CMH) system funds attachment-based IMH home visiting programs (Weatherston & Tableman, 2015) and the federal government has provided funding for maternal, infant, and early childhood home visitation, such as Early Head Start (EHS) and Nurse Family Partnership (NFP) (Azzi-Lessing, 2013). Meeting with infants and families in their homes promotes the development of therapeutic relationships and places the IMH professional into the center of the infant's experience.

There are advantages to home-based intervention. It provides opportunities to involve all family and non-familial relationships that are important in supporting family outcomes and personalized services that are focused upon individualized goals and needs (Sweet & Appelbaum, 2004). The use of the home as the location for service delivery also assists those who are experiencing barriers to accessing office-based intervention, such as transportation or child care (Woodford, 1999; Harden, 2010). However, home-based intervention also intensifies the IMH professional's emotional response to the infant and family's situation. Home visitors are direct observers of the poverty, neglect, relationship difficulties, and environmental stressors experienced by high-risk families and communities.

**IMH Professionals have Unique Supervision Needs**

Because the nature of home-based work often exposes IMH professionals to high levels of trauma, poverty, and other risk factors, access to high quality supervision has been a key element of IMH programming (Harden, 2010; Stroud, 2010). Families involved in IMH intervention are experiencing community and neighborhood risks such as poverty, isolation, and community violence; as well as interpersonal and relationship risks, such as mental illness, substance abuse, domestic violence, and child abuse and neglect. Working within this realities, IMH professionals are charged with supporting families in providing safe and secure environments within which their infants can experience joy and warmth, as well as grow and develop. The high risk nature of the families served by IMH compounded by the urgency of early development can often elicit strong emotional responses in the IMH professional (Harden, 2010; Hinshaw-Fuselier, Zeanah, & Larrieu, 2009; Zeanah & Zeanah, 2009). In addition, the complexity of systemic and cultural influences and the relational focus of IMH treatment underscore the necessity of regular access to supervision that includes reflection and supports the professional's reflective capacity (Harden,

2010; Zeanah & Zeanah, 2009). Although it has not been adequately tested empirically, it is believed throughout the IMH field that through their relationship with a reflective supervisor, the IMH professional has an opportunity to carefully consider the perspectives of the infant and parent, and also safely explore their own emotional responses that have been evoked through their work with vulnerable infants and families (Fenichel, 1992; Heller, 2012; Pawl, 1994).

**The reality of early development.** IMH professionals understand the crucial nature of the first three years of life in the social-emotional and overall development of a young child (Weatherston, 2000a/2005). In IMH clinical intervention, this often translates to a sense of urgency related to the child's early relationship and developmental needs (Harden, Denmark, & Saul, 2010; Lieberman & Van Horn, 2008). For example, when working with parents who have experienced inadequate caregiving in their own histories, who may have been exposed to violence , and who are struggling with environmental stressors such as poverty and systemic oppression, IMH professionals can experience a tension between taking the time to develop a strong therapeutic relationship with the parent and addressing the developmental and relationship needs of the child (Lieberman & Van Horn, 2008; Harden, 2010; Harden et al., 2010). Sometimes the difficulties of the parent and family can take precedence over the child's developmental needs, as IMH professionals often encounter families who present with a host of concrete needs that may be crucial to their survival (Fraiberg, 1980; Weatherston, 2000b; Weatherston, 2005). Conversely, the IMH professional may focus solely on the infant's needs, overlooking the parent's perspective. In this situation, the IMH professional is at risk of taking over the parenting role and disregarding the parent's needs. This could lead to a strained working relationship or even a discontinuation of services (Lieberman & Van Horn, 2008). The clinical and theoretical IMH literature argues that

engaging in reflective supervision (RS) can aid the IMH professional in maintaining a reflective stance wherein the experience of the infant and the parent are both held in mind (Pawl, 1994).

**The parallel process.** Clinical experience suggests that effective supervisory relationships that include the time and space for the IMH practitioner to reflect on the experiences of the infant, the parent, and their relationship, as well as the professional's own responses to the work (Eggbeer, Mann, & Seibel, 2007; Many, Kronenberg, & Dickson, 2016; Pawl, 1994) can provide the IMH professional with an experience that parallels her developing relationship with the parent. In what is referred to as a *parallel process* (Doehrman, 1976; Searles, 1955; Watkins, 2011), as the IMH practitioner is exposed to consistent support from the supervisor, she will be better able to provide consistent support to the parent. In turn, as the parent feels supported, she will be better able to provide sensitive and attuned parenting to her infant, thereby improving the social-emotional development of the infant (Gatti, Watson, and Siegel, 2011). In other words, the parallel process construct suggests that relationships impact relationships at many levels across time and are embedded within the supervisory and the intervention systems (Emde, 1991; Pawl & John, 1998). By including supervisory relationships within this parallel process, one can posit that the relationship between the supervisor and the professional will impact the professional's therapeutic and working relationship with the primary caregiver.

In summary, infant attachment relationships are crucial to their early experiences and ongoing development, and these relationships are impacted by the parent's capacity to engage and respond to their infant. IMH professionals provide important support to parents and families who are experiencing any number of interpersonal and/or social risks that impact their capacity to care for their infant. Clinical scholarship posits that IMH professionals need a trusted, safe space to reflect upon the difficult and emotionally evocative therapeutic work with at-risk infants and

families (Heller, 2012; Shahmoon-Shanok, 2009). Personal emotional responses, the intimacy of the home environment, and understanding parallel relationships underscore the necessity of regular access to supervision that will hold these constructs in mind (Pawl, 1994; Mikus, Benn, & Weatherston, 1994).

**CHAPTER TWO – SOCIAL WORK SUPERVISION**

**SUPPORTING WHAT THEY DO: SOCIAL WORK SUPERVISION AND
REFLECTIVE PRACTICE**

"Tell me and I forget, teach me and I may remember, involve me and I learn."

― Benjamin Franklin

Access to high quality supervision in social work is critical to supporting professionals in their efforts to provide consistent, appropriate, and culturally-sensitive interventions that successfully address client goals and program outcomes (Beddoe, 2010; Kadushin & Harkness, 2014; Munson, 2012). Integral to supervision in social work is reflection and reflective practice. *Reflection* involves thoughtful and intentional thinking about observations, emotions, values, biases, and perspectives (Fonagy, 2002; Knott & Scragg, 2016) and requires stepping back from an experience and wondering about our role within it. *Reflective practice* involves putting reflection into action (e.g. decision-making, problem-solving, responses to challenging behaviors; Knott & Scragg, 2016; Weatherston, 2013). In other words, an understanding of our emotions when intervening with a challenging client (reflection), can help us to craft a response that is based on the needs of the client rather than on our own needs (reflective practice).

Although reflection can be an *intra*personal exercise, *inter*personal experiences are necessary to fully understand our reflections and put them into practice (Fonagy, Gergely, Jurist, Target, 2002). The presence of another person with greater knowledge, experience, or objectivity, can assist in working through challenging situations by offering a safe, trusting place to explore, helping us to identify patterns of behavior, and offering guidance regarding decision-making (Collins, Seely Brown, & Holum, 1991; Marvin et al., 2002; Schön, 1987). Extrapolating these ideas to supervision, the supervisor becomes the trusted person with whom a safe space is created to explore responses to social work practice (Heller, 2012). The inclusion of reflection and

reflective practice within supervisory relationships promotes opportunities for the supervisee to hone clinical intervention skills, as well as critical thinking and decision-making skills (Lietz, 2009; Ruch, 2000).

Within the field of Infant Mental Health (IMH), in particular, *reflective supervision* (RS) infuses these ideas of reflection within supervisory relationships to support reflective practice (Shahmoon-Shanok et al., 1995; Weatherston et al., 2010). RS is considered best practice in IMH, yet there remains a relative paucity of research that directly assesses the hypothesized influence of RS on professional outcomes such as increases in clinical insight and professional self-efficacy. The current study aims to fill this empirical gap by using qualitative methodology to explore RS from the perspective of the supervisee so to gain a deeper understanding of its role in supporting the work of IMH professionals who work with high risk infants and their families.

**The Supervisory Process**

Within all professional disciplines, from Architecture to Social Work, there is an apprenticeship process that provides the professional with the skills necessary to successfully practice in their field (Collins et al., 1991; Shahmoon-Shanok, Lapidus, Grant, Halpern, & Lamb-Parker, 2005). In traditional views of apprenticeship, the student learns professional skills from the supervisor/expert/teacher. The teacher demonstrates what to do, watches over the student as they put their skills into practice, and provides ongoing feedback. Over time, the teacher allows the student to engage in their work independently. Collins et al. (1991) define four aspects of traditional apprenticeship as:

· *Modeling*: the teacher demonstrates the work to the student, explicitly showing the student what to do and how to do it. Aspects of the work are made visible to the student.

· *Scaffolding*: the teacher allows the student to take over the work while offering hints as to what to do next, responding to a student's decision making with feedback, and remaining close-by to provide support.

· *Fading*: the teacher slowly removes his or her support from the student as the student takes over more and more of the work independently.

· *Coaching*: an important part of apprenticeship, coaching allows the teacher to respond *throughout the student's learning experience* by offering his or her knowledge, helping the student with challenging tasks and decision making, supporting the student in identifying their strengths and weaknesses, and giving feedback and encouragement.

Social work has codified the apprenticeship model by putting into place learning opportunities that parallel this iterative process. For example, supervisors/teachers *model* professional skills as social work students grapple with theory in the classroom and experience on-the-job learning through student internships within the community. Students and new career clinicians also receive regular supervision where they can present clinical material and receive feedback and *scaffolding* from their supervisor. Supervisors may also accompany new clinicians and students on initial visits with clients so as to provide direct feedback and support, with the eventual goal of the student/new clinician *taking over the work independently*. Ongoing supervision for social workers parallels the ongoing *coaching* of the apprenticeship model; where supervisors continue to be available to provide feedback and emotional support, help to address challenging situations, and identify areas of professional growth. This model parallels reflection and reflective practice as it underscores the importance of the ongoing supportive relationship between the supervisor/teacher and supervisee/student to promote professional growth and confidence, continued learning, and honing of clinical skills.

**The Case for Relationship-focused Supervision**

Existing research that has investigated the use of reflective and relational strategies within supervision has identified benefits over utilizing solely administrative supervision, such as work satisfaction, turnover, and greater adherence to the intervention model (Collins-Camargo, Sullivan, Washeck, Adams, & Sundet, 2009; Lietz, 2013; Lietz & Julien-Chinn, 2017; Peled-Avram, 2017). Nevertheless, supervision focused exclusively on managerial oversight, worker accountability, efficiency, and job performance is the dominant model of supervision in many areas of social work practice (Beddoe, Karvinen-Niinikoski, Ruch, Tsui, 2015; Carpenter, Webb, Bostock, & Coomber, 2012; Davys & Beddoe, 2010; Munro, 2010; Noble & Irwin, 2009; Wilkins, Forrester, & Grant, 2017). Although a managerial approach to supervision may be necessary, Bogo & McKnight's (2006) review of 13 studies noted that supervisees value and find most meaningful relational aspects of supervision that include mutual communication and positive relationships with their supervisors. Moreover, Mor Barak, Travis, Pyun, & Xie's (2009) meta-analysis of 27 quantitative empirical studies of the impact of supervision on practitioner outcomes highlighted the relationship between lower levels of social and emotional support provided by supervisors with higher levels of detrimental professional outcomes such as turnover, burnout, and depression. These findings suggest that professional outcomes may improve when supervision includes reflection and relational strategies.

There is also evidence that reflective and relationship-focused supervision impacts practice outcomes (Carpenter et al., 2012; Cearley, 2004; Lietz, 2009.). For example, Gilkerson (2015) identified positive shifts in early intervention staff's capacity to support families when they participated in supervision and consultation infused with reflective and relationship-based strategies. Using a similar sample, Watson & Neilson-Gatti (2012) found that when monthly

reflective consultation was offered to early intervention staff, they became better listeners, more flexible in their responses to clients, and more family-centered in their approach. Furthermore, Virmani, Mayson, Thompson, Conners-Burrow, & Mansell (2013) found that early childhood teachers experienced an increase in sensitivity toward the young children in their classrooms when offered classroom-based reflective consultation. Anecdotally, clinical case study reports in the literature have suggested that professionals who participate in consultation relationships incorporating reflective practice strategies such as self-awareness and perspective-taking, are ultimately better able to *slow down* their interactions with children and families. This slowing down, or more purposeful interaction, was associated with a better understanding of the presenting problem and improved clinical outcomes (Bertacchi & Coplon, 1992; Brandt, 2014; Gatti et al., 2011; Larrieu & Dickson, 2009; Tomlin, Sturm, & Koch, 2009; Watson & Neilsen Gatti, 2012; Weigand, 2007). Taken as a whole, these empirical studies and case study reports suggest that infusing reflective practice strategies within supervision can positively impact professional practice and clinical outcomes.

**Barriers to relationship-focused supervision.** Despite these positive outcomes, supervisors often experience tension when attempting to balance administrative direction and oversight with emotional support and reflection within the limited supervisory time they have available (Gibbs, J. A., 2001; Ruch, 2007; Wightman et al., 2007). For example, Lietz (2009) surveyed 348 administrators, supervisors, and caseworkers in Arizona and found that inconsistent supervisor availability due to fragmented responsibilities (including the need to meet programmatic goals) was linked to limited capacity to build supportive relationships with supervisees that promote learning and critical thinking. McGuigan, Katzev, & Pratt (2003) found that among 1093 at-risk families participating in a home visiting prevention program, the number

of direct supervision hours the home visitor received significantly impacted program retention rates for practitioners and families. Home visitors with less supervision time were more likely to leave their position, while regularly scheduled supervision supported feelings of value and provided opportunities to learn and hone clinical intervention skills. Moreover, McAllister & Thomas (2007) sampled Early Head Start (EHS) home visitors and found that the primary factor influencing full adherence to the evidence-informed intervention protocol was the availability of a supportive and empathic supervisor. These studies suggest that professionals provide better services to their clients when they engage in consistent and responsive supervisory relationships. Another possible barrier to relationship-based supervision may be differences in supervisor and supervisee perspectives about the essential components of supervision. Kadushin (1992) surveyed 1,500 supervisors and 1,500 supervisees who were identified through NASW membership lists and responded to questions about the strengths and weaknesses of supervisory practices. Supervisors most often noted that their knowledge of practice was their most important strength (40%), however, supervisees most often cited their relationship with their supervisor as the most important aspect of social work supervision (31%). Despite the evidence underscoring the importance of a relationship-based focus within the supervisory relationship, current social work supervision continues to focus upon case management and oversight with little opportunity for reflection, emotional support of the professional, or time for relationship-building between the supervisor and supervisee (Lietz, 2009; Turner-Daly & Jack, 2017; Wilkins et al., 2017).

In reality, social workers and social work supervisors have limited time and are often pulled in multiple directions due to the nature of their work. It may feel like a luxury to have the opportunity to slow down and think deeply about an experience with a client that evoked difficult emotions. However, the connection of reflection, reflective practice, and relationship-based

supervision to the successful practice of a social worker is important to consider. Increased understanding of the central components of reflective practice as it relates to supervision can help us to better train supervisors about how to integrate these components and strategies into relationships with their supervisees; and therefore better support supervisees in their work.

In the next sections, reflection and reflective practice will be defined. This will be followed by a review of the theoretical and conceptual literature focused upon *reflective supervision*, a form of supervision that integrates the concept of reflection and thereby supports reflective practice within the social work and IMH fields.

<div align="center">**Reflection and Reflective Practice in Social Work**</div>

**Reflection**

John Dewey, in his seminal 1910 text "How We Think," defined reflective thought as "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends" (p. 6-7). Reflective thinking and reflective processes emphasize an opportunity for careful thought about experiences to inform action, yet require a willingness to engage in this process on the part of the learner, and the time and availability of the teacher (Dewey, 1910; Heffron, Ivins, & Weston, 2005; Rogers, 2001).

Dewey's idea of reflective thought is evident within contemporary ideas of reflection. Rogers (2001) highlights an individual's active engagement and examination of responses as fundamental to reflection and participation in the reflective process. Theoretical considerations of four types of reflective process expounded upon by Ruch (2007) and supported by Yip (2006) demonstrate different ways individuals can engage in reflective thinking: a) technical reflection is focused upon the use of information or sources of knowledge to solve problems; b) practical

reflection uses specific experiences as a guide to understanding and learning; c) critical reflection poses challenges to status-quo thinking; and d) process reflection involves providing opportunities to consider both unconscious and conscious drives of the self and the other (Ruch, 2007, p. 661). Thinking back to the apprenticeship model, these types of reflection offer a possible developmental trajectory of reflection, that is, as the student/supervisee learns from the teacher/supervisor, they gain confidence in the technical aspects of their job, are better able to critique their work in ways that promote learning, and through deepening reflection, are able to identify emotional responses and/or biases that may be barriers to interaction with others.

Reflection has also been described as "transformative learning" (Rogers, 2001; Yip, 2006). Engagement in the process of reflection can bring about new perspectives and insights related to uncertain situations. Schön (1983) introduces the concept of reflection as essential to learning and identifies the idea of 'reflection *on* action' (thinking about a past event) as a catalyst for 'reflection *in* action' (using understanding of past interactions in the present). Allowing themselves the opportunity to reflect on past actions or behaviors, professionals are able to ask questions, such as 'what was I feeling?' or 'what was my response and why?' or 'what was it like for me to be with that client?' Through these questions and subsequent answers, they are able to further their understanding about their own behaviors and actions, connecting that knowledge to their professional role and increasing their professional competence. This type of reflection can shift the professional's responses from automatic and impulsive, to deliberate, mindful, and responsive to the situation, thereby promoting improvement in the capacity to successfully engage in difficult situations (Chow et al., 2011; Knott & Scragg, 2016; Yip, 2006). In summary, the reflective professional is able to examine their thoughts and feelings about their work, use the supervisory relationship to think deeply about the experience of all those involved, and demonstrate a level of

curiosity and openness that allows for differing perspectives or ideas to shape their understanding of a situation and better inform their decision-making and problem solving (Heffron, 2005; Pawl, 1994; Shahmoon-Shanok, 2009; Weatherston, Kaplan-Estrin, & Goldberg, 2009; Weatherston et al., 2010; Weatherston & Tableman, 2015).

**Reflection advances critical thinking**. Critical thinking is an important skill within human service professional training and growth, and has been a focus of social work education programs (Behar-Horenstein & Niu, 2011).   Allowing time for the social worker to think about emotions, perceptions, and actions, as well as the encouragement of analytic understanding and interpretation proves to be especially important within complex clinical situations (Lietz, 2009).   As social workers often provide intervention within the home and often during times of crisis (Harden, 2010; Lietz, 2009), critical thinking and analytic skills are core to the decision-making process (Beam, O'Brien, & Neal, 2010; Emde, 2009; Shahmoon-Shanok et al., 2005).  Reflection advances critical thinking within the professional environment, as reflective persons use new knowledge to challenge their beliefs, understandings, and possibly even personal values, which may lead to a change in their behavior (Rogers, 2001) and the development of a professional self (Urdang, 2010).

## Reflective Practice

Reflective practice is used within the social work profession to impact the client/social worker relationship and the practitioner/supervisor relationship and thereby improve clinical outcomes (Knott & Scragg, 2013; Mann, Gordon, MacCleod, 2009; Weatherston et al., 2010). Reflective practice is a complex construct that utilizes the capacity for self-awareness, curiosity, and critical thinking in clinical social work practice (Knott & Scragg, 2013; Ringel, 2003; Ruch, 2000/2007).  Strategies that support reflective practice include the opportunity for evaluation of personal beliefs, assumptions, ideas, and emotional responses that surface when engaged in

professional practice experiences. That is, reflective practice helps the social worker in acknowledging and understanding *how they are* versus *what they do* when they are with their clients (Pawl, 1994).

Social workers are observers and facilitators of human behavior who engage with vulnerable populations in order to support their current and future well-being and capacity to engage within their families, neighborhoods, communities, and society. Social workers believe that relationships facilitate change and strive to value the "dignity and worth of the person" and the "importance of human relationships" (National Association of Social Workers [NASW], 1999, pp. 5-6), through their treatment of individuals, groups, and communities with kindness, care, and respect. They are mindful of the individual's culture, diversity, and knowledge and "engage people as partners in the helping process" (NASW, 1999, p. 6). In these ways, the social worker is thoughtful about *how they are* when they are providing intervention. However, this aspect of human interaction adds complexity to the work that social workers do and to the ongoing teaching and learning that supports their work. Reflective practice strategies can facilitate professional development through a relational process that allows the time and space to reflect on the practitioner's emotional response to their work, support personal growth, and learn critical thinking skills; all of which are primary goals of professional supervision (Heffron et al., 2005; Kadushin & Harkness, 2014; Lawrence, 2005; Rogers, 2001; Ruch, 2000; Wilson, 2013).

**Reflective Practice within Parent-Infant Programs**

Based on decades of clinical experience, but lacking an empirical approach, clinical scholars advocate the use of reflective practice strategies within the provision of parent-infant programming (Slade, 2002; Weatherston, 2000a). Weatherston (2000b, 2010, 2013) describes the importance of reflective practice within home-based, therapeutic infant mental health (IMH)

intervention programs. She posits that IMH specialists working with young children and families must possess fundamental beliefs, skills, and clinical strategies that are grounded within a reflective practice, and relationship-based approach. Examples of these include: building trusting relationships with families and using those relationships to promote change; helping the parent to find joy in their relationship with their infant; wondering about the parent's thoughts and feelings related to parenting, as well as the infant's experiences when with the parent; and attending and responding to parental histories of abandonment, loss, and trauma. These skills illustrate the need for the IMH specialist to be emotionally available to the parent, as well as self-reflective and insightful about their own experiences and reactions. Thus, clinical expertise posits that IMH specialists benefit from supervision and training that holds these emotionally complex and evocative experiences in mind.

The IMH literature is rich with clinical case studies that describe the deeply profound and meaningful experiences IMH specialists have had within supervisory relationships that are guided by reflective strategies (Alexander, Gallen, Salazar, & Shahmoon-Shanok, 2012; Bernstein, Lewis, Daniher, & Murphy 2013; O'Rourke, 2011; Weatherston, 2007). Case studies describe the centrality of relationships, reflection, and reflective practice in the therapeutic work with at-risk infants and families, as well as within the supervisory relationship (Shirilla & Weatherston, 2002). For example, Bernstein et al. (2013) describe a clinical case with a young mother of three who experienced abuse and homelessness and who was ultimately able to connect and flourish with the support of IMH staff at a specialized homeless program. O'Rourke (2011) describes the powerful nature of a reflective supervision group for IMH therapists who serve very vulnerable infants and their parents, noting that the opportunity to be heard and feel understood by the members of the group had a profound effect on the professionals' capacity to do the same with parents. Shea &

Goldberg (2016) describe an 8 session training series for both supervisors and supervisees aimed at supporting reflective capacity and collaborative supervisory relationships. They found that the training supported the supervisor's level of sensitivity to reflection and the capacity for supervisees to use reflective supervision in their work. Finally, Weatherston (2007) identifies the unique needs of a home-based IMH professional and ways that reflective practice and reflective supervision supported her work, including consistent meetings and emotional availability. Taken together, these clinical perspectives suggest the potential benefits of integrating reflection and reflective practice within the supervision and training provided to IMH professionals.

Reflective practice and relationship focused supervision may be influential even when the intervention model is focused on provision of parent education (vs. psychotherapeutic intervention). For example, within a sample of Early Head Start home visitors, Harden, Denmark, & Saul (2010) found that when monthly reflective consultation was provided, home visitors identified an increasing capacity to deal with the challenging parts of their work, such as difficult family interactions and organizational barriers that included excessive work demands and limited daily emotional support.

Additionally, there is evidence that implementing reflective practice within programs that have already been shown to be effective at improving parent-infant outcomes, can enhance existing services, leading to increased program efficacy (Olds et al., 2014). For instance, reflective practice strategies supported through supervision have been implemented within Nurse Family Partnership (NFP), a program targeting the health and development of first-born children and pregnant mothers (Olds et al., 2014). NFP is an evidence based program employing nurses and paraprofessionals to provide home visiting services. NFP programs emphasize reflection in supervision and provide home visitors with supervisors who engage in strategies that allow for reflection on their work

with children and families, and processing of their emotional responses to the work (Beam et al., 2010; Olds et al., 2014). Reflective practice strategies such as regularity, collaboration, mutual respect, and open communication are put into place within the supervisory relationship which allows the nurse home visitor to experience consistency, develop trust, and value the perspectives, thoughts, and feelings of others (Beam et al., 2010). Consequently, in a parallel way, the nurse home visitor is then better able to listen and collaborate with the family in order to develop an intervention action plan that takes into account the family's unique presentation and needs (Mikus et al., 1995).

Reflective practice is also potentially useful for professionals focused on the more concrete health needs of families (Gilkerson, 2004; Shahmoon-Shanok & Geller, 2009). For example, allied health providers, such as speech-language pathologists, physical therapists, occupational therapists, and audiologists are often employed in programs that work in-home with vulnerable infants and families (Hinshaw-Fuselier et al., 2009). Not having been trained in mental health and the impact of early relationships, these professionals are employed to focus mainly on the child's health needs. But, in doing their jobs, they run into relationship-based issues that prevent parents from fully utilizing their services. As a result, and to counter this problem, reflective consultation has been growing within these fields, especially in programs serving infants and toddlers who have an identified disability or developmental delay (Gilkerson, 2004; Watson, Neilsen Gatti, Cox, Harrison, & Hennes, 2014; Wimpenny, Forsyth, Jones, Evans, & Colley, 2006). Reflective process strategies have also been successfully implemented in neonatal intensive care units and other hospital settings that include individual reflective consultation for developmental specialists, teams, and physicians (Gilkerson, 2004).

In summary, social work supervision is viewed as important to the field and to the ongoing training of social workers. Additionally, reflective practices are presented in the clinical literature as beneficial to professionals providing interventions targeting at-risk, vulnerable populations. However, the social work supervision and reflective practice literature is largely theoretical and clinically-oriented (Bogo & McKnight, 2005). Empirical research connecting supervision and reflective practice to professional and clinical outcomes is needed to support these clinical assumptions.

## CHAPTER THREE – REFLECTIVE SUPERVISION

## SUPPORTING HOW THEY ARE: PERSPECTIVES OF REFLECTIVE SUPERVISION

"No significant learning can take place without a significant relationship"

- Dr. James Comer, Yale Child Study Center

### Clinical and Theoretical Perspectives of RS

The previous chapter argued and provided evidence for the inclusion of reflection, reflective practice, and relationship-based strategies into supervision for social workers, who by the nature of their jobs, engage with highly vulnerable and disenfranchised populations. Infants, toddlers, and families represent a unique subgroup of these populations who are served by social workers and other disciplines (education, nursing) through infant mental health (IMH) interventions. Many IMH professionals have access to reflective supervision (RS), a form of clinical supervision that embraces reflection and reflective practice strategies (Fraiberg, 1980). The practice of RS has its roots in the theory and practice of psychoanalytic supervision and is viewed within the clinical realm as essential to providing culturally sensitive, developmentally-informed, and relationship-based services for at-risk infants and their families (Ghosh Ippen et al., 2012; Weatherston & Tableman, 2015; Weatherston, et al., 2010). However, despite overwhelming acceptance of the importance of reflective supervision within the IMH field, there is limited empirical research supporting its effectiveness.

A body of clinical and theoretical literature applying RS to diverse clinical and supervisory experiences has proposed a framework of RS. Within the extensive clinical literature, reflective supervisors have hypothesized the existence of essential components of RS including reflection, regularity, and collaboration; a focus on the infant and the relational context of the therapeutic intervention; and the professional's emotional response (Heller, 2012; Pawl, 1994; Shahmoon-

Shanok, 2009).  Although these constructs have not been empirically tested, they have been well articulated within the clinical literature, from the point of view of the supervisor, and are described here.

**Reflection, collaboration, and regularity**

Reflection, collaboration, and regularity have been described as the building blocks that support the framework for the RS relationship.

**Reflection.**  As described in Chapter Two, reflection requires a stepping back to observe intervention experiences from a more objective position.  Relationship-based clinical intervention can feel intimate and emotionally evocative (Harden, 2010; Harden et al., 2009).  Reflection provides distance from evocative emotions and situations and thereby offers an opportunity to examine situations with objectivity rather than impulsivity (Shahmoon-Shanok et al., 1995; Shahmoon-Shanok et al., 2005).

**Collaboration**. Collaboration in the supervisory relationship involves communication, tolerance for differences, clear mutual expectations, and shared power (Fenichel, 1992; Heffron & Murch, 2010; Parlakian, 2001; Pawl, 1994; Shahmoon-Shanok, 2009). Together, the supervisor and supervisee create an egalitarian space to discuss and strategize about the therapeutic work. Sharing his/her work with a supervisor can feel overwhelming to the supervisee, especially when they have experienced negative feelings or difficult interactions with a family (Siegel & Shahmoon-Shanok, 2010). Via the development of a collaborative partnership, a relationship can emerge that allows each partner to feel secure, trusting, and safe to explore thoughts and feelings that may be difficult (Heller, 2012; Michigan Association for Infant Mental Health [MI-AIMH], 2016a; Weatherston et al., 2010).  Additionally, this collaborative relationship has the potential to grow the critical thinking skills of the practitioner through shared discussions and support of the

practitioner's knowledge about the infant and family (Cearley, 2004; Eggbeer et al., 2007; Fenichel, 1992; Weatherston et al., 2010).

**Regularity.**  Fenichel (1992) posits that maintaining a consistent, regular schedule is essential for the development and maintenance of most clinical relationships, including the RS relationship.  There is general agreement within the RS clinical literature that regularly scheduled supervisory sessions that are protected from interruption, cancelation, or tardiness allow for the development of trust within the supervisory relationship (Fenichel, 1992; Heller, 2012; Weatherston et al., 2010).  Predictability and consistently aid in the development of safety and allow for relationships to deepen over time, while irregular meetings that are interrupted or frequently rescheduled create an insecure foundation that may not be strong enough to support the development of trust necessary to share evocative, difficult experiences and emotional responses (Fenichel, 1992).

Fenichel and others contend that the importance of regularity within supervisory relationships can be overlooked by home-based IMH professionals and supervisors who often feel overwhelmed by the needs of the families with whom they work (Fenichel, 1992; Heller, 2012; Shahmoon-Shanok et al., 1995) and for whom time is a precious commodity.  Also, when the program is community / home based, IMH professionals are often physically away from the office without opportunities to connect with peers or supervisors.  This makes it especially difficult – and perhaps especially important – for IMH workers to have regularly scheduled supervision so that they can come back to their "home base" for guidance and support (Barron & Paradis, 2010; Harden et al., 2010).

**Family- and relationship-focused content**

Watson, Harrison, Hennes, & Harris (2016) describe essential aspects of RS related to family focused content as "understanding the family's story" and "holding the baby in mind" (p. 16). The phrase "holding the baby in mind" is used frequently in the IMH literature and signifies that the wellbeing of the infant is a primary focus of IMH intervention and therefore is also central focus point within RS. This ensures that the infant's experiences do not become overshadowed by the needs of the parent or family. Taken together, aiming to fully understand the family's story and keeping the baby's experience in mind are important and unique in IMH clinical work, as they imply that neither the parent nor the infant is forgotten within the dialogue and the treatment, nor within the supervisory relationship.

**The professional's response to the work**

Heller (2012) notes that taking time to pay attention to our emotional response helps us to better organize and understand the world around us and that we often respond to our emotions before we have fully and consciously processed the events eliciting them. In other words, human beings often act before they think. This relatively normative response to emotionally activating situations poses problems for the clinician, however. Specifically, clinical expertise suggests that, in order to intervene effectively with at-risk infants and parents, IMH professionals need to have conscious awareness of their emotional response and to have developed strategies to regulate this response in the context of their work (Heller, 2012; Heffron et al., 2005). Thus, the content of RS sessions also includes the IMH professional's response to relationship-based work with at-risk infants and toddlers. Through our clinical understanding, it is believed that providing IMH professionals with a time and a place to share and reflect upon their range of emotional responses with a trusted supervisor is crucial to effective practice (Heffron et al., 2005; Heller, 2012; Parlakian, 2001; Shahmoon-Shanok, 2009; Tomlin et al., 2014; Weatherston et al., 2010).

**Forms of RS**

Within IMH programmatic settings, RS is most often implemented through individual supervisory relationships with an agency supervisor; and group consultation, often facilitated by an outside reflective consultant (Heffron & Murch, 2010; Heffron, Reyonlds, & Talbot, 2016; Larrieu & Dickson, 2009; O'Rourke, 2011).

**Individual supervision.** Support for the importance of individual RS comes from clinical case studies (see Foulds & Curtiss, 2002; Many et al., 2016; Weatherston & Barron, 2009; Weigand, 2007). These studies report that when the supervisee was allowed to take the lead in presenting material and afforded an opportunity to reveal a range of emotional responses without judgement from the supervisor, the supervisee experienced a "consistent and unconditional positive regard" (Many et al., 2016, p. 722) and a strong belief in the supervisor's genuineness (Weigand, 2007). This was important for paving the way for the deepening of the supervisory relationship, and the capacity for the supervisee to acknowledge his/her own vulnerability within his/her work. For example, Weigand (2007) described his experience of receiving RS while teaching in an early childhood classroom and how this experience allowed him to expand his skills and understanding of the child's experience. Weatherston & Barron (2009) use a conversation between an IMH home visitor and her supervisor to demonstrate the development of an RS relationship over the course of a year, highlighting the supervisor's and supervisee's roles and the clinical growth of the supervisee over time. These ideas are supported within the clinical RS literature, yet they have not been tested empirically.

**Group facilitation.** Group RS is typically facilitated by an outside consultant who provides opportunities for a group of professionals to reflect together on their therapeutic experiences and gain knowledge and understanding from the expertise within the group. Group

RS is used within community mental health and home visiting settings (Heffron & Murch, 2010; O'Farrelly, Gurin, & Vicotry, 2017; O'Rourke, 2011); public health settings (Beam, O'Brien, & Neal, 2010) and early childhood settings (Heller, Steier, Phillips, & Eckley, 2013; Hepburn, Perry, Shivers, & Gilliam, 2013; Johnston & Brinamen, 2012; Perry & Conners-Burrow, 2016). In some settings it is the only form of RS provided (Heffron & Murch, 2010; Heffron et al., 2016; O'Rourke, 2011).

Group RS uses strategies described within the group therapy literature such as the importance of group cohesiveness in providing feelings of safety and security (Heffron & Murch, 2010). Similar to group therapy, the emotional safety of group members is promoted through actions of both the supervisor and the supervisees (Heffron & Murch, 2010; Heffron et al., 2016; O'Rourke, 2011). Along with qualities such as active listening, skillful observation, and encouragement, supervisors must also possess group facilitation and group management skills (Heffron et al., 2016). Supervisees must also be willing to thoughtfully witness and support each other's exploration and reflection, as well as share their own perspectives while being respectful of others', which may differ from their own (Heffron & Murch, 2010; Heffron et al., 2016). CMH-housed IMH home visiting programs in Michigan provide both individual and group RS to their staff. However, there have been no empirical studies to date comparing these two forms of RS.

To summarize, within the clinical and theoretical literature, consistency, collaboration, and reflection have been described as providing the framework for the development of a supervisory relationship that allows for a deeper understanding of the professional's emotional response to their work with high-risk infants and families (Pawl, 1994; Shahmoon-Shanok et al., 1995). In addition, the complexity of systemic and cultural influences and the relational focus of IMH treatment underscore the necessity of regular access to supervision that includes reflection and

supports the professional's reflective capacity (Harden, 2010; Zeanah & Zeanah, 2009). Through their relationship with their reflective supervisor, the IMH professional has an opportunity to carefully consider the perspectives of the infant and parent, and also safely explore the emotional responses that have been evoked by their work (Fenichel, 1992; Heller, 2012; Pawl, 1994).

**Empirical Study of Components of RS**

Thus far, the components of RS presented here have been well described within the theoretical and clinical IMH literature. However, these clinical assumptions need to be corroborated using empirical research methods. The limited empirical literature investigating RS provides some evidence to support these clinical assumptions, although there are limitations and research gaps that need to be addressed. Two studies inform the current work and are described here.

Tomlin et al. (2014) used empirical methodology to systematically identify essential components of RS and offered preliminary evidence to substantiate several of the components of RS that have been described in the clinical literature. Using a three-phase quantitative survey method designed to gather information and reach consensus without convening face to face meetings, the authors sampled experts in the field, i.e. those who had published on RS, presented RS at professional conferences, or had experience providing RS to individuals or groups (Phase 1 & 2: n=35; Phase 3: n=16). Survey results highlighted consensus categories of RS and corresponding supervisor and supervisee behaviors and qualities perceived as central to the provision of RS and that mirror clinical and theoretical assumptions. Figure 2 lists these categories, along with examples and their connection to the clinical RS literature:

Figure 2

Consensus categories of Reflective Supervision from Tomlin et al. (2014)

| Consensus Categories (from Tomlin et al. 2014, p. 5) | Examples (from Tomlin et al. 2014, p. 5) | Connection to conceptual/theoretical literature |
|---|---|---|
| Qualities a supervisor demonstrates during each reflective supervision session | • Tolerant/nonjudgmental<br>• Reliable and predictable<br>• A safe and confidential resource | • Regularity<br>• Development of a trusting and safe relationship |
| Behaviors a supervisor demonstrates during each reflective supervision session | • Attentive<br>• Self-aware<br>• Skillful observer | • Collaboration<br>• Self-awareness<br>• Reflection |
| Mutual behaviors and qualities necessary for reflective supervision | • Mutual respect and professionalism<br>• Confidentiality | • Collaboration<br>• Regularity |
| Structure of reflective supervision sessions | • Private, quiet setting<br>• Regularly and consistently scheduled | • Regularity<br>• Collaboration |
| Process of reflective supervision sessions | • Supervisor encourages continuous learning and improvement | • A relationship for learning<br>• Reflection |
| Behaviors a supervisee demonstrates in reflective supervisory sessions | • Nondefensive stance<br>• Realistic expectations about supervision<br>• Ability to ask for help | • Collaboration<br>• Self-awareness |

This study is important to the field, as it provides preliminary empirical evidence to support the theoretical and clinical view of RS. This description of RS has been useful in the creation of quantitative measures (see Shea, Weatherston, & Goldberg, 2012; Watson et al., 2016) that could be applied to further delineate its role within IMH interventions, and connect it to professional and clinical outcomes.

Greacen et al. (2017) also used the three-phase quantitative survey method to reach consensus on the characteristics of quality supervision in perinatal home-visiting programs in France. The authors surveyed eight supervisors working with a program designed to provide home

visits to families with new babies throughout the child's first two years. Four thematic categories of quality supervision emerged: 1) organization and setting of supervision sessions (e.g. confidential; regular; supervisor is not in a hierarchical position regarding the supervisee); 2) supervisor competencies (e.g. has experience working with mother-child relationships; experience in supervision); 3) relationship between supervisor and supervisee (e.g. creates a secure relationship with the supervisee); and 4) supervisor's intervention strategies within supervision (e.g. shows empathy; does not have a judgmental attitude). This study's results coincide with Tomlin et al.'s (2014) consensus categories of RS and also offers additional views of the organization and setting of supervisory sessions, such as the perspective that the reflective supervisor not hold any hierarchical position over the supervisee. While this may be true for this study's supervisor sample, it may not be feasible in practice for IMH programs in the United States.

Although these studies make a significant contribution to the field, they also have similar methodological weaknesses. First, in both studies, sample size is small, with only 16 participants included in the final iteration of the Tomlin et al. (2014) survey and eight participants in the Greacen et al. (2017) study. Also, both studies leave out the voice of the supervisee. As these studies purport to define essential components of RS, results would be more comprehensive if both supervisors and supervisees responded to the surveys. For example, if included in the above surveys, would a supervisee place the same emphasis on a particular component of RS or supervisor quality? Answering these questions would provide yet more evidence and support for these critical aspects, and help inform supervisors and program directors about the needs of their supervisees. It is imperative that ongoing research keep in mind this deficit in the existing literature and strive to obtain information from all those who are directly impacted by RS.

**RS and Empirical Research: Slowly Building a Foundation**

Empirical research using quantitative and qualitative methodology is a recent development within RS.  Empirically designed research investigating reflective supervisory practices is now needed to inform and evaluate its use within multi-faceted IMH programming.  To date, along with two studies describing components of RS, there are five studies that have empirically examined RS on practitioner and child outcomes.  These studies are described here.

**Research related to outcomes.**  Virmani & Ontai (2010) hypothesized that the provision of RS would impact early childhood educators' insightfulness and their perspectives of children's behaviors and emotions.  This study used naturally occurring comparison groups.  Caregivers from an early childhood program where RS was already implemented (the "reflective site"; n=10) were compared to caregivers from a "traditional site" where only didactic training was offered (n=10).  Using a measure of insightfulness, results showed that 7 of the 10 caregivers from the reflective site, in contrast to only 1 out of 10 in the traditional site, were classified as positively insightful on the measure.

In addition, Virmani et al. (2013) investigated whether and how the use of RS within early childhood education promoted change and increased quality within teacher-child interactions. Early childhood teachers (n=141) participated in the study and received RS through a state-wide implementation over the course of three years. Measures included classroom observations of teacher-child interactions using three subscales of the Caregiver Interaction Scale (CIS; as cited in Virmani et al., 2013) – positive interaction, punitiveness, and detachment – and questionnaires gathering information on the teacher's experience of the consultation.  Teacher-child interaction quality was assessed at seven time points – every six months throughout the duration of the study.  Analysis of the CIS over the course of the study demonstrated that teachers who perceived RS as helpful became more engaged and less punitive in their interactions with children.  These studies

suggest that RS may promote growth and change among teachers which, in turn can directly impact child outcomes. However, they are specific to the early childhood classroom environment, therefore further research is necessary in order to apply these results to professionals of other disciplines working with families in their homes.

In a third study that utilized qualitative methodology, Harrison (2014 & 2016) examined RS in a sample of early intervention professionals. In this study, professionals from a range of disciplines (n=29) participated in monthly group RS with a licensed mental health clinician trained in IMH and RS. Subsequently, 15 of the group members participated in semi-structured interviews to explore their group RS experience. Harrison (2016) identified four main themes in the narratives that that described their experiences with RS: release, reframe, refocus, and respond. Practitioners described that participation in RS allowed them to *release* overwhelming and helpless feelings brought about through their work with vulnerable families through sharing with their reflective supervisor. As a result, they were better able to *reframe* the experience of themselves, the child and family and *refocus* their observations and assessments with a sense of professional confidence and self-efficacy. Finally, these experiences allowed them to *respond* to the situation by observing, listening, and being flexible in their interventions with children and parents. This study connects with the clinical descriptions of RS and reflective practice that have been previously described using case study methods, and provides support for a process of change that can be further investigated and connected to family outcomes.

Watson et al.'s (2016) study of 26 reflective supervisors and 66 home visitors posed research questions related to RS and practitioner outcomes, including burnout and reflective functioning. Along with qualitative interviews, this longitudinal study used a standardized measure linked to reflective functioning and a professional burnout measure. Semi-structured

interview data revealed that home visitors believed they learned a great amount related to reflective practice skills. However, there was no significant change on the reflective functioning measure or on the burnout measure. Furthermore, home visitors reported *increasing emotional exhaustion* (which is associated with burnout) throughout the project. Although these results seemed to contradict each other, that is, supervisees stated they felt RS supported their reflective capacity, yet this was not reflected in the standardized measures; this study offers a foundation from which to ask questions and further delineate what outcomes might be meaningful to supervisees.

Using a similar sample, Frosch, Varwani, Mitchell, Caracccioli, & Willoughby (2018) investigated the impact of RS on perceptions of self-efficacy, job satisfaction, and job stress in a sample of early intervention home visitors. The authors used an adapted version of the Reflective Supervision Self-Efficacy Scale (RSSESS; Shea et al., 2012) and additional questions assessing levels of job satisfaction and stress. Thirty-three participants completed pre- and post-assessments and received nine months of approximately bi-weekly group RS facilitated by an Endorsed (IMH-E®) Infant Mental Health Mentor. Study participants reported significant increases in self-efficacy for all of the items on the adapted RSSESS, yet, also reported *significantly more job stress* from pre- to post-assessment. Further, 85% of participants reported that RS contributed positively to their overall job satisfaction. This study is important because it is the second of only two longitudinal studies investigating RS among IMH professionals. Also important to consider is the participant's experience of increased job stress from this current study, as well as Watson et al.'s (2016) finding related to emotional exhaustion. These results are in direct opposition to theoretical ideas related to RS relationships. Further examination of other variables, such as the form of RS, discipline-specific characteristics, and the level of experience of the home visitor may be important to tease out the impact of RS on outcomes.

Taken together, these studies provide preliminary support for clinical interpretations of RS that have been used within the IMH field. However, they also reveal several research gaps. First and quite simply, there is a lack of empirical study related to RS and outcomes. Clinical and empirical scholars agree that further empirical research investigating RS is essential to warrant its continued implementation (Frosch et al., 2018; Tomlin et al., 2014; Watson et al., 2014). Returning to Watson et al.'s (2016) and Frosch et al.'s (2018) unexpected results regarding reflective functioning, emotional exhaustion, and job stress, perhaps, for supervisees, RS impacts their work in other, as yet undefined, ways. Finally, these studies are focused upon early childhood educators and early interventionists. Their experiences may be different from those trained with a mental health perspective, such as social workers; or a medical background, such as nurses. This dissertation will contribute to the existing RS empirical literature by adding perspectives of supervisees to the current descriptions of essential components of RS and identify outcomes of RS most meaningful to supervisees that can be investigated in future research.

**CHAPTER FOUR - METHODS**

The primary aims of the current study are to: 1) Identify the <u>components</u> of reflective supervision (RS) that infant mental health (IMH) supervisees find most important and impactful to their work; 2) Identify the <u>professional satisfaction outcomes</u> (e.g., job satisfaction, burnout, etc.) of supervisees that are associated with receiving RS; 3) Identify the <u>practice behavior outcomes</u> (e.g. capacity for reflection and insight, implementation of interventions) of supervisees that are associated with receiving RS. To address these aims, this study employed a qualitative, cross sectional, Grounded Theory design (Charmaz, 2015; Creswell, 2013). Qualitative research provides the opportunity to gain a comprehensive understanding and a full description of a particular social experience (Creswell, 2013). Specifically, qualitative inquiry can provide an in-depth and meaningful examination of how the supervisee experiences reflective supervision and how this type of supervision impacts their work. As the experience of the supervisee within RS has been neglected in the empirical literature, engaging in a qualitative study was essential to create a foundation from which a future quantitative study can be built (Padgett, 2008). Qualitative inquiry was important to the current study in three ways.

First, although RS has been described and explored theoretically in the literature over the past three decades, the vast majority of this body of work has addressed supervisors' clinical perspectives regarding the *provision* of RS (Fenichel, 1992; Heffron & Murch, 2010; Heller & Gilkerson, 2009). There is a relative paucity of work addressing the perspectives of supervisees with regard to their experiences *receiving* RS. This study filled this empirical gap by collecting focus group and individual interview data from IMH practitioners who provide services to families and are receiving RS to support their work.

Second, there are multiple ways of defining and providing RS that are currently practiced. These range from a single, supervisor-supervisee "check in" about the intervention process (Counts, Gillam, Perico, & Eggers, 2017), to programs that provide comprehensive RS components including mindful self-regulation, empathic inquiry, and collaborative exploration (Gilkerson & Imberger, 2016). In order to effectively evaluate the effects of RS on key outcomes, the components of RS that are truly essential to the work need to be isolated.

Third, the field of IMH is multidisciplinary, yet the majority of empirical research related to RS and the use of reflective processes has been almost exclusively focused on the early intervention and early childhood education disciplines (Harrison, 2016; Virmani & Ontai, 2010; Watson et al., 2014). The current study recruited and enrolled practitioners from a range of disciplines, including social work, nursing, psychology, and education, to participate in the study. The inclusion of a variety of disciplinary perspectives within this study highlighted essential components of RS that cut across disciplines and programmatic goals.

This study was implemented in two phases. Phase 1 tapped supervisees' perspectives regarding the essential components of RS and associated professional satisfaction and practice behavior outcomes using *focus group methodology*. Thematic data analysis was conducted to describe the experience of reflective supervision and determine the elements and outcomes associated with RS that are most salient and meaningful to supervisees. Phase 2 involved the use of *individual interviews* to further investigate themes generated by the focus groups. Grounded theory analysis procedures were used to develop a theoretical model of reflective supervision from the supervisee perspective that includes the process in which supervisees engage in RS over time, variables that can impact engagement in RS, and outcomes that are impacted by this engagement.

**Design**

A focus group format (Phase 1) followed by individual interviews (Phase 2) was used to collect qualitative data and the approach utilized a *grounded theory* framework (Charmaz, 2014; Padgett, 2008). This method is appropriate when the goal of the research is to examine a particular phenomenon from the point of view of those who have experienced it and identify an explanation or theory about the particular issue or question being studied (Creswell, 2013; Padgett, 2008). The goal of the current study was to better understand the experience of IMH professionals who are concurrently working in the IMH field and receiving RS in order to inform theory development regarding how they use RS in their work.

**Grounded theory.** The central premise of grounded theory is that the research theory or outcome is "grounded" in the data that is collected (Charmaz, 2014). The data are analyzed in specific ways throughout the collection period so that the theory that emerges comes directly from the themes that are identified. It is preferable in grounded theory research to have a sample size of 20-60 participants who have all experienced the process identified in the research questions (Charmaz, 2014; Padgett, 2008). The current study included a total of 50 participants – 25 focus group participants and 25 individual interviews.

The grounded theory technique of "constant comparison," was used in the current study. This is an iterative process that begins with the first interview and involves comparing data from each subsequent interview with the data from previous interviews (Charmaz, 2014; Padgett, 2008). All interviews were transcribed verbatim and coded line by line. Open coding was used to identify patterns and develop categories, moving back and forth between these categories and the data collected. This process continued until the data no longer produced new themes or new categories (termed "saturation"; Charmaz, 2014; Padgett, 2008). Through a process of axial coding, the initially identified categories were further described until a core framework emerged related to the

research question. Next, using selective coding, core categories were further refined, resulting in a theory, or explanation, of the research questions.

It is also important for grounded theorists to remain grounded themselves, throughout the data collection process. A practice called *memoing* or memo-writing was used in order to document ideas, thoughts, and questions throughout data collection, analysis, and interpretation (Charmaz, 2014; Padgett, 2008). Memoing aids the researcher in remaining true to the data, helping the researcher to set aside any preconceived theoretical ideas or biases, and making certain that the theory comes from the data collected. This promotes intentionality and provides opportunities to think deeply about coding and developing categories throughout the research process (Charmaz, 2014).

The aims of the study were as follows:

**Aim 1**: To identify the <u>components</u> of RS that IMH professionals find most important and impactful in their work.

**Aim 2**: To identify the <u>professional satisfaction outcomes</u> that IMH professionals view as associated with receiving RS.

**Aim 3**: To identify the <u>practice behavior outcomes</u> that IMH professionals view as associated with receiving RS.

## Phase 1 – Focus Groups

**Participants**

The sample for Phase 1 was drawn from IMH professionals in Michigan who provide services to parents and infants and who participate in RS either individually or in group

consultation[1].  Professionals from all disciplines (e.g., social work, nursing, education), educational levels (e.g., bachelor or graduate degree), and programmatic foci (e.g. mental health, parenting, child development) were recruited to participate in the study.  The use of a diverse sample of professionals supports the identification of common core experiences and central dimensions of RS resulting in a definition of RS that is robust across disciplines (Patton, 2002).  Table 1 lists the educational background, discipline, and job description of the focus group participants.  The focus group sample represents a range of professionals with different disciplinary training and job descriptions.

---

[1] I currently provide reflective consultation to two IMH intervention teams in Michigan.  Since I conducted all of the focus groups and the individual interviews, this would have posed a conflict of interest. These teams, therefore, were not eligible for enrollment in this study.

Table 1

Professional Credentials of Focus Group Participants

| Professional credentials | Number of participants N=25 |
|---|---|
| Type of work/programmatic focus | |
| EHS Home Visitor | 3 |
| EHS Classroom Teacher | 3 |
| Parents as Teachers Home Visitor | 1 |
| IMH Home Visitor/Mental Health | 16 |
| Administrator – home visiting program | 2 |
| Level of education | |
| Associates degree/para-professional | 2 |
| Bachelor degree | 4 |
| Graduate degree | 17 |
| Professional discipline | |
| Social Work | 14 |
| Education | 3 |
| Psychology | 5 |

**Procedures**

**Sampling.** Focus group participants for Phase 1 were recruited from a population of IMH professionals from both rural and urban communities within the State of Michigan. There are large differences in the density of IMH practitioners across the rural and urban counties in Michigan and these differences affect their experiences providing IMH services and receiving RS. Specifically, there is variation in, 1) the number of IMH professionals providing home based services, 2)

practitioner access to RS, and 3) the format within which RS is provided (e.g., individual, group, etc.). For example, in Wayne County, an urban setting where the city of Detroit is located, there are over 100 master's prepared IMH professionals, while in the rural counties of Bay and Arenac there are only three master's prepared IMH therapists who service both counties (Michigan Association for Infant Mental Health [MI-AIMH], 2016b). Partly due to these geographic and density features, IMH professionals in Michigan have varying levels of access to RS. Typically, in higher density regions of Michigan where there are more IMH practitioners and more supervisors within a smaller geographic region, RS is offered weekly, via face-to-face, individual sessions with an agency supervisor. In contrast, in more rural areas where IMH practitioners and supervisors are located dozens of miles from each other, RS is often offered via monthly group supervision sessions facilitated by an outside consultant, or quarterly online sessions offered simultaneously to several practitioners from different geographical areas.

There is also a great deal of diversity with regard to the specific intervention foci of programs across the state. For example, home visiting programs such as Early Head Start (EHS), utilize an educational approach to support parents and young children through provision of parenting and developmental information; while IMH home visiting programs housed within community mental health settings employ graduate level social workers who are trained to expand their intervention to include the use of relationship-based, therapeutic intervention strategies to support the young child's developing attachment relationship. Further, both master's prepared IMH therapists who engage in IMH home-based intervention, including infant-parent psychotherapy, and bachelor's prepared EHS home visitors receive RS in Michigan.

To account for the geographic, disciplinary, educational and program diversity, a purposive sampling process was utilized to ensure that the focus group sample included practitioners from

different areas of the state who are receiving differing methods and frequency of RS (Padgett, 2008). To accomplish this, the focus group locations were chosen to include both urban and rural locales that are accessible to at least 10 IMH professionals who met the study's eligibility criteria. Locations were also selected based on the availability of conveniently located meeting places that were free of charge. Using these criteria, the following areas were selected as sites for the five focus groups: Metropolitan Detroit (2); West Michigan/Grandville (1); Northwest Michigan/Traverse City (1); and Southwest Michigan/Hillsdale (1).

*Sample size.*    A total sample size of 25 IMH professionals participated in focus groups: Metropolitan Detroit (n=13); West Michigan/Grandville (n=1); Northwest Michigan/Traverse City (n=5); and Southwest Michigan/Hillsdale (n=6). It is unclear why the sample size in West Michigan was so low. According to the participant and my colleagues in this area, there were a number of IMH professionals eligible to participate in the focus group. One possibility is that the location and time of the meeting was not convenient; other focus groups were held at IMH programs and agencies, however, this group was held in a local public library.

*Recruitment for focus groups.*    Focus group participants were recruited via the Michigan Association for Infant Mental Health's (MI-AIMH) membership mailing list.    MI-AIMH personnel forwarded an IRB-approved email to chapter membership lists that included information about study eligibility, time commitment, focus group location, and compensation.    IRB approved (IRB# 104217B3E) recruitment flyers for the focus groups were included as attachments to this email.    As it became clear that the number of participants was much lower than proposed for the Metro-Detroit focus groups and the Grandville focus group, the flyer was additionally sent out via the individual local chapters. Flyers were also shared among colleagues at relevant trainings and chapter meetings. IMH personnel who were interested in participating in the study contacted me

directly at which time I provided further information about the intent of the study. Participants were enrolled in the study when they committed to attend the focus group.

*Confidentiality.* Due to the face-to-face interactions with the researcher and other participants, focus group data collection was not anonymous. In some cases, participants were professional colleagues and were working together at the same agency. As a professional within the field of IMH, I also had previous relationships with some of the focus group participants. To address this inherent lack of confidentiality, focus groups began with an introduction asking participants not to use names of supervisors, colleagues, or families in the course of the discussion. Participants were asked to keep the content of the group private and to refrain from discussing it with anyone outside of the group. The focus groups were audio recorded and transcribed by me. All identifiers were removed from the transcription.

*Compensation.* Each IMH professional received a $25.00 Amazon.com gift card upon the completion of the focus group. Snacks, lunch, or dinner were also provided to the participants depending upon the time of day the focus group was held.

**Measures.** Qualitative data were gathered using a semi-structured interview process. The focus group discussion was guided by questions to prompt thinking about essential components of RS, the impact of RS on professional satisfaction outcomes, and the impact of RS on the perceived quality of their clinical practice. Focus group questions therefore, probed for descriptions of RS and its central components, what professional qualities they felt were impacted by RS, and how RS impacted their clinical practice approach with infants and families. Barriers to RS, the effects of modality of supervision (i.e. group, individual, weekly, monthly), and how they perceived their role as supervisee in the RS relationship were also probed. See Appendix A for the complete Focus Group Discussion Guide.

*Demographic information*.  A demographic form was used to gather information related to each participant's professional status within the IMH field, including:  how long they had been receiving RS; type, frequency, and location of RS; level of education and field of study; job title; and intervention focus.  It also asked for information about their current reflective supervisor such as his or her level of education, field of study, length of time providing RS, type of RS provided (individual/group), whether he or she was an agency supervisor or an outside consultant, and whether the supervisor himself or herself receives RS.  See Appendix B for the complete focus group demographic form and Appendix C for tables of all participant demographics.

**Data Analysis.** The goal of Phase 1 was to examine IMH professionals' experience of RS in order to identify essential RS components and discern professional and practice behavior outcomes that are impacted by RS.  Therefore, thematic analysis, an inductive, data-driven qualitative analysis procedure guided the identification of patterns, themes and sub-themes from the focus group transcripts (Patton, 2002; Braun & Clarke, 2006).  Data analysis took place throughout the process of transcribing and facilitating focus groups.  During the transcription process, I made notes on the transcripts themselves, as well as within qualitative memos.  This allowed me to begin to analyze my data early in the collection process and to refine the interview questions to ensure that they were generating the information necessary to address the aims of the study (Charmaz, 2014).  By utilizing this iterative approach to data collection, subsequent focus group interviews were used to assess the meaningfulness of the emerging themes and aid in the refining of patterns and themes (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009).  For example, as I facilitated each focus group and engaged in memo writing and transcription, I noticed that while supervisees were able to identify how RS positively impacts their work, this was often qualified with statements such as *"but I didn't always see it that way"* or *"it wasn't always like*

*that."* These statements seemed to point to a process of RS that, when perceived as positive or when the supervisee experienced a positive relationship with their supervisor, supported growth and change within the RS relationship and within the supervisee's capacity to use RS in their work. Therefore, I began to probe for this in a direct way in subsequent focus groups. As a result, focus groups honed in on unique areas of this experience and identified questions that would be important to delve deeper into during Phase 2.

Following the completion of the focus groups, a research assistant was hired to aid in the analysis of the focus group data and to assist in transcription of the individual interviews (to be discussed as Phase 2 of this project). The research assistant and I met bi-weekly over the course of three months. These meetings included discussion of the major themes identified, identification of individual codes, descriptions of individual codes and patterns, and consolidation of codes and themes. To begin the grounded theory analysis, focus group transcripts were read in their entirety in order to obtain a textural description of the participants' experiences and to note initial ideas (Padgett, 2008). Data analysis to support theory development took place when the focus group and the individual interview codes were combined (to be discussed in Phase 2). The following coding process was used to begin initial coding and identification of themes within the focus group transcripts:

*Initial codes.* Initial codes were generated using the participants' words and extracts from the transcripts. Examples of initial *in vivo* codes are "didn't know what to do", "allowed self to understand purpose", and "it took time" which were evident in a quote from a participant in the Detroit focus group who said: *"when I came here, it was like, why are we talking about all these things, why are we sharing, why are we doing all of this… I guess it took me a minute…but then I*

*was able to see a benefit…when I let myself understand what the purpose was, 'cause I really didn't know what the purpose was [when I started]."*

***Identification of potential themes.*** Initial codes were then collated into potential themes. For example, a theme developed that was related to how supervisees understood RS. "Understanding RS" included the following codes: 1) resistance related to understanding; 2) what could improve understanding; 3) RS must be experienced in order to understand it; and 4) it takes time to understand purpose.

***Review of themes.*** Themes were reviewed and further distilled using samples from the data. This iterative process involved returning to the initial codes' descriptions and generated data excerpts to determine whether the themes accurately represented participant views. For example, the above theme "understanding RS" was included in a broader thematic category, "it takes time" as other codes were identified that seemed to point to a developmental or time-related aspect of RS.

***Finalization of themes.*** Lastly, themes were refined, named, and clearly defined. For example, the theme "it takes time" included the following codes: 1) to understand what RS is; 2) to understand the work itself; 3) to buy into RS; 4) to understand why/how it connects to the work; 5) to notice how it can impact the work; and 6) to develop relationships.

This inductive and iterative coding process was supported by the use of NVivo qualitative software (QSR International Pty Ltd., 2012). Upon the identification of codes and themes, an NVivo project was created within which all themes, codes, and descriptions were entered. Focus group transcripts were then uploaded into the software and my research assistant and I re-coded each transcript using the finalized codes and themes. An NVivo coding comparison query resulted in a 90% or above agreement rating on all codes.

**Phase 2 – Individual Interviews**

**Participants**

The sample for Phase 2 was also drawn from IMH professionals in Michigan who provide services to parents and infants and who participate in RS either individually or in group consultation. Professionals from all disciplines (e.g., social work, nursing, education), educational levels (e.g., bachelor or graduate degree), and programmatic foci (e.g. mental health, parenting, child development) were eligible to participate in the individual interviews. Table 2 lists the educational background, discipline, and job description of those who participated in the individual interviews. None of the individual interview participants took part in the focus groups, therefore all of the phase 2 participants were new to the study.

Table 2

Professional Credentials of Individual Interview Participants

| Professional Credentials | Number of participants N=25 |
| --- | --- |
| Type of work/programmatic focus | |
| EHS Home Visitor | 1 |
| EHS Classroom Teacher | 1 |
| Mental Health/Social Emotional Consultant | 1 |
| IMH Home Visitor/Mental Health | 15 |
| Other Home Visiting Program (i.e. HFA, MIHP) | 7 |
| Level of education | |
| Associates degree/para-professional | 1 |
| Bachelor degree | 2 |
| Graduate degree | 22 |

| Professional discipline | |
| --- | --- |
| Nursing | 1 |
| Social Work | 16 |
| Education | 1 |
| Psychology | 6 |

**Procedures**

**Sampling.** IMH professionals across the state of Michigan made up the sample population for the individual interview phase. Individual interview participants were recruited via the Michigan Association for Infant Mental Health's (MI-AIMH) membership mailing list. MI-AIMH membership includes IMH professionals who work in a variety of programs, including home visiting and early childhood education. Membership also includes a variety of disciplines and levels of education.

*Sample size.* A total sample size of 25 IMH professionals participated in individual interviews. Individual interviews took place in person or over the phone.

*Recruitment for individual interviews.* MI-AIMH personnel forwarded an IRB-approved email to their full state-wide membership that included information about study eligibility, time commitment, focus group location, and compensation. IRB approved (IRB# 104217B3E) recruitment flyers for the individual interviews were included as attachments to this email. IMH personnel who were interested in participating in the study contacted me directly at which time I provided further information about the intent of the study. Participants were enrolled in the study when they committed to participate in the interview.

*Confidentiality.* Phase 2 data collection was not anonymous – 12 interviews took place over the phone and 13 were face-to-face interactions with the researcher. In some cases, the participant, their supervisor and I were well known to each other. In these cases, I started the interview with a discussion about our relationship and what it might mean to the participant that I am asking questions about their experience of supervision with a supervisor who I know. This discussion seemed appreciated by the participant and set the stage for them to provide honest and genuine answers to the interview questions. The interviews were audio recorded and transcribed by me or my research assistant. All identifiers were removed from the transcription.

*Compensation.* Each IMH professional received a $25.00 Amazon.com gift card upon the completion of the individual interview.

**Measures.** Qualitative data was gathered using a semi-structured interview process. The interview discussion was guided by questions to prompt thinking about essential components of RS, and the impact of RS on professional and clinical outcomes. Similar to the focus group questions, they probed for descriptions of RS and its central components, what professional qualities they felt were impacted by RS, and how they perceived their role as supervisee in the RS relationship. Additional questions were added related to how RS had impacted their practice behaviors over time and whether their experience or perception of RS had changed over time. Questions about feelings of safety within the supervisory relationship and whether and how components of reflective supervision supported the development of these feelings of safety were also added to the interview. See Appendix A for the complete Individual Interview Discussion Guide.

*Demographic information.* Similar to the focus groups, demographic information gathered included type and quantity of RS received, level of education, field of study, and

information about their reflective supervisor.  In addition, the individual interview demographic form asked for the participant's race and whether they were also a provider of reflective supervision.  See Appendix B for the complete individual interview demographic form and Appendix C for demographic tables.

**Data analysis**

The aim of Phase 2 was to facilitate individual interviews that delved more deeply into themes and patterns that were identified following the initial analysis of focus group transcripts by utilizing grounded theory analysis (Charmaz, 2014).  Data analysis took place throughout the process of facilitating and transcribing the interviews. Memo writing was used throughout initial reading of transcripts, as well as throughout the coding and analysis process.

The grounded theory coding process was supported by the use of NVivo qualitative software (QSR International Pty Ltd., 2012).  I created a separate NVivo project for the individual interviews and uploaded all transcripts into the software.  Each transcript was read thoroughly and codes were created within the software program.  Individual transcripts were read and coded independent of the focus group coding.  Lastly, individual interview themes and codes were compared and combined with the focus group themes and codes.

**Initial coding**.  Starting with the first transcript, I coded segments of the transcript using *in vivo* codes, these are codes that use the participant's words as descriptions of the data (Charmaz, 2014).  For example, an initial code related to the experience of group reflective supervision was "opportunity to connect with colleagues" that came from a segment of an interview transcript that read: *"it's an opportunity to connect with my coworkers who we don't often have an opportunity to you know sit down with and spend time with."*  Another example of in vivo codes were "provides encouragement" and "reminds them how hard the work is" related to the support the reflective

supervisor provides during stressful times when it is easy to forget how important their work is. These codes were derived from the segment: *"she often reminds us that this is really hard work and that we're doing the best that we can and just provides that encouragement that I think we need to just be confident in the work that we're doing and not second guess ourselves so often."*

As each subsequent transcript was coded, the *in vivo* codes were combined with other codes that were identified using an iterative process that grouped codes together based upon their meaning and their connection. In this way, the data were sorted and integrated into the most significant initial codes (Charmaz, 2014). Following this initial coding phase of the individual interviews, codes related to outcomes, essential components, the supervisee and supervisor contribution, and the supervisee's understanding and perception of value of RS were developed.

**Focused coding.** Following the coding of each individual interview transcript for topics and themes, a framework for the experience of the supervisee in RS began to develop. As I returned to the codes, I re-read each segment of the transcripts that were associated with the particular codes and engaged in conversation with my research assistant and my consultants. We identified a theme that highlighted the supervisee's understanding of RS and their perception of its value to their work as an important construct to consider when attempting to distill the essential components of RS from the data. For example, using focused coding, the following codes were developed and grouped into a theme named "a process of RS":

1. Early stages of the work

2. Early experiences of RS

3. Shifting from concrete needs to emotional support

4. Using RS in work with infants and families

5. It takes time

6. RS has to be experienced

These codes and theme suggest that there is an ongoing process related to the supervisee's experience of RS, that begins early in their work with infants and families and continues throughout their professional IMH experiences.

**Axial coding:** In the final stage of coding and theory development, I used axial coding techniques to identify links between the categories and subcategories developed during the initial coding phase (Charmaz, 2014). At this phase of the coding process, I merged the focus group codes and the individual interview codes in order to organize and synthesize the large amount of data, codes, and categories. Some focus group and individual interview codes were merged into new codes, while others were combined with codes that implied the same meaning. Again, moving back and forth from the data to the coding structure allowed for a refining of the data and a theory of the supervisee's experience of RS to come through (Charmaz, 2014).

## Considerations of trustworthiness

As I was the facilitator, transcriber, and data analyst, it was important for me to use memoing to document theory notes, such as ideas and thoughts about what might be important, as well as operational notes that include logistical or other concerns (Padgett, 2008). Memo writing throughout data collection and analysis was an important part of my effort to ensure that my biases and judgments remained in check (See Appendix D for examples of my qualitative memos used throughout the study). Bracketing, peer debriefing, and triangulation are qualitative strategies used to ensure data is collected and analyzed with an open mind and free of the researcher's personal opinions or preconceptions (Padgett, 2008). Bracketing in qualitative research refers to the researcher's deliberate effort to identify potential biases and to suspend any assumptions or beliefs related to the phenomenon to be studied (Padgett, 2008). As I am both a reflective supervisor and

supervisee in Michigan, and have worked in the IMH field for 20 years, it was important that I work to identify my own personal biases so that the information provided by the participants was fully understood from their perspective.

To do this, I utilized peer debriefing and support, provided by a colleague who is knowledgeable about reflective supervision. Nichole Paradis, LMSW, IMH-E®, Director of the Alliance for the Advancement of Infant Mental Health, provided peer debriefing throughout data collection and analysis and met with me on five occasions throughout this process. Also, multiple coders can be considered a form of triangulation within qualitative research (Padgett, 2008). Collaborating and comparing codes and themes between my research assistant and myself aided in the development of ideas and categories that were shielded from my bias and beliefs about reflective supervision. We also engaged in consensus coding (Padgett, 2008). When we disagreed on any codes or themes, we discussed our ideas openly and if necessary went back to the data in order to identify support for our ideas until we came to a consensus on that particular issue. Lastly, qualitative data gleaned from different sources, that is, focus groups and individual interviews can also be viewed as a form of triangulation (Creswell, 2013; Gibbs, G. R., 2007).

**CHAPTER FIVE - RESULTS – COMPONENTS OF RS**

This chapter details the results for Research Aim #1.  The categories, themes, descriptions, and participant data associated with this aim are explained in detail.  For Research Aim #1, five main categories were identified, with three to six themes within each category.

**Research Aim #1**

*"You have to sort of take this leap of faith and be vulnerable, even though it doesn't feel comfortable" – focus group participant*

*"I need you, I need to sit in supervision and make you feel what I felt in that house. I need to bring you there with me, so we can come out together." – interview participant*

Research Aim #1: To identify the <u>components</u> of reflective supervision (RS) that infant mental health (IMH) supervisees find most important and impactful to their work.

**1.1 Essential components of RS**

The components of RS that study participants stressed as essential to their experience of RS are (1.1a) feelings of safety and (1.1b) trust, (1.1c) consistency and predictability, (1.1d) nonjudgmental responses, and (1.1e) a commitment to being emotionally present to the experience. As supervisees in this study described these components, many of them noted that these develop over time and experience and are also interconnected.  For example, study participants stressed the importance of feelings of safety and trust within their supervisory relationship.  They described that these feelings were developed through consistency and predictability of supervisory meetings and responses from the supervisor that were non-judgmental.  They described that the components of RS are impacted by the intentionality of both the supervisor and supervisee to be present, physically and emotionally, to the experience of the relationship.  Table 3 delineates the number of times these components were coded throughout both the focus group and the individual interview transcripts.

Table 3

Consensus of Essential Components of Reflective Supervision Among Focus Group and Interview

Participants

| Essential Component | Files | References |
|---|---|---|
| 1.1a Importance of feeling safe | 23 | 119 |
| 1.1b Importance of trust | 17 | 36 |
| 1.1c Consistency and predictability | 10 | 23 |
| 1.1d Non-judgmental responses | 18 | 54 |
| 1.1e Being present – both supervisor & supervisee | 18 | 66 |

"Files" refers to the number of interview or focus group transcripts (n=30) where the particular component was mentioned at least once, and "references" refers to the number of times it was coded across transcripts.

**1.1a Importance of feeling safe.**  Focus group participants stressed the importance of feeling safe within their relationship with their supervisor.  This feeling of safety also extended to their colleagues when they talked about group RS.  Moving to the individual interviews, I asked specifically, *what does feeling safe mean within the context of a supervisory relationship?* The hope was to expand on this idea of feeling safe and learn specifically what that means within a professional supervisory relationship.  One participant who is an infant mental health home visitor described feeling safe as a place where she can share a range of emotions, thoughts, and experiences without worrying about feeling less than or judged:

> *"To me, safe means that I can say whatever I'm feeling, and I won't be judged, or I won't be, I guess, corrected in feeling that way."*

She went on, stating that she realized reflective supervision was a safe environment when her supervisor was not expecting lists of tasks that were done and demonstration of 'perfect'

paperwork. She noticed, instead, that her reflective supervisor allowed time for challenges to come to light, difficult emotions to be discussed, and opportunities to think about how this work was for her:

> *"I noticed reflective supervision was a safe environment for me…when I realized that my supervisor…was going to be able to hold whatever I was feeling. She would tell me that, but mostly, she just showed it to me in just the way she responded to my challenges, or when I felt really angry about a family or something…she was really able to hold it…without judging and just accepting it, and thinking about it further, like, where is that coming from? But…I have never felt like it's wrong for me to feel that way…Just that there's a reason for it."*

Another infant mental health home visitor put it differently, by describing feelings of safety as related to relationships with her colleagues within group RS:

> *"The first thing was definitely about the relationships with the people in the room. There was something that just felt jarring or uncomfortable that, I didn't feel like I could bring my authentic self and like, there just wasn't that trust there, it didn't feel like a safe space."*

Many participants identified a connection between feeling safe in RS and their practice behaviors when providing services to infants and families. Another IMH home visitor highlighted the importance of being able to share a range of feelings in RS in order to be able to better understand their experience and better serve their clients:

> *"To me, it's a very intimate time that I'm spending with the family, so…whatever feelings I'm getting when I'm with them, I need to have a safe space to talk about [them]…so that I could be my best for this family. And I can't give my best to a family if I have feelings that I can't work through. Because I'm not being authentic to that family. And so for me, that's feeling safe - knowing that I can say exactly how I'm feeling and not feel like I'm being criticized or being told what to do and how to do it, but a place where we can talk through "Why are you feeling this way? And how do we work through this?"*

**1.1b The importance of trust.** Many study participants described that the development of trusting relationships between supervisees and supervisors, as well as between RS group members was an essential component of RS. This supervisee described trust as being able to share

a range of feelings and experiences, including those that feel especially challenging, with no risk

of judgment:

> *"I think a core component for everything [in supervision] is just trust. It's having a trusting…and safe environment to explore feelings that I'm having that I'm not proud of…I sometimes talk about really disliking a family or…just certain things like that and to know that there's a non-judgmental person on the other end of that is really powerful."*

This participant added the supervisor's capacity to contain the emotions of the group, as well as

the behavior of fellow supervisees to the development of a trusting environment within RS:

> *"I think it…is…also trusting our consultant and our supervisor - trusting that they'll be able to hold and contain all of us. And also knowing that we're in a room that other staff outside of our…infant mental health group aren't gonna come in and out…that [there's a] protected space."*

Furthermore, the following participant identified that trust develops over time and experience:

> *"So…my first experience…with reflective [supervision] I remember feeling the need to prove that I'm an amazing therapist to my reflective supervisor…I would feel anxious, going into supervision, initially, but then once I felt like I could trust my supervisor, you know, after like, a couple months or so, when I really [felt] like okay, she's in this, [then I felt] like I'm able to be more vulnerable and share my concerns and share opinions and thoughts…and just be honest with [her]."*

This IMH home visitor has had a different experience and stated that she censors what she

discusses in RS because she doesn't trust her supervisory relationships:

> *"Sometimes some of the stuff that I said [in RS], has popped up other conversations, or people were saying things that I said [in RS], and I don't like that. So there are things that I do not say at my work because I don't trust that whatever I say is gonna to stay in that room. So I…kind of hold back."*

**1.1c The importance of consistency and predictability.** Consistency and predictability

within RS is essential to many of the supervisees in this study. This early intervention home visitor

described how having a consistent schedule contributes to the development of feelings of safety

and trust:

> *"Having a predictable schedule of reflective supervision [is so important]. I know, at 2pm every week…2pm every Wednesday is my time…if I've had a really rough week, that's my*

*time, that's a safe time for me that I know that I can have. So as a supervisee, I'm able to expect that and that's a safe [secure] feeling."*

Similarly, this IMH home visitor identified how important it was for her, after a particularly difficult therapeutic session, to be able to count on the fact that her next reflective supervision was already scheduled. She also connected her experience with that of families, who also benefit from consistency and predictability from their home visitors:

> *"Knowing we'd have our regular day and time that coming Monday felt so comforting because I knew I had a place when ready. In the parallel process that is how families feel when we're not available 24/7 or they're not ready yet, we're coming back, and we're coming back consistently. That alone can be enough fuel to keep going"*

Furthermore, this supervisee stated that when RS is consistent and predictable, they begin to look forward to it, and to appreciate the time to connect with colleagues during their home visiting work, supporting relationship development and team building:

> *"I'm very glad that we have the opportunity to do this regularly and it's something that I do look forward to having every other week. And knowing that I have this time to just like connect with my team and take a little break from…being in homes and just have a couple hours to just sit and eat and talk with my co-workers about, you know, everything that's going on. It really does benefit the work that we do."*

**1.1d Listening without judgment.** Study participants include listening without judgement as an essential component of RS and important to the development of safe and trusting relationships. Many supervisees in this study brought up how important it felt to them to be able to share the range of emotional responses that they have toward the infants and families that they are working with so to better serve them:

> *"For me, reflective supervision is a place where I can be totally honest, I can reveal how something is impacting me, my real initial thought when I experienced something new. The raw, the ugly, the skepticism, and I'm not judged. It's something that we work through so that I get…my subjective perspective out of the way so that I'm [better] able to engage the client."*

This IMH home visitor noted that supervisors who are able to listen without judgement create an environment where the supervisee feels accepted and able to share difficult feelings in ways that allow for exploration and understanding:

> *"So for me, if I feel like the person can explore my feelings with me. And not make me feel less than for those feelings. That's how I start to feel it work. Like, okay, this person understands my position. I'm not saying I'm right or wrong, but they understand what I'm going through so I can get the support that I need."*

Lastly, this participant cautioned that feeling judged in RS could lead to a decrease in sharing of experiences as well as a decrease in reflection about the work:

> *"I think that setting, like, if you're constantly feeling judged, or, you know, like you're being evaluated during your supervision, I don't know that you're going to be very forthcoming or very reflective yourself about how the work is impacting who you are as a clinician, or even in your personal life."*

**1.1e Being present.** Many study participants underscored the importance of being intentional about being present in RS – remaining engaged, actively listening, and providing thoughtful responses based upon the other's perspective:

> *"[A] core component to me [is dedication] to what's happening with the dyad or the group, whatever the setting is. [That is], we're entering together, and we are really intending…intending to do meaningful serve and return…deep listening is happening and deep consideration is happening."*

It is important to realize that, for many study participants, it is difficult to feel safe or develop a trusting relationship if either part of the dyad or group is not present, physically or emotionally. Participants noted that there can be many challenges to being present at any particular moment – challenges for themselves, their supervisor, and their colleagues. This participant who is new to RS and to IMH home visiting, described feeling challenged by being in a group setting and hearing so many difficult family stories:

> *"Sometimes it can be hard to pay attention throughout the whole two hours…especially at the beginning, when the staff person is explaining the situation to [our consultant]…it [is] a lot of details, and it's just easy for me to sort of zone out a little bit (laugh) and lose track*

*of what we're talking about. [I mean] how much can we all hear these terrible stories, you know, and really be able to process much of any of it."*

The following IMH home visitor described a supervisor who wasn't physically or emotionally available during RS. She connected the supervisor's lack of 'being present' with feeling unheard, and then connected that feeling to a negative impact on potential outcomes of RS:

*"She just…wasn't available. When she was available, she wasn't available, meaning that there was [always] a computer between her and I, and her phone was next to her and [with] the computer and the phone, I don't think she ever looked at me, hardly…and I just need to talk to somebody and…know that they're hearing me. But when I sit in [RS] and I'm not being heard - how does that affect my outcomes? Not very good."*

**Other Components Essential to the Experience of RS**

Originally, Aim #1 was focused upon the RS session itself, e.g. what is it the interaction between a supervisor and supervisee makes it reflective? What is unique about this type of supervision? Along with the essential components of RS described above, study participants identified constructs related to the supervisor and supervisee themselves, as well as relational constructs and contextual factors outside of these individual and relationship variables, as important elements in how they engage within RS and its essential components.

**Supervisee, Supervisor, and Relational Constructs**

Things the supervisee and the supervisor bring to the RS relationship were identified as important to consider in terms of how the supervisee experiences RS. Figure 3 below identifies elements of these constructs as they were described by supervisees in this study:

Figure 3

Supervisee, Supervisor, and Relational Constructs

| 1.2 Supervisee Constructs | 1.3 Supervisor Constructs | 1.4 Relational Constructs |
|---|---|---|
| • Expectations of RS & previous experiences of supervision<br>• Understanding of RS & perceptions of value<br>• Perceptions of admin/reflective balance<br>• Perception of supervisee role<br>• Intrinsic qualitites<br>• Experiences of trauma | • Level of experience and skill<br>• Support supervisee's professional development<br>• Asking questions VS giving answers<br>• Reflective capacity<br>• Capacity for perspective taking<br>• Capacity to contain emotions | • Quality of the supervisory relationship<br>• Sharing vulnerability<br>• Mutual Availability |

**1.2 Supervisee constructs.** Supervisees in this study agreed that they had a role to play within the RS relationship. Participants noted that their experiences and relationship histories, their unique personality and temperament, as well as their professional experiences and expectations could impact the RS relationship and experience.

*1.2a Expectations of RS & previous experiences of supervision.* Many supervisees in this study identified that in the beginning of engaging in RS they had no expectation of what it would or should be like. They described not understanding how it would be different from other forms of supervision they had received, such as supervision required to obtain a professional license or administrative supervision and not understanding how it would connect to their work:

*"I really didn't know that I was supposed to be like, sharing and reflecting on like actual families and reflecting on the like, the work I was doing."*

This lack of clarity and understanding about what to expect was uncomfortable for some participants. This Early Head Start (EHS) home visitor acknowledged that the focus on reflection

and emotional response was a new experience and although it wasn't unwelcome, they needed time to feel at ease:

> *"I hadn't experienced it before and when I joined the agency it was part of the process and so it took some getting used to for me…to get to that comfort zone of being able to speak openly and freely."*

Some participants described past experiences of RS and how these can either facilitate or hinder the developing relationship with their new supervisor. The following focus group participant brought with her a level of understanding and confidence in RS that she could draw on as she was developing a relationship with her new supervisor:

> *"I think after having such a good experience with that first supervisor, I then had a buy in when I went to my next supervisor to say, I know this will work, I just have to like, at some point, trust in her and just do this"*

However, the interview participant below offered a slightly different perspective related to expectations. She had recently changed supervisors in her program and brought with her expectations for how RS should be, and indeed was, for her previously. Her feelings of frustration stem from these expectations and her current supervisor's inability to connect with her in the same way:

> *"It's a little frustrating sometimes…when [I'm with] my current supervisor, and sometimes I feel like, I have to tell her…I need you to really try to [help me] figure out what is going on with me [when with a particular family]."*

 ***1.2b Understanding of RS and perception of its value.*** Upon entering into RS, many supervisees in this study talked about needing time to build their understanding and awareness of this type of supervision, such as how this type of supervision supports their work and what is expected of them as a supervisee. These participants described being better able to embrace the concept and explore, discover, and use aspects of RS when they understood its value. They connected their perception of the value of RS to their understanding of it:

*"Now that I've seen the value of it, it's a lot easier to take that step and that leap and go, OK, I can do this and it will be OK."*

*"Now I feel a lot more comfortable and I actually look forward to it…it's just a very…validating and positive experience for me. I feel like I've grown a lot in my understanding of it…which has helped it to be more effective for me, too."*

A focus group participant who was an early childhood educator and had been attending an RS group for six months, felt that she was not given any preparation regarding her participation in RS – she described just being told to go to *"this group."* She helps us understand that when supervisees do not value or understand RS, they are less inclined to embrace and participate in the process:

*"I'm still kind of apprehensive because I don't see the 'quote' benefit of it. We are in a group setting, but it kinda turns into a one-person show and just a banter about the same specifics all the time. Instead of it being used for what I believe it should be used for. So, I'm kinda on the fence with it, I think it's a waste of time."*

**1.2c Perception of administrative/reflective balance.** Many participants in this study had reflective supervisors who also had administrative oversight over their job performance. Some described feeling unsure about sharing vulnerability with their supervisor, yet understood that this is part of the RS process. This participant used humor to describe feeling caught because she's nervous about sharing vulnerability, yet understands RS is time to explore her emotions:

*"I remember now…having that feeling of…being nervous about being vulnerable with my supervisor. And then the realization came to me that…she's also going to be judging me for not being vulnerable (group laughter)."*

However, this participant feels more comfortable with this administrative/reflective role and connected her willingness to share difficult things, such as struggles with paperwork, to the time she has had in RS to build a trusting relationship with her supervisor:

*"I think I've had good experiences because for me, if I don't meet productivity one month, or if I have something that's like super late to be signed, my reflective supervisor is going to know [why I'm struggling]. So, if I'm used to getting this [and] this done and [then]*

*something changes, [my supervisor] knows what's going on for me, because I have built this space with her where I can be honest about those things."*

In contrast, this participant feels they risk being judged if they are honest and share personal experiences or emotions within the workplace. Also, she described being protective about how much personal information she wants to share with the person she views as her boss:

*"I think one of the biggest barriers for me...was knowing that the person giving me RS was also the one that was essentially [evaluating my performance at the agency], so [I struggle with] the idea of wanting to be vulnerable in a session, but also maybe not wanting someone directly supervising me to know too much about me. And how that might then, build their judgments about me, moving forward...this is my boss, how much do I tell the person who is my supervisor, and how much do I hold back?"*

The following quote offers another perspective, which is cautious, yet hopeful, that within the unique RS relationship, the supervisee could begin to feel comfortable sharing difficulties they may be experiencing on the job:

*"Sometimes when maybe I'm behind in something I'm supposed to be doing, [supervision] can't always feel like a safe space...going into supervision, knowing, oh, shoot, I didn't turn that in, or I'm two days late on a due date. But I think it can be an opportunity as well, to build on that relationship with your supervisor...coming in with that open and honest feeling of, hey, I didn't get this done, and this is what I'm dealing with and I feel embarrassed that it's not done and I feel down on myself that it's not done and, or whatever the case may be."*

**1.2d Perception of the supervisee role.** Participants were asked how they viewed the supervisee role in RS. They were open about their responsibility in the RS process and acknowledged that how they are in RS, impacted their experience. This EHS teacher felt that her role was to be supportive to her colleagues and actively listen when they were in a group RS setting:

*"[My role in group is] just listening until you feel that you have something important that you could share to help them...listening goes a long way. [It helps to] know that someone's hearing you, not just the reflective supervisor. Being supportive...so that person [presenting a case] is not feeling helpless and not feeling...judged. Because [we] need that support from everyone."*

The following participant noted that RS is a time to focus on themselves, and therefore they should be active in their role, that is, think about what they would like to present to the supervisor and be aware of what they want from RS:

> *"I started thinking about how do I want to use this time to address my needs…this is what this person's here for…helping myself be more organized going into it, just thinking about…what are some things that have come up concerning my work that I need some perspective on, or that I need to talk about. I think that kind of helped things shift a little bit."*

Many participants in this study stated that supervisees in RS have to be willing to be open and honest with their emotions and responses to the work. This participant concurred and stated that sometimes this work evokes feelings that are related to our past experiences that are important to process:

> *"[We have] to be willing to be open enough…when you're struggling with [a] family, to look at not only what the family's struggling with but what you're personally struggling with. It's about the family or about your role with the family, or things that get stirred up in you from your own past."*

> ***1.2e Intrinsic qualities.*** Often, supervisees in this study mentioned ways that they were different from their colleagues, or reflected upon their level of comfort with vulnerability or sharing emotions. They connected these intrinsic qualities to their engagement in RS. For example, this participant noted that sometimes she may feel cautious or hesitant to share feelings of vulnerability in RS:

> *"You could be at a spot where you were ready to come in and ready to share a lot, but then something happens and maybe you won't. You know, you're just at a point where you're just not feeling it today and just gonna sit back and listen..."*

This participant described having a natural tendency toward being reflective. She felt she was a good fit for RS:

> *"I would say that I've always been on board for something like reflective supervision, I've never been resistant to it as long as I've been pursuing social work."*

On the other hand, these IMH home visitors described initially being resistant to the expectation of vulnerability in RS:

> *"I think part of it was almost like a stubborn reflex of like, this is what you want to happen, this is what reflective...is supposed to be? And I think there was like a really big stubborn part of me that was like, no, nope!"*

> *"I'm sure that my group probably struggled for a while when I first started, because I was so resistant. I'm not going to share my feelings! What are you people doing? I don't share my feelings!"*

**1.2f Experiences of trauma.** In the individual interviews, a few participants wondered about how their own past experiences of trauma and current experiences of vicarious trauma have shaped their experiences of relationships and their work with vulnerable infants and families at risk. This EHS teacher appreciated how her reflective supervisor helped her identify and work through feelings that were evoked related to a childhood trauma:

> *"There have been situations where I was with a child and it [brought up traumatic] memories that I kind of flushed away and don't want to remember. And she helped me work through them, so that I could help the child. And if I didn't have reflective supervision, I probably wouldn't have been able to handle the situation the way I did."*

This participant described RS as important when experiencing vicarious trauma. She notes that RS provides a space to share these difficult situations and emotions:

> *"You know, on a personal level, for my own mental and emotional health outcomes, it's a great release for some of that secondary trauma...that we [experience] in this work. To have that space to...let it out and be contained and held...also helps me be able to better engage in the work because I'm not as bogged down by the hard stuff and the pain."*

**1.3 Supervisor constructs.** Along with their role in RS, supervisees in this study reflected on what the supervisor brings to the RS relationship and how these qualities impact the RS process. The supervisor's level of experience and skill and their support of the supervisee's professional development were important, as was the supervisor's capacity for reflection, for containing emotions, and perspective-taking.

*1.3a Level of experience and skill.*  Study participants appreciated having supervisors who understand the work they are doing and have knowledge about IMH theory and IMH intervention experience:

> *"For me, the essential, personally for me…[is] someone who has done the work so they can relate, they've experienced it, they can, in a way – in their mind's eye – they can visualize what I'm talking about."*

They also want supervisors who are skilled in RS and they want group facilitators to be able to facilitate, hold, and understand group dynamics.  This participant appreciates when her group consultant can help the group move from problem solving to reflecting:

> *"A group situation [can sometimes become] administrative and [focused on] problem solving but [our reflective consultant] does a really nice job of bringing us back to how we can reflect together as a group and how each person's history in the group can contribute in really unique ways and really valuable ways."*

*1.3b Support of professional development of the supervisee.*  Supervisees in this study also appreciated when their supervisor demonstrated trust in their professional judgment and abilities and allowed the supervisee time to discuss their perspective of the work and come to their own answers about how to move forward.  This participant connected essential components of RS, non-judgmental responses and feeling safe, with this role of the supervisor, to listen and help guide her to her own clinical conclusions:

> *"[When a reflective supervisor is non-judgmental] - and it's a safe environment for me to share – [she could] point out some things that she heard me say, and bring a little spotlight on some of the comments I made, so that she can help me to think about [and] clarify some of the things I've said.  By clarifying, it kind of helps me, and gives me direction as to where I want to [go with a family]."*

Furthermore, many supervisees in the study stated that due to the emotional load of this difficult work, they sometimes lose sight of how their work with their clients is helping or supporting the family's goals.  This supervisee stated that RS can be a place where supervisors remind supervisees of the importance of their work and their relationships with their clients:

*"Because our work is so deep…we hold such intangible feelings, thoughts, and experiences from our work, and [they] need to be seen and heard by somebody else who can relate. [We need] to feel validated, that [we're] doing the right thing…and to not second guess yourself and wonder why am I sitting on my hands, I'm not doing anything. [Reflective supervisors] provide validation and to help you to see the benefit you might have for families, when you can't always see it."*

***1.3c Ask questions rather than give answers.*** Supervisees in this study often described times when their reflective supervisors asked important questions that allow them to come to conclusions on their own. They appreciate supervisors who help guide the supervisee, instead of providing them with answers:

*"What she was doing was helping to clarify and helping me to figure out, come back and point out parallels, make connections for me that sometimes I was too in it to understand. And she wouldn't give me the answer. She would just ask the right questions."*

This participant stated that when supervisors take this stance, supervisees are more likely to be able to do the same with the parents they work with. Instead of telling the parents what to do, they are better able to ask reflective questions that allow the parent to feel heard:

*"I think it's helped me to think less about…the problem or the surface level things that are contributing to this issue that they bring up. [Now I am] getting more into their experience of their child or being a parent. It's helped me to ask questions of families that get beyond just the basics and get more into [their emotional experience]. It helps them to feel heard, which makes it easier for them to hear their child."*

However, for this participant who was reflecting on being new to RS and IMH practice, this stance was uncomfortable, as she was looking for more concrete guidance for her new role:

*"It was a little bit uncomfortable to realize that my supervisor was just going to sit there and not necessarily provide the answers, but just kind of help me explore and validate what I was experiencing and all of it was new to me too; my role was new to me and everything. So it was definitely a little bit uncomfortable at first."*

***1.3d Reflective capacity.*** Study participants appreciated reflective supervisors who could wonder about and express their emotional responses, as well as acknowledge times when they

don't know or feel helpless. This focus group participant stated that she feels validated when her supervisor shares her feelings of uncertainty:

> *"It's so helpful for me when [my supervisor says] I don't know either and that's OK (laughs), [I'm reminded that] oh, it's OK to not know. It helps me to be more comfortable in that space of uncertainty. So, [it's] validation of being in an uncomfortable place and [even though] she can't fix it, she gets it."*

This study participant described her supervisor's capacity to regulate her own emotional response in ways that then allow the supervisor to hold and respond to the supervisee's experience:

> *"I think in a reflective supervisor - having someone who knows how to regulate their own system but also be truly present with whatever you're bringing, whether that's avoidance or ambivalence or things like that. I feel like having a nurturing other person to hold the stuff with you, who is also regulated or present and open to repair…that's huge in this work."*

> ***1.3e Capacity to take the perspective of the supervisee.*** For supervisees in this study, their experience in RS was enhanced when their supervisor took time to understand and appreciate the supervisee's perspective of their work with families and their emotional experience. This includes supervisors being curious about the supervisee's experience, withholding judgments, and acknowledging their own bias. This participant acknowledged that she and her supervisor have differences, but clearly felt that her supervisor appreciated her perspective:

> *"I felt like she was on my side…she made a really strong effort to see my perspective and I know that we have at least some differences, just based on how she was raised, and how she lives and so there was potential for that to be difficult. I recognize that it could be difficult for her to see things from my perspective and I respected that she made the effort."*

In contrast, this participant described a time when her supervisor was unable to take her perspective and that this disruption in their relationship impacted her level of engagement in RS in a negative way:

> *"I had a situation where I felt unsafe in the [family's] home. And that wasn't taken seriously. Because for that person [the supervisor], she didn't understand my perspective. So she wasn't able to think past her thoughts about it. And so that shifted for me, my ability*

*to trust and to want to share how I was feeling about being with that family. So not feeling protected will change things [in the supervisory relationship]."*

*1.3f Capacity to contain emotions.* Study participants often brought up the heavy emotional stressors they experience when providing intervention to high risk infants and families. They identified the need for a supervisor who had the capacity to contain this emotional response, so they could share it fully without fear that their supervisor would become overwhelmed. These participants found words to describe their felt experience when with a supervisor who is able to listen without becoming overwhelmed:

> *"She's very calm and neutral and open and genuinely interested in understanding. She didn't overreact or start crying with me, but she had that, you know, crinkle in her brow that says, yeah, I'm with you (laughs)."*

> *"And she just showed that she was available for me, and that she could contain...my experience of her was, she can handle what I have to share, what I have to say, the big feelings I have, like, she could handle all that. And I just felt supported."*

**1.4 Relational constructs.** Supervisees in this study also identified the relationship between themselves and their supervisor as an important variable that impacts their experience of RS. Study participants identified aspects such as (1.4a) the quality of their relationship with their supervisor, (1.4b) sharing vulnerability within their relationship, (1.4c) the availability of both parties to engage in relationship-building, and (1.4d) how disruptions were handled within the relationship as important relational variables that will impact their engagement in RS.

*1.4a The quality of the supervisory relationship.* Supervisees in this study reflected on the quality of their relationship with their supervisor, either individual or group, and identified this as an important part of their willingness to engage in RS. As one focus group participant noted: *"If there's not a established relationship with the person that you having reflective supervision with, you're not gonna accomplish anything."* This participant noted that this relationship develops over time and also connected it to her developing relationship with her client families:

*"So I feel like over time, we developed a relationship, which is very much parallel [to] what happens in the home visiting relationship…with the client…[we are] getting to know each other, getting to see what we have in common, what we don't, assumptions I may make about her, assumptions she may make about me, and coming to some common ground."*

This participant described wanting to feel known and cared about by her reflective supervisor.

She noted that when she feels cared about, she is more willing to be vulnerable:

*"How well does she know me or has she taken the effort, the time to get to know me as an individual? That plays a part in how open I am I think. If I feel like she knows me [and] cares about me, I think I'm more willing to share, go deep, be vulnerable, than if I feel like she just knows me as one of the staff people here, and that's it."*

**1.4b Sharing vulnerability.** Study participants identified how important it feels to them when their supervisor is able to share their feelings of vulnerability – that is, to share their emotional response with the supervisee. This participant described feeling supported at a deeper level when her supervisor shares that they, too, are emotionally affected by the families they are working with:

*"If the reflective supervisor can be comfortable enough with themselves to share some of themselves with their team when it's appropriate, when it makes sense, when it's necessary… it feels (sighs) nice, good…there's something about it that feels like, oh, you're in this too, with us…you have some feelings about this. I do think that when the reflective supervisor shows bits and pieces of how they're also human, and they're affected by the pain of the world, I think that that's powerful."*

This participant added that when supervisors and supervisees commit to this mutual relationship, they learn and grow together:

*"I do think that the commitment to being curious together, to being gentle together, that commitment to what I call serve and return, just knowing that we both will have an opportunity to say, this feels right, or this doesn't feel right…that will be in the spirit of us both learning something."*

**1.4c Availability of the supervisee and supervisor to engage in RS relationship.**

Supervisees in this study acknowledged that they, along with their supervisor, have a responsibility

to be available and open to the development of the RS relationship. This participant highlights this dual responsibility:

> *"I think there has to be an openness from both supervisor and supervisee, that you're both open with one another, and nonjudgmental."*

This participant noted that when one member of the dyad, in this case the supervisor, isn't available, this can be a barrier to the development of the RS relationship, which she compares to an attachment relationship:

> *"I've had it where supervisors, either don't show up physically, or kind of emotionally or mentally. And that makes it really difficult to kind of build that attachment relationship in the way that it's supposed to be."*

Some supervisees in this study talked about being held in mind by their supervisor, that the supervisor's level of availability and presence within their supervisory relationship supported a felt sense of being held and cared about by their supervisor. This participant described how this differentiates RS from other forms of supervision:

> *"It's my supervisor…remembering the stories or the families…when my supervisor remembers where I left off last week, that feels really good…. And just noticing me and how I may be talking about this family in a different way. How I'm not acting like I normally do, or there's something different about the way I'm talking. That's what makes it different than a regular supervisor."*

This participant added that even outside of RS sessions, she feels that her supervisor is with her, and therefore feels less alone in her work:

> *"I think it's probably just feeling held in her mind, that like, even when we're not meeting, like, my work is not just me by myself. [My supervisor] knows when I'm out there, she knows these families that I'm working with. So I think it feels like I'm not so alone."*

***1.4d Relationship disruptions.*** Some study participants brought up times when they experienced disruptions within their supervisory relationships. For example, supervisees talked about conflicts with their supervisor related to clinical assessments of the family, inconsistent availability of the supervisor, and differences in cultural or ethnic values that they did not feel safe

enough to discuss. These disruptions, if not dealt with, could negatively impact their experience in RS. This participant described a difficult experience with her supervisor that was not resolved and therefore she felt unable to use her supervisor in a way that would support her work with families:

> *"I think [after the disruption], part of me closed down…[and then since I no longer had] the emotional space to…be held or explore…[I questioned] my capacity in terms of being able to hold all of this for all of my families…I think if there's repair that comes with that, it's OK because I think we're all humans. But when there's not repair or validation…then it can be really hurtful."*

### 1.5 Contextual factors

Along with these individual and relational constructs, study participants also brought up things that seemed bigger or outside of their direct control. These contextual factors can impact their engagement in RS and the impact of RS on outcomes. Participants described things that can get in the way of the supervisee's understanding of RS, for example, by presenting as barriers to relationship development or access to RS; or they can be facilitators of RS, such as through agency commitment to providing RS to their staff. Figure 4 lists these factors as described by study participants.

Figure 4

Elements of Contextual Factors that Impact the Experience of Reflective Supervision

1.5a. Agency Support of RS
1.5b. Format of RS - Group VS Individual
1.5c. Issues of Diversity
1.5d. Resource Limitations

**1.5a Agency support of RS.** Many study participants praised their agency's commitment to providing RS and supporting its provision based on best practice guidelines. This IMH home

visitor noted that her agency's commitment to providing time and space to engage in RS is essential to her work:

> *"I think what my agency does is prioritize supervision…like we need to meet every week, this is part of doing infant mental health. So I would say…to keep doing that and…[even] with budget worries, to not ever skimp on that or on [reflective] consultation or training. I think [that is] what keeps me here…the trainings and [the time to have RS]."*

This participant used the parallel process to connect agency support to the type of support and intervention they want IMH professionals to provide to families. She contends that agencies need to provide the same to them:

> *"Leadership and administrators or management [should] give to us and model for us…what you want to see us give to families. If you want these outcomes with the families…[then] give us tools, give us resources, give us support…so that we feel it and [then] we can give [it]."*

**1.5b Format of RS – group VS individual.** Supervisees in this study talked about the differences between group and individual RS, which, according to their perspective, can impact their experience of RS. Participants described differences in how their groups are structured or how often they meet for RS. They had different perspectives on their levels of comfort in groups or individual RS relationships. This participant noted that adjusting to group RS has been more difficult due to the decreased amount of time spent in group and the realities of group dynamics:

> *"[With group] the adjustment period I think was a little bit longer, compared to my experience in individual supervision. I think, part of that is probably just, it was less time - it's every other week, not every week [like individual], so it's less face to face time and contact. The other part of it is just getting to know everybody in the group…it is really hard and so I think the relationship building and alliance building took a little bit longer."*

This participant has a slightly different view, as she stated that she feels more comfortable in the group setting:

> *"I just in general feel a lot more comfortable with the group one, because it's not so one-on-one (laughs) and [individual RS] can feel like a little bit of pressure, not in a bad way, but just kind of, I wanna come up with good things to talk about and make it really valuable."*

In contrast, this participant doesn't like the idea of reflecting on her emotional response in a group setting. These differing opinions call to mind a possible connection to the supervisee's intrinsic qualities related to level of comfort with vulnerability:

> "Well, it's a new experience for me, and at first I was not open to even the idea, because it was a group setting, I mean, you know, reflective supervision one on one is totally different than group…it wasn't something I was really open to at first."

**1.5c Issues of diversity.** Some supervisees in this study brought up race and cultural diversity, as well as diversity of perspectives, experiences, and values as important to consider within the RS relationship. Developing safe and trusting relationships with supervisors or colleagues who may be of a different race with diverse perspectives felt challenging to some participants. This study participant described what it is like for her to be the only African American on her team:

> "I'm the only African American on my team. And sometimes that impacts me. Um, sometimes talking about something and there's a shift – no I'm not the spokesperson for the race today, I left that all at home. Sometimes that's uncomfortable."

Furthermore, this participant stressed how important it is for her to be able to discuss issues of diversity and difference within her RS relationship:

> "When I was the only African-American therapist, not that I felt like I had to be the voice for African-American families, but in some ways, you do kind of feel that way…So, just understanding that that might be hard to talk about…or if you have…supervisors of one race and supervisees of other races, [it's important to] talk about things…Whether it's religion, race, or culture, just being able to talk about how that does impact your work. I think it's important [but] you have to feel safe, to be able to say those things."

**1.5d Resource limitations.** Supervisees in this study identified the cost of RS, the demands of their job, and time as issues that have the potential to get in the way of their participation in RS. These realities can also impact how RS is implemented with the agency and how supervisors and supervisees can embrace RS as part of their busy work days. This participant

talked about the time it takes her to drive to her RS group and how this poses a challenge to her

already busy home visiting schedule:

> *"I drive an hour each way [to group RS] and a lot of times on the way home from that…I'm exhausted…[but] I have a home visit on the day that we have reflective…So I am tired…Two hours out of the day and then reflective [group], it's a big chunk of time. Even though I think it is valuable, it is a big chunk of time. It's like that double edged sword."*

This participant added that the cost of RS could be a barrier if her agency did not pay for it:

> *"I'm really grateful that the state requires RS because then our agency pays for it. But if I had to pay for it on my own, that would be a barrier."*

**Summary**

This chapter described results related to the components of RS that supervisees find most

important and meaningful, as well as other variables that have the potential to impact the

supervisee's experience, their willingness to engage in RS, and their capacity to use RS in their

work with infants and families. The next chapter will describe results related to outcomes

supervisees view as impacted by RS.

# CHAPTER SIX - RESULTS – OUTCOMES OF RS

This chapter details the results for Research Aim #2 and #3. The categories, themes, descriptions, and participant data associated with each aim are explained in detail. Research Aim #2 has two main categories, with four themes within the first category and three themes within the second. Research Aim #3 contains five main categories. This chapter also details an additional finding related to a process of understanding RS that supervisees described as being important to their use of RS in their work. This additional finding has three main categories. See Appendix E for a reference list of all final categories, themes, and descriptions.

## Research Aim #2

*"I think of it, it's kind of like, when you're out and working with families it feels like your kind of going into the dark and when you have RS it's like somebody has given you a flashlight. You might not be able to see the whole gigantic picture but you can see enough in your flashlight to know, OK, that's where I'm headed for." – focus group participant*

Research Aim #2: To identify the <u>professional satisfaction outcomes</u> (e.g., job satisfaction, burnout, etc.) of supervisees that are associated with receiving RS. Table 4 lists two categories of professional satisfaction outcomes that were identified through the data analysis: Professional Wellness and Personal Growth.

Table 4

Consensus of Professional Satisfaction Outcomes Among Focus Group and Individual Interview

Participants

| Outcome | Files | References |
|---|---|---|
| 2.1 Professional Wellness | | |
| 2.1a Burnout and vicarious trauma | 14 | 51 |
| 2.1b Employee engagement | 6 | 13 |
| 2.1c Professional development motivation | 7 | 16 |
| 2.1d Professional efficacy | 25 | 83 |
| 2.2 Personal Growth | | |
| 2.2a Empowerment | 16 | 40 |
| 2.2b Emotion regulation | 25 | 73 |
| 2.2c Reflective capacity | 22 | 85 |

"Files" refers to the number of interview or focus group transcripts (n=30) where the particular component was mentioned at least once, and "references" refers to the number of times it was coded across transcripts.

**2.1 Professional Wellness**

Supervisees in this study described RS as a potential buffer for experiences of burnout and the negative impact of the experience of vicarious trauma. They stated that RS can also impact employee engagement, such as job satisfaction, productivity, and retention. Along with these outcomes, participants noted that engaging in RS also supports their ongoing professional development, such as impacting how they view themselves as a professional within the broader IMH field.

**2.1a Burnout and vicarious trauma.** Many study participants described feeling as though participating in RS lifted the burden of difficult, stressful feelings resulting from their work with infants and families who are at high levels of risk. This decreased their feelings of burnout and helped them to deal with challenging situations and ongoing crises. This participant described the emotional support RS provides as a buffer for feelings of burnout:

> *"I think I would have already fallen apart if I didn't have the emotional support that reflective supervision gives. I would be burned out already by now, and so that's what it brings for me [when] I get it regularly."*

This participant described needing a place to bring their emotional responses to the work, so that they can 'leave work at work' and not bring difficult stories or emotions home to their families and friends.

> *"It's burdensome to listen to other people's problems all day long. There is vicarious trauma that goes on. There is a deep sense of wanting what's best for that other individual. And so in order to not internalize everything that we hear from our clients…we need to have a reflective supervisor who will work with us and allow us to leave work at work, otherwise we would burn out."*

Lastly, this early childhood educator pointed out that when she feels less burden and stress, she is able to be fully present for the children in her classroom:

> *"In my classroom I don't feel stressed out, [I mean, I do sometimes], but I don't feel the weight of all these things weighing on me…I feel that [reflective supervision] helps the kids see the best of me."*

**2.1b Employee engagement.** Study participants described what it is like to be an employee of a human service program that primarily serves very high-risk young children and their families. Although the work can feel rewarding, it is also difficult, challenging, and emotionally taxing. This supervisee stated that she believes RS helps her to feel more content and happy with her job:

> *"I believe that if you're happy at your work…if you're happy with what you do, you're going to do a phenomenal job. Cause you like it…and you want to learn and you want to*

*do it the very best that you can. And if you're not happy with it, you will always struggle with making that work. I feel like reflective supervision can help us be more content with our job."*

This participant was honest about how this work can feel very overwhelming at times. She notes

that RS helps her to consistently process her experiences:

*"I think it will come in waves where things feel so overwhelming, like I can't do this anymore. But being able to have that space to process and kind of hold what's been going on…[RS has] been able to…meter things a little bit and make it so I feel able to stick through it and…process the emotions. [I don't feel like] I need to [leave this position and] go into a different role and do something else."*

This participant also noted that when she feels valued in her work, she feels more satisfied with

her job:

*"I think if you're less stressed and you feel like someone is hearing you and listening to you, I think that makes you more likely to feel valued. Which would ultimately make you more satisfied in your work and if you're more satisfied in your work, you would be more likely to stay in that position."*

**2.1c Professional development motivation.** Some participants brought up how engaging

in RS with a supervisor who supports their professional work bolsters their motivation to go further

with their careers. This supervisee stated that she is challenging herself to apply for the MI-AIMH

endorsement:

*"Professionally, it's like pushing me…every week I'm home like, let me get this MI-AIMH stuff uploaded (laughs). But [being in RS] is pushing me professionally, too, just to take that extra step."*

Similarly, this participant is motivated to apply for endorsement at the IMH Mentor level and

believes that RS will help her attain her goals:

*"I want to get to infant mental health level four. I wanted to get my Limited License, and I got that and I wanted to get trained in empirically evidence based intervention, which [I just finished]. I guess my outcome [of RS] was just to be the best that I can be."*

Interestingly, this participant stated that she is going to apply for graduate school after her

reflective supervisor noticed her interests and brought it up as a possibility:

*"I don't really think I would have thought about wanting to do grad school if she didn't bring it up a bunch of times and asked me about it. So I think it's brought up these different career paths that I never really thought about before. And I think that's not something that would necessarily come up with another type of supervision."*

**2.1d Professional efficacy.** Many supervisees in this study described that engaging in RS helped them to feel as if they are "enough" to do the work. That is, through ongoing RS, they gain a professional sense of efficacy; they have confidence that they will be able to be successful in their attempts at intervention. This supervisee stated that engaging in RS that feels positive and supportive has built up her sense of confidence and competence in her ability to do effective work:

*"For me it's built confidence…to hear [my reflective consultant] or a supervisor, even another colleague, you know, appreciate or reflect back to you that you're on the right track or that was a good point, or that was an interesting question. Like validates your professional brain…it just gives you this sense of confidence when you reflect and share with each other that you're on the same page."*

This participant is encouraged in her work when she feels heard and validated by other IMH professionals:

*"I think the opportunity to be heard and to be questioned in a way that's constructive and encouraging [is important]…feeling heard and seen by another professional in your field, that can be a validating experience that can then contribute to feeling like your work matters...and that you're doing your job effectively."*

## 2.2 Personal Growth

As study participants discussed outcomes they believe are connected to their engagement in RS, some of them brought up experiences from their personal lives and reflections on how RS has supported their overall growth as a person. These supervisees described experiencing feelings of empowerment that came from being supported by their reflective supervisors to take risks in their work, as well as an increase in their reflective capacity and their capacity for emotion regulation.

**2.2a Empowerment.** Already discussed was the supervisor stance of asking questions rather than providing answers, thereby allowing supervisees to generate thoughts, insights, and solutions on their own. Some study participants described a resulting feeling of empowerment that connected to other areas of their work and personal life. This participant stated that engaging in RS is about coming to the answers on their own with support, which is a parallel to how they are trying to empower parents in the same way:

> *"There's something empowering about reflecting and then discovering [the answer] on your own…you coming up with [it], versus this supervisor or this expert saying try this, try that…there something that feels very social work-esq. [Just] like empowering the client, the [reflective] supervisor…it feels like they are empowering us."*

Similarly, this participant noted that it is the support of the other person to share in the reflection of their experience that promotes insight and decision-making:

> *"Reflective [supervision] to me feels more like, not so much about, I need you to give me some sort of an answer, [but] actually, it helps me come to more of the answers on my own, because I have that support and that person to just reflect on my experience and the family's experience, rather than tell me, oh, this is what you should do."*

This participant described a time when she felt supported by her reflective supervisor in making a change that she had been debating for a while. The exchange with her supervisor left her feeling confident about her decision:

> *"This feels empowering, this feels doable, why not? I feel proficient at my job now, so I feel like I can take on other things, I feel compelled to.*

**2.2b Emotion regulation.** Study participants described growth in their capacity to regulate their emotions in ways that then allow them to be fully present and available to families who present with a variety of challenging situations. This supervisee described the importance of being regulated and calm when working with high-risk families:

> *"[RS] has me take a step back and take a breath before I go into homes…and think about being present with people and families…because if we're rushing around…and people are in crisis and families are constantly in crisis, it's very difficult to work through and figure*

*out…[but] being in the presence of someone who's calm, I think, helps all of us to regulate."*

In addition, engaging in RS gives the supervisee an experience of being vulnerable with another. This supervisee believes that this vulnerability helps us to grow in our understanding of ourselves and our emotional responses:

*"There's [benefit] in learning about yourself and knowing how you…could react to things because of your own experiences….for my own personal growth…I feel like you learn about yourself…every time you are vulnerable."*

**2.2c Reflective capacity.**  Supervisees in this study often described how RS supported their capacity to reflect upon their own experience and on the experience of the families they are working with.  This participant identified an increase in self-awareness that is related to engaging in RS:

> *"I've learned so much about myself, and about…the strengths that I have, and the things…that are constantly a work in progress for me and, just space to give myself a break…that I don't have to be perfect, and that I can see things as learning opportunities …to think about. [RS has] given me a growth mindset, rather than kind of a fixed mindset."*

Furthermore, this participant noticed that they are now able to delve deeper into their emotional responses to their home visiting work:

> *"[RS has] promoted my reflective capacity…I've noticed that change most when I come back from a visit that's either really tough or really confusing. And I'll have a surface emotion…maybe I'm feeling irritated or maybe I'm feeling really sad. Before reflective supervision I was [not] able to tolerate going beneath that surface emotion, [but now I'm] reflecting a little bit deeper into like, what's driving my feeling of being sad or being irritated. And I have [my supervisor] on my shoulder guiding that."*

### Research Aim #3

*"RS is so I can feel held, so that I can hold these parents or caregivers, so that they can hold their children. And same thing with being consistent and providing emotional support and being heard. And having somebody who actually understands your story. And, you can tell that you messed up that one day. And, you know, then I am able to be that person for somebody else, who's probably never had a person like that before." – interview participant*

Research Aim #3 states: Identify the <u>practice behavior outcomes</u> (e.g. capacity for reflection and insight, implementation of interventions) of supervisees that are associated with receiving RS (see Table 5).  Main themes related to this aim highlighted the capacity for the supervisee to persevere in their work during times that felt challenging, overwhelming, or difficult. They described RS as supporting their capacity to discuss difficult things with families, such as when they needed to call Child Protective Services, or to return to homes when they were struggling to find empathy for or strengths within the family.  They also described RS as supporting their growth as an IMH professional through learning how to be a better observer, engaging in positive working relationships with families, and learning new perspectives or intervention ideas. Furthermore, many of the supervisees were able to directly connect their experiences in RS to experiences they had with the infants and families they work with, providing evidence for their understanding of the parallel process which is important when providing relationship-based interventions to infants and families.

Table 5

Consensus of Practice Behavior Outcomes Among Focus Group and Interview Participants

| Outcomes | Files | References |
|---|---|---|
| 3.1 Infant and Family Engagement | | |
| 3.1a Bringing up difficult things with families | 8 | 13 |
| 3.1b Becoming a better observer | 4 | 7 |
| 3.1c Developing relationships with families | 15 | 36 |
| 3.1d Perspectives and ideas | 25 | 83 |
| 3.1e Re-energizing to keep moving forward | 21 | 59 |

"Files" refers to the number of interview or focus group transcripts (n=30) where the particular component was mentioned at least once, and "references" refers to the number of times it was coded across transcripts.

**3. Infant and Family Engagement**

**3.1a Bringing up difficult things with families.** Some study participants described how RS helps them to find the confidence and words to talk about difficult things with families. When they experience supportive, consistent RS, they are better able to be present, available, and aware of concerns within the family situation. This participant was insightful about her experience when home visits feel chaotic and worrisome. She credited RS with helping her to be confident when addressing concerns:

> *"I think it makes me braver when I go into families and I feel less intimidated and overwhelmed by the chaos…and all the challenges that they are experiencing. And I'm more willing to…join in the process with them, instead of hanging back…and feeling like kind of frozen."*

This participant, however, described feeling hesitant to use feedback obtained in RS to discuss difficult things with families. She worries that the protected space of the RS session doesn't always translate to the often chaotic and crisis-driven experience in the home:

*"[You get] great ideas and great feedback, of course, at the time [in RS]…[but] then we go back to the families [and] it's sometimes a different scenario…when you have that parent in front of you in the middle of a crisis, or just clearly really doesn't want to hear anything that you have to say. So, [about] half the time we can't [use] what we heard or try something new, or suggest something new [that was discussed in RS]"*

**3.1b Becoming a better observer.** A few study participants credited having to think deeply about families and present cases in RS as supporting their growth as an observer of development and relationships. This participant noted that she feels more confident in her capacity to observe and understand family dynamics as a result of RS:

*"I think…I'm more in tune with family dynamics…and I feel like it's sharpened my ability to pick up on those things and observe…it's made me feel more confident."*

Similarly, this participant finds herself noticing things that she may not have noticed before RS:

*"I feel like I'm more observant…and when I notice things, [it] kind of makes me pause, I'm just wondering…if I would have noticed all of those things before [RS]."*

**3.1c Developing relationships with families.** Many supervisees in this study identified the parallel experience of RS and the relationship-based perspective of IMH intervention. The components of RS described thus far, when experienced, can be translated to the home visiting or early childhood classroom situation. This IMH home visitor clearly stated that when she is receiving consistent and predictable RS, she is able to be more consistent with her client families, thus allowing for the development of positive working relationships:

*"And, for me, as far as how RS affects my work with my families, I think…it's just the parallel, when I have a reflective supervisor and team…who is there and consistent and reliable, I am also there and consistent and reliable with my families. And when my supervisor doesn't really care and is not present or they…cancel or forget to show up for our supervision, I am doing the same thing to my families. I notice for me, when I'm not getting consistency, I'm not giving it. You, you have to, you have to get it to give it."*

This participant believes that RS has helped her to think deeply with families about their relationships and offer support that is focused on the family's situation, rather than her perspective or bias. This leads to buy-in and better working relationships. She noted that engaging in

supportive, nurturing, and positive relationships with reflective supervisors can promote the development of similar relationships with parents and families:

> *"I think I'm more thoughtful and less quick to come up with an answer for a family…[instead I view] them as really knowing or trying to figure out what's going on…I think the outcomes are better, because there's more buy in from the families…I think it's building that relationship and that trust…But [RS] helps because I'm able to vent or talk about something that's very frustrating [with my supervisor and not take those feelings into my relationship with the family]. So it translates into…better relationships with [parents]."*

**3.1d Perspectives and ideas.** The majority of study participants identified that engaging in RS with supervisors and colleagues who have done or are currently doing the same work they are doing is an important part of growing their capacity to successfully intervene with infants and families. Many supervisees in this study credit RS with having an opportunity to think deeply with others about a particular family's experience, which can promote better understanding, perspective taking, and identification of potential intervention strategies. This participant appreciated the opportunity to discuss cases and different perspectives:

> *"[RS provides] the opportunity to talk and process what's going on, especially for those more difficult cases and to gain some other perspectives…to just [get] some different ideas or feedback on what you've been doing so far and how you can maybe enhance that. It's nice to be able to throw ideas around and have the opportunity to connect and talk about harder things that you might be struggling with."*

This participant also described the benefit of reflecting with another experienced person, rather than just on their own:

> *"I think it, it's important to have [an] outside perspective on things. Even though your supervisor isn't like necessarily even saying that much or telling you what to do…I think if I'm wondering by myself and questioning by myself, it really doesn't go anywhere. Usually it just kind of keeps spinning around in the same thing…Usually when you say it to somebody else and they reflect it back, then you're usually able to think about things differently."*

This participant agreed that other perspectives can be valuable to their work, however, also noted that sometimes ideas and perspectives from colleagues or supervisors are unhelpful:

*"I think we can be really protective of our families and feel like somebody's assessment of them is really way off...but other times, it's incredibly valuable. They see something that for whatever reason, may be a blind spot we couldn't see."*

**3.1e Re-energizing to keep moving forward.** According to many supervisees in this study, the support they receive in RS is re-energizing and helps to keep them going in their jobs, especially during difficult times, such as when they are struggling to find empathy or hope for a family or when they feel evoked by a particular family member or dyad. This participant uses her group RS to help her to process difficult things so that she feels able to keep going in her work:

> *"So, we can just...take [a] breath [and] process some of these harder things. I always find that it does help kind of re-energize me and [remind me], Ok, yep, I'm doing what I can, I'm doing OK, I just gotta keep going forward. And...it helps make me feel like I have the support I need to do the job. I think the encouragement and...the different ideas gives me the ability to be like, OK, I can do this, keep going, and being, I'm doing something helpful, they're letting me back in their home, so something is happening that's at least helpful."*

Similarly, this participant highlighted the importance of being vulnerable with her group and supervisor, accepting support so that she is able to provide that support to families:

> *"In order to be able to go week after week and still be...that strong person for that family - cause you're the only consistent piece - you have to be able to let your guard down with that group or that supervisor so you can continue. It's like a refill, you have to refill so you keep going, that's what [reflective supervision] is."*

**Additional Findings**

Additional findings identified during data analysis captured three categories that complemented but were not specifically related to the three aims of this study. These categories and their subsequent themes suggest a developmental progression in how supervisees come to understand and use RS in their work (see Figure 5).

Figure 5

Categories of Supervisee Development in Reflective Supervision

| 4.1 Entering into an experience of RS | 4.2 Exploring and Discovering Aspects of RS | 4.3 Integrating and Internalizing RS into how they are |
|---|---|---|
| • Building an awareness of RS<br>• Learning the work AND learning RS<br>• Need concrete guidance<br>• Developing supervisory relationship | • Becoming more intentional about RS<br>• Growth in RS parallels clinical growth<br>• Experience self-discovery<br>• Shift from concrete skills to emotional support | • Are experienced, but still need support<br>• Perception of self as instrument of change<br>• Using RS in work with infants and families |

**4.1 Entering into an experience of RS**

**4.1a Building an awareness of RS.** Many supervisees in this study stated that they didn't understand RS when they were new to RS. They were unsure of the expectation to share their emotional response and they were unsure about their role in RS, as it seemed different from previous experiences of professional supervision. This IMH home visitor highlighted her struggle with RS over the time she had been receiving it:

> *"I struggled with it through the years because I didn't truly understand what reflective [supervision] was."*

This sentiment is repeated throughout many of the individual interviews and focus groups:

> *"I have to say, when I first started in this work…I didn't really understand what it was."*

> *"I had very limited understanding of what it was at the time because my only experience with supervision prior to that had been in an internship setting and it wasn't very structured and it wasn't reflective."*

> *"I think at first, I didn't really understand how…I think in general I'm a pretty reflective person, but I didn't fully understand really, what my role was."*

These quotes are from an early childhood consultant, an IMH home visitor, and a behavioral health clinician and demonstrate a common experience related to the supervisee's understanding of RS and expectations of their role.

**4.1b Learning the work AND learning RS.** Supervisees in this study identified having difficulty balancing expectations for a new job or a new career alongside expectations for RS. Beginning a new job means learning new systems of documentation, meeting new colleagues, and getting to know the culture of the agency. Supervisees described that they wanted to appear competent in their work and they worried that the additional unknown of RS would be a barrier. This IMH home visitor had recently started her first IMH job and expressed worry about how the agency would view her work and her participation in RS:

> *"Will I be accepted by this agency? Will…people see me…[as] a hard worker, and as someone who shows up for families. And just because I don't know a whole lot about, pretty much anything, actually; I don't know much about the community, [I'm new to reflective supervision]…I'm just starting out."*

Similarly, this IMH home visitor reflected on being new to the field of IMH and new to RS. She connected her new experiences in RS to the new relationships she was forming with her client families:

> *"I think at first, I was just like, OK, check this off, get this done and not actually being willing to be vulnerable about what it's like to work with this family, what it was [like]…in these early stages of developing these relationships; because I think that at first I was in the beginnings with all my families. And so it was just all new to me."*

**4.1c Need concrete guidance.** Supervisees identified that early in their experience of RS, they were often focused on what to do with their families and how to approach aspects of their job such as paperwork and access to community resources. This IMH home visitor who had been receiving RS for approximately seven years reflected on what it was like when she was new to the work and needing concrete feedback:

*"I feel like when I was new to the work, I was needing concrete, do this, do that intervention and looking for ways to grow as a professional, an IMH therapist."*

However, she also noted that over the years she has received RS, it was also a place for her to gain specific knowledge about IMH intervention:

*"I feel like I've learned everything about IMH through RS, hearing other people present cases…I feel like that is where I learned the core and continue to learn a lot of things about interventions and strategies and reflection and thinking about families, and relationships and parallels."*

This supervisee noted that when she was new she appreciated RS as a place to receive concrete guidance and scaffolding to assist her in her work:

*"[RS] helped me to figure out what to do…or just assurance that I'm on the right path…just like a lot of confidence building and then also scaffolding or helping figure out what to do next."*

**4.1d Developing supervisory relationships.** Supervisees in this study identified that it was important for them to take the time necessary to develop relationships with their supervisor. Yet, some supervisees noted that when they were new to RS, their relationship with their supervisor was difficult to navigate, especially when they were unsure about their role. This IMH home visitor equated the RS relationship to any new relationship in her life:

*"I feel like it's just like starting any new relationship; it's new, you don't know the person, you're trying to get to know the person…and so part of it is just navigating that early stuff…get to know each other and feel each other out."*

Another IMH home visitor noted that in the beginning of her work when she didn't know her supervisor well and didn't feel connected, she felt protective of her client families and held back information that may have been helpful to share:

*'I think at the beginning, not really knowing your supervisor and if you haven't really connected, you get protective of families and you [do wonder] do I want to share this part of them with [my supervisor] because their story is their story and this is my interpretation of their story."*

**4.2 Exploring and discovering aspects of RS**

**4.2a Becoming more intentional about RS.** Some supervisees talked about using RS in an intentional way, such as being thoughtful about what they wanted to bring to RS and having an understanding of what they wanted to get out of a supervisory session. These descriptions conveyed that the supervisee had an understanding of what they could learn from RS, had a better idea about what they contribute, and thus were intentional in their thinking about what they would like to gain from the experience. This is different from those supervisees who described being unsure about their role and RS' connection to their work. This home visitor described a recent shift in her thinking about her RS sessions, but acknowledged that this shift took time:

> *"Recently, I've been alert and I have been more intentional about what I want to talk about, and having a plan instead of just walking in like, okay, what are we gonna to talk about today...so, I think once I started, you know, asking more questions within the session, that caused more alertness too, [but] I think it took a while, I think it probably took about a year."*

**4.2b Growth in RS parallels clinical growth.** Supervisees in this study identified a parallel between their growth in, or understanding of RS and their growth in their work with families. They were able to see their development and growth in their work, while at the same time they were better able to understand RS and its connection to relationship-based intervention. This supervisee noted that her understanding of RS has grown as she has been doing the work and engaging in RS:

> *"I think it's [understanding of RS] gotten stronger as I've been in the work more. Like the idea that what I'm putting in is determining what get out of it."*

Elaborating on this point, she stated:

> *"Once I got more into the work, it became more real, [our] supervisory relationship - knowing that my supervisor could kind of go there with me. That she would ask questions about my feelings or what the families are going through, and just sitting with some of the harder stuff that I saw. I think it did, it shifted. There's a different level of trust that I think was built after starting to work more closely with families and doing some of that deeper work."*

This supervisee described a deepening over time of her relationship with her supervisor, her engagement in and use of RS, and her relationship-based intervention with families.

**4.2c Experience self-discovery.** Some supervisees in this study described a level of self-awareness and discovery that emerged during their engagement in RS. This self-discovery was often deeply personal and connected to their caregiving histories, such as this supervisee who described how RS helped her to identify and heal from a negative sense of self-worth:

> *"Given my own history, it hasn't always been the case [that I feel] just enough as I am. I think that my individual supervision and my group reflective supervision both have given me this opportunity [to have a] corrective emotional experience, where I've re-learned that I really am enough, just as I am, coming to this work."*

**4.2d Shift from concrete skills to emotional support.** Some supervisees in this study, when reflecting on their early experience of RS, noticed a shift from wanting and needing concrete direction and support, to having a sense of confidence in their jobs, and therefore wanting and needing more emotional support. They noticed a difference in how they approached RS and what they brought to RS. This supervisee noticed that not only did she shift from needing concrete direction to emotional support, but she also noticed that she felt more at ease with bringing difficult experiences to her supervisor:

> *"I think in the past, I put more pressure on myself to be this information gatherer, but I think also in the past, I felt like I needed to have it all together and just know what to do and be seamless. Now I'm more able and willing to be like, ah! this is a mess, I don't even know where to start and being okay with saying that with my supervisor."*

This IMH home visitor noticed a shift in how she was being with families, as well as within her RS. She described this shift as moving from 'doing for' to 'being with':

> *"The 'doing for, being with' which is definitely the shift I felt in myself in supervision, as I've grown into being more comfortable being with families versus 'we got to fix these things that they want fixed', you know. Then when I realized my supervisor wasn't going to just, you know, check things off with me; she was gonna like, make me sit back and think*

*about it, I was like, Oh! So, I think that's also transferred into my work with my families today."*

**4.3 Integrating RS into how they are**

**4.3a Are experienced, but still need support.**  When reflecting on their experiences in RS and working with high risk families, many supervisees in this study talked about how difficult this work is.  They described working with families and in homes that were very challenging to them, emotionally, and clinically.  These experiences sometimes caused them to doubt their capacity to do the job.  Even when they had experience in the work and strong feelings of professional confidence, they worried about their clinical decision-making.  These supervisees acknowledged the support that RS provides as important to their ongoing work in these high-stress jobs.  Again, this level of insight into how RS supports their work, even when they have a good deal of experience and when RS feels difficult and challenging, portrays a level of acceptance and understanding that was not as prominent when supervisees described their early or new experiences in RS.  This IMH home visitor was insightful about her experience and embraced RS as an important support in her capacity to show up for families:

> *"It's a very, very hard, stressful job to do. And you deal with a lot of horrendous things that may have happened to these babies and innocent little children, and you're taking all this in and you're seeing this and week after week. And in order to be able to go week after week and still be that strong person for that family, cause you're their only consistent person, you have to be able to let your guard down with that group or that supervisor so you can continue. You know it's like a refill, you have to refill so you keep going, that's what it is."*

**4.3b Perception of self as instrument of change.**  A small number of supervisees in this study described a view of relationship based work that highlighted a deepening understanding of themselves and the relationship they develop with the family as an essential instrument of change within IMH intervention. This IMH home visitor expressed the belief that supportive relationships matter more than material goods:

*"I feel more confident in knowing that supporting is enough…[not] through tangible items…[or] because I took you to the doctor and I did this or did that. It's because I listened, I showed up, I supported, I normalized for you. Those are the things that matter."*

This IMH home visitor connected her experience with her reflective supervisor with understanding that how you are with families is an important part of the intervention:

*"This is just a really great place where you get to explore your own stuff while you're exploring your family's stuff and someone gets to hold that for you. [They] also help you to understand what you're doing is important, and that you being there [with families] and how you are when you are there, is the most important piece."*

**4.3c Using RS in work with infants and families.** Some supervisees noticed the connection of engaging in RS and how they are with families. They gave specific examples of their work with families and noted how their experiences in RS connected to their understanding of the family and their intervention. These descriptions differed from those that focused on learning the work and concrete needs to those that demonstrated a deeper knowledge and understanding of relationship-based, therapeutic intervention. This IMH home visitor eloquently described how what they receive in RS from their supervisor aids them in providing the same to their clients:

*"What I hope to get out of reflective supervision, I try to give that to my families. So I try to make sure that I'm open to my families, you know, off the top, and that I try to give them a standard time and a location. It's really kind of, like, what I want someone to say to me, is what I try to say to my family. I remind my families, that I'm not there to tell them what to do, and how to do it. But I'm there to support them through what they're going through. And that's how I feel about supervision. Like, it's supposed to be a place of support. I feel like I take my RS essentials with me - that I'm here to support, not to tell you what to do, and how to do it, or to be critical of you, you have enough of those people in your life, you need support, and that's what I'm here for."*

This IMH home visitor described that she came to understand that her capacity to express warmth and delight toward a mother who she viewed as harsh, was developed in part by experiencing the same toward her from her reflective supervisor:

*A family who comes to mind has kind of a harsh, punitive mom who has a really tough history of her own. [After working with her for a while] there was this moment in a home visit where she was able to really hold her baby closer than I've ever seen her hold her baby before. And, I was delighted! I was over the moon and [thought] wow, this is working…she's able to really meet her baby's emotional needs right now. I said something like gosh, you are her favorite person in the whole world. Because the baby was really excited to see her. And then later in the week, I went to supervision and was just like, over the moon about it, and talking to my supervisor about it. And she took a moment where she was like, Wow, you're doing such important work with this family, and they're lucky to have you. And I think it just, it filled me up too, but it also, I'm sure that mom, the feeling that her baby got when she pulled her close and she just looked totally delighted. I'm sure that the mom was feeling something similar. Because before she had kind of dismissed those types of comments. But this time she was like, you know, I am! So I guess in a similar way that I felt like I'm enough, you know, I always have moments where I doubt myself, but through my work with my supervisors, I've kind of felt like, I'm enough. I guess this family is feeling that, too.*

**Summary**

This chapter described results related to how RS impacts professional wellness and personal growth outcomes, as well as practice behaviors when with high-risk infants and families. This chapter also described additional findings detailing categories and themes related to a how, over time, supervisees come to understand and use RS in their work. The next chapter will discuss how the findings from this study were used to develop a theoretical model of RS and how they fit with existing theory and literature related to the experience of RS.

**CHAPTER SEVEN - DISCUSSION**

This dissertation aimed to capture the experience of reflective supervision (RS) from the supervisee's perspective. Supervisees who participated in focus groups and individual interviews described their experience of RS and their views of whether and how RS supported their work with high-risk, vulnerable infants and families. Three primary aims were investigated using qualitative methodology and analyzed using grounded theory analysis. Aim #1 set out to identify the components (inputs) of RS that supervisees found most important and impactful to their work. Several themes emerged from the data that underscored the role of the supervisee and the supervisor, as well as their developing relationship as important to RS. Contextual factors, such as the agency's support of RS were also described by participants as important. Aims #2 and #3 focused on the outcomes (outputs) that supervisees felt were most impacted by RS. Themes related to both professional and personal growth were identified and participants connected these outcomes to their capacity to engage with, assess, and intervene with infants and families. In addition, themes were identified that suggested a developmental progression in how supervisees came to understand and use RS in their work. This chapter will discuss the themes that emerged from the data and present a model of RS that is suggested by an integration of these themes.

### Summary of Key Findings

### Aim #1 - The Supervisee's Experience of RS

As summarized in Figure 6 below, the participants in this study eloquently described the deep and connected ways in which a number of variables influenced their experience of RS and subsequently their work with high-risk infants and families. Each of the five meta-themes will be reviewed and discussed in turn.

Figure 6

Variables that Impact the Supervisee's Experience of Reflective Supervision

| 1.1 Essential components of RS | 1.2 Supervisee Constructs | 1.3 Supervisor Constructs | 1.4 Relational Constructs | 1.5 Contextual Factors |
|---|---|---|---|---|
| • Importance of feeling safe<br>• Importance of trust<br>• Consistency and predictability<br>• Non-judgmental responses<br>• Being present – both supervisor & supervisee | • Expectations of RS & previous experiences of supervision<br>• Understanding of RS & perceptions of value<br>• Perceptions of admin/reflective balance<br>• Perception of supervisee role<br>• Intrinsic qualitites<br>• Experiences of trauma | • Level of experience and skill<br>• Support supervisee's professional development<br>• Asking questions VS giving answers<br>• Reflective capacity<br>• Capacity for perspective taking<br>• Capacity to contain emotions | • Quality of the supervisory relationship<br>• Sharing vulnerability<br>• Availability<br>• Relationship disruptions | • Agency Support of RS<br>• Format of RS - Group VS Individual<br>• Issues of Diversity<br>• Resource Limitations |

**1.1 Essential components of RS.** For the supervisees in this study, feelings of safety and trust within the supervisor-supervisee relationship, consistency and predictability of the supervisory sessions, the non-judgmental responses of the supervisor, and the capacity of both the supervisor and supervisee to be emotionally present during supervision stood out as essential components of RS. For instance, supervisees described that when supervisors honored their perspective without judgment, they set the stage for relationships where supervisees felt valued and accepted. Consequently, they felt comfortable sharing a range of thoughts, feelings, and beliefs in a way that allowed for exploration, understanding, and learning. Further, supervisees described that consistency and predictability within RS supported the development of a foundation for the supervisory relationship; when RS meetings were routinely scheduled and consistent, there were more opportunities for interactions, relationship building, and learning. In contrast, when supervisory sessions were infrequently scheduled or frequently cancelled, the RS relationship did

not have an opportunity to develop in a healthy way and supervisees tended to feel alone in the work.

Interestingly, the essential components of RS that supervisees described as promotive of the development of their professional selves are similar to aspects of the caregiving environment that are promotive of healthy infant development. For instance, infants who feel safe and secure in their relationship with their parent are more confident in the exploration of their environment and are more persistent and open to learning (Sroufe, 2005) than infants who do not feel safe. For infants, these feelings of safety and security develop via moment to moment transactions over time, within the context of the caregiving relationship (Stern, 1985). Thus, infants need caregivers who are emotionally present and sensitive and responsive to their behaviors and experiences in order to learn to organize and regulate their emotions (Cassidy, 2008). Data from the current study suggest that supervisees, too, appear to need sensitive and responsive interactions to thrive within their professional environments. When supervisors are trustworthy, predictable and emotionally available, supervisees feel more confident, secure, and better able to manage emotional responses to their work. Thus, these data support the idea that development at any stage - and within both personal and professional contexts - is dependent on safe and sensitive relationships (see Figure 7).

Figure 7

A Comparison Between Components of Attachment & Supervisee Perspectives of Reflective

Supervision

| Parents who: | Reflective supervision that is: |
|---|---|
| • Are *consistently available to their baby* | • *Consistent and predictable* |
| • Offer *a warm, safe, comfortable relationship* | And supervisors & supervisees who: |
| • Provide *sensitive, contingent, attuned responses* | • *Listen without judgment* |
| | • Are *physically & emotionally available* |
| Support the infant's development of: | Supports the development of supervisory relationships that: |
| • A *safe haven* to refuel and feel safe | • *Feel safe* enough to share difficult experiences |
| • A *secure base* from which to explore the world | • Supervisees can *trust* to support their growth |

Several of the findings from the current study were consistent with prior work investigating the essential components of RS from the supervisor's perspective (Tomlin et al, 2014; Greacen et al., 2018). For example, Greacen et al. (2018) surveyed eight supervisors who were developing and integrating RS for home visitors in a program that provided perinatal support and intervention to families at risk for mental health disorders. Consistent with findings from the current study of supervisees, data analysis from Greacen and colleagues revealed that supervisors in their study felt strongly that the provision of RS should be regular and organized, confidential, private, and uninterrupted. In addition, supervisors described feeling that their own behaviors such as being

fully present and free from distractions were critical to the success of the RS relationship. Furthermore, and consistent with the current findings, supervisors in the Greacen study reported that the development of a safe and secure relationship with the supervisee was core to providing RS.

Similarly, Tomlin et al. (2014) surveyed supervisors who were experienced practitioners of RS in order to identify critical components of RS from the supervisory perspective. Consistent with findings from the current study, supervisors in the Tomlin et al. study described consistency and regularity of RS meetings as central to the success of the RS relationship. Furthermore, participants reported that supervisors who maintained a non-judgmental and reflective stance set the stage for the development of a safe and trusting relationship between themselves and their supervisees.

Importantly, findings across these two prior studies and the current study are consistent with the theoretical and clinical literature where consistency and regularity and maintaining a non-judgmental stance are considered central features of a safe and trusting RS relationship (Fenichel, 1992; Shahmoon-Shanok, 1995; Weatherston et al., 2010; Weigand, 2007). Taken together, these studies provide preliminary empirical evidence in support of the essential components of RS that have been described in the theoretical and clinical literature. Further, the current study provides novel and confirming evidence that strengthens the results of prior work with supervisors by adding the supervisee's support of these critical components.

**1.2 Supervisee constructs.** Supervisees in the current study described that their own expectations of RS and previous experiences with supervision, their understanding of RS and perceptions of its value, as well as their perceptions of whether or not a supervisor could effectively maintain both administrative and reflective roles, played a significant role in their experience of

RS. In addition, supervisees in this study connected their intrinsic qualities, such as their level of comfort with vulnerability, and their own histories of trauma, to their engagement in RS.

Themes emerged from the data that described the supervisee's expectations and perceptions of RS that were informed by their prior experiences with clinical supervision (one supervisee called this the *ghosts of supervision*) as impactful on their current expectations of and experiences within RS. For example, supervisees who experienced a previous supervision that was warm, accepting, and helpful described being more willing to be vulnerable with a new supervisor compared with supervisees whose prior supervision was inconsistent, judgmental, and unhelpful. Further, some supervisees described having no understanding of RS whatsoever and equated RS with general views of supervision that characterize it as a place where they are told what to do and how to do it. These supervisees felt unsure about what was expected of them in RS and therefore were hesitant to engage in it. Data from this study, therefore, suggest that it may be important to provide supervisees with information to help them to understand RS prior to their first RS meeting. Furthermore, these data suggest that allowing time for supervisees to reflect on their previous experiences with RS and discuss their expectations and understanding of RS as they enter into new supervisory relationships may help them better acclimate to the unique aspects of RS.

The current study also found that supervisees described different views regarding whether they could feel safe enough to express their vulnerabilities and worries when the reflective supervisor was also the administrative supervisor (e.g., evaluated their job performance and maintained administrative oversight of their work). Further, some supervisees expressed doubt about the capacity of reflective supervisors to truly implement the essential components of RS when they also maintained administrative duties within the agency or program. Thus, supervisees

expressed hesitation about sharing their authentic concerns in supervision and doubts about the ability of supervisors to reliably hear and respond to those concerns when their role included administrative oversight. These findings highlight a debated topic within the IMH field (N. Paradis, personal communication, June 20, 2018): the question of whether or not a reflective supervisor can have administrative oversight over their supervisee and still be effective or whether this sets up a power structure that can cloud the development of safety and trust within the RS relationship (Bertacchi & Gilkerson, 2009). Some supervisees in this study described the dual role of the supervisor as actually being a benefit to their job performance, while others found this to be inhibitive of their full experience in RS. Supervisees who were uncomfortable with the dual role described feeling that the resultant hierarchical structure impeded their ability to feel comfortable sharing vulnerable feelings in supervision. In fact, the existence of a hierarchical structure in RS is in contrast to recommendations within the clinical and theoretical literature that the RS relationship should be collaborative and egalitarian (Fenichel, 1992; Shahmoon-Shanok, 2009; Shahmoon-Shanok et al., 1995). In addition to their own feelings of safety within the supervisory space, supervisees in this study described supervisors who were skilled at balancing these dual roles, as well as supervisors who had difficulty maintaining this balance. In the latter case, supervisors either focused mainly on administrative requirements, or conversely, concentrated only on aspects of reflection and emotional response in a way that neglected the supervisee's understanding of documentation or administrative requirements. Given these mixed results, future research is called for that targets this issue specifically, especially as federally funded home visiting programs are increasingly training administrative supervisors to also provide RS (Beam et al., 2010; Low et al., 2018).

Supervisees in this study also identified that their own intrinsic qualities, such as their level of comfort with being vulnerable and their own histories of trauma, were influential to the RS experience. For example, many participants described their level of comfort with vulnerability as a key element in the establishment and maintenance of the RS relationship. Specifically, participants described differences in the ease with which they were able to demonstrate feelings of vulnerability with their supervisors. For instance, some supervisees seemed to be cautious or hesitant to share difficult feelings, especially within a professional environment, whereas others were resistant and even stated they were *stubborn* when it came to sharing feelings of vulnerability with supervisors and colleagues, believing that the work environment was not the place for such emotions. Still others seemed comfortable and even nonchalant about sharing difficult emotions with colleagues and supervisors. These individual differences are important to consider, as the clinical literature argues that the degree to which a supervisee is willing to be open and authentic shapes the RS relationship in fundamental ways (Emde, 2009; Fenichel, 1992; O'Rourke, 2011; Watson, Harrison, et al., 2016). Specifically, this literature has argued that in order for IMH professionals to better understand their own responses and the emotions that are evoked when they are with infants and families, it is important that they feel comfortable sharing these experiences with their supervisor. If supervisees feel cautious or resistant to sharing their observations or emotional responses to the work with their supervisor, it may be difficult to use RS as an opportunity to learn through reflection. Further, some supervisees identified their own trauma histories as influencing the RS relationship. Given the dysregulating effects of trauma and the impact on an individual's feelings of trust within relationships, the experience of past trauma may influence and interact with a supervisee's ability and propensity to express vulnerability within RS. Future research is needed to test whether this is the case.

Finally, findings from this study extend prior research with supervisors in important ways and offer potential explanations regarding the ways in which the essential components of RS play out within the supervisory relationship. In research conducted by Tomlin et al. (2014), for example, the investigators found that reflective supervisors identified several characteristics of the supervisee that they felt were important elements at play within the RS relationship. These included the supervisee's ability to maintain a nondefensive stance when asking for help, their capacity to be open to suggestions and input from their supervisors, and their willingness to try out new clinical strategies recommended by their supervisors. Importantly, themes emerged from the current study that may account for a supervisee's ability, or inability, to engage in these RS tasks. That is, supervisee characteristics identified by participants in the Tomlin et al. study may be dependent on the constructs that supervisees identified in the current study as influential. For example, the ability of a supervisee to ask for help from their supervisor may be predicated on their feelings of safety within the relationship. Similarly, if a supervisee doesn't value or understand how RS fits with the work they do with infants and families, they may not be open to suggestions from the supervisor. Further, when supervisees have previous negative experiences of RS, they may not be willing to take risks and try new things within the new RS relationship. In these ways, the essential components of RS that were identified by supervisees in the current study may actually affect the constructs that supervisors have identified as critical to the RS relationship. Future work is needed to test these hypotheses but the current findings offer a novel view of understanding the conditions that may be necessary for RS to be fully embraced, understood and used by supervisees to enhance their work with vulnerable families.

Taken together, these findings shed light on the supervisee's co-creation of the RS relationship and highlight their active and impactful role in the RS process. Rather than being

receivers of information from the supervisor, supervisees in this study were clear that their expectations and previous experiences of supervision, their understanding of RS and their perspective of the dual administrative/reflective role influenced whether and the degree to which they were able to authentically enter into a meaningful RS relationship.

**1.3 Supervisor constructs.**  Themes that emerged in this study related to supervisee's views of the supervisor's contribution to the RS relationship included their level of experience and skill in providing IMH intervention and their skill in asking careful, thoughtful questions that help the supervisee come to their own conclusions about their work.  In addition, themes related to the supervisor's reflective capacity, their ability to take the perspective of the supervisee, and their capacity to contain emotions were described by participants as connected to the RS experience.

Supervisees in this study appreciated supervisors who were experienced in IMH intervention.  In the same way that the infant needs an attachment figure that is "bigger, stronger, and wiser" (Marvin et al., 2002; Powell et al., 2013), themes that emerged from these data suggest that supervisees benefit from a supervisor who has been trained in IMH intervention and has experience doing the same work they are doing with families.  In this way, the supervisor has a sense of the environment the supervisee is working in, and has experienced similar challenges.  This finding is consistent with the views of supervisors reported by Greacen et al. (2017) and Tomlin et al. (2014).  Both of these previous studies found that supervisors believe experience providing direct services to infants and families from similar populations is an important component of providing RS.

In addition, supervisees appreciated supervisors who guided the supervisee in coming to their own decisions, rather than simply telling the supervisee what to do.  This finding is consistent with learning and apprenticeship theory that suggests the student/learner benefits when the teacher

scaffolds their learning by allowing the student/learner to take over the work, but remaining close by to offer help when needed (Collins et al., 1991). Scaffolding is a concept that refers to helping another person learn by supporting their current developmental capacities and challenging them in ways that promote deeper thinking and problem solving (Vygotsky, 1978). For example, supervisees in this study appreciated supervisors who asked thoughtful, reflective questions that helped them come up with conclusions on their own, rather than simply providing them with the answers. This theme, identified here with a supervisee sample, was found empirically in the Tomlin et al. (2014) study with supervisors, and is also identified throughout the clinical RS literature. That is, supervisees are hypothesized to benefit most when supervisors engage in exploration, curiosity, and a 'not-knowing' perspective versus giving of advice and sharing expertise (see Fenichel, 1992; Heffron & Murch, 2010; Siegel & Shahmoon-Shanok, 2010; Weigand, 2007). This finding is also parallel to a caregiving environment that supports the infant's growth and development through scaffolding and support of their exploratory behaviors (Marvin et al., 2002). In infancy, parental scaffolding behaviors include remaining present and providing a balance of support and challenge that is based on the infant's developmental capacity (Bigelow et al., 2010). Allowing the infant to experience developmental challenges balanced with encouragement and support has been found to increase the infant's level of persistence and engagement, resulting in high levels of play and learning (Bigelow et al., 2010). The themes that emerged from the current study suggest, then, that when a sensitive supervisor carefully listens to the supervisee's experience and adapts his or her responses to the supervisee's capacities and needs, rather than offering answers or advice, supervisees may experience increased levels of efficacy and confidence, and will presumably grow in their clinical and practice capacity.

Moreover, this study found that the supervisor's reflective capacity, including their capacity for perspective-taking and containing emotions was important to supervisees and connected to their experience of RS. Interestingly, these qualities are also important concepts in the development of reflection and reflective functioning (Fonagy et al., 2002). Capacities for reflection are developed in infancy, and early relationships are essential in this development. Parental reflective functioning (Slade, 2002) has been found to be important in responding to and helping infants learn about their own emotions. Important aspects of parental reflective functioning include the capacity to take their child's perspective and see things from their child's point of view and the capacity to engage with the child in an emotional way without becoming overwhelmed or withdrawn (Slade, 2002/2005). The supervisor constructs identified by supervisees in this study parallel these aspects of parental reflective functioning: 1) the capacity to take the supervisee's perspective and see things from the supervisee's point of view; and 2) the capacity to aid the supervisee in identifying and regulating emotions that are evoked by this work without becoming overwhelmed themselves. These data highlight aspects of *supervisor reflective functioning* that are important to support the development of the supervisee's own reflective capacity related to their work with infants and parents.

In summary, themes that emerged from supervisees suggest that when supervisors are experienced in IMH intervention, can skillfully scaffold learning rather than provide answers or advice, are reflective, can regulate their own emotional response, take the perspective of the supervisee, and contain the supervisee's emotions, they offer an environment for the supervisee to explore their response to the work and develop a professional sense of self. These findings suggest that several aspects of the reflective supervisor-supervisee relationship parallel models of teaching and learning that highlight the supervisor/teacher role as supporting and guiding rather than telling

and doing. Further, these findings also parallel parenting strategies that stress the importance of understanding the perspective of the child and containing their emotions as they engage in challenging developmental tasks.

      **1.4 Relational constructs.** Themes emerged from the data to suggest that it is important to consider constructs that focus on the relationship between the supervisor and supervisee when describing the experience of RS. Considerations of the quality of the relationship, the importance of shared vulnerability, mutual availability, and whether and how disruptions within the RS relationship were handled were identified as themes within the data. The theme identified by supervisees regarding the shared feelings of vulnerability by both themselves and their supervisor is consistent with the clinical literature describing the RS relationship (see Many, Kronenberg, & Dickson, 2016; Shahmoon-Shanok, 1992; Siegel & Shahmoon-Shanok, 2010; Weigand, 2007). Supervisees benefit from being a witness to the supervisor's willingness to share their own feelings of vulnerability, as this can be a demonstration of being vulnerable with another. In addition, it also deepens the supervisor-supervisee relationship in a way that can be profoundly impactful to the supervisee, in that their supervisor (one that holds a position of power) is willing to share their own vulnerabilities and reactions to this work. One supervisee in this study described this as the supervisor being willing to share their *human-ness* with the supervisee.

      In addition, data from this study suggest that it is important to acknowledge and work through any disruptions that may arise within the supervisor-supervisee relationship. This theme is consistent with constructs that are important within the IMH professional-parent relationship (Lieberman & Van Horn, 2008; Many et al., 2016; Proulx, 2002), as well as within the parent-infant relationship (Marvin et al., 2002; Muzik et al., 2015). That is, disruptions in these relationship structures are common and through the identification and resolution of these

disruptions, the individuals deepen their experience of the relationship and each other. In the ability to repair a disruption, the supervisor and supervisee demonstrate their secure and trusting relationship, as they are able to hold difficult feelings about and toward each other, while also being committed to maintaining the relationship (Marvin et al., 2002). In contrast, if a disruption occurs within any of these relationships and there is no attempt or capacity to repair this disruption, this may impede their ongoing relationship. In RS, this could impact the supervisee's ongoing learning and potential to use RS in their work.

**1.5 Contextual factors.** In addition to interpersonal considerations, this study found that supervisees were impacted by the context within which they were practicing IMH. They identified contextual factors such as their agency's commitment to RS, the format of RS offered, issues of diversity within RS, and the realities of their work with high-risk infants and families. For example, regarding the format of RS offered, in Michigan, professionals who provide home-based intervention with at-risk infants and families through the community mental health system have to obtain endorsement through the Michigan Association for Infant Mental Health (Michigan Association for Infant Mental Health, 2014). This endorsement requires a number of RS hours with specialists or mentors who are also endorsed. Because of this mandate, programs across the state implement RS for their IMH staff. However, the format of this implementation may vary; one program may offer monthly groups to their staff by hiring an outside consultant, but not offer individual RS by a supervisor who is on staff and available on a daily basis. Conversely, another program may offer monthly groups with a consultant, as well as hire supervisors who have the training and endorsement to provide weekly individual RS. IMH professionals at these programs will differ, then, in their level of access to RS. This is important to consider, as some supervisees described feeling more comfortable sharing in an individual setting, rather than in a group. Further,

some supervisees described meeting weekly with their individual supervisor and felt that these more frequent meetings promoted their understanding of RS. Thus, the format of RS offered to supervisees is not always of their choosing yet can impact their experience. These data suggest, then, that it may be important for agencies and programs to consider the supervisee's perspective when making decisions about how to offer RS to their staff.

In addition, supervisees in this study described potential barriers to RS that were connected to concrete but important realities of their work with infants and families. For instance, many home visitors in this study talked about meeting with families in the community or in their homes and having to drive back to the office to meet with their supervisors. Depending upon the geographical area, this could mean an additional 2-3 hours of driving in the middle of their busy day. Additionally, there is an increasing amount of paperwork that home visitors, social workers, and early childhood educators are being asked to complete (Beddoe, 2010; Kadushin & Harkness, 2014). Some supervisees in this study described paperwork as a reality of their work that can easily become overwhelming when trying to balance urgent client family needs and documentation demands. In the face of these realities, some supervisees stated that at times RS feels like a luxury that is easily pushed aside when they are feeling pressure to complete required paperwork. These paperwork requirements are demands that they lack control over, and can potentially impact how they are able to embrace RS and commit to the time it may take to develop safe and trusting relationships with their supervisors.

Along with interpersonal constructs, these data suggest that the supervisee's experience of RS may also be impacted by contextual factors, such as their agency's level of support for RS or the format of RS that is provided. In addition, data suggest that we should consider the difficult realities of the work that supervisees do, often in communities and homes with infants and families

experiencing high levels of risk and urgent needs.  IMH professionals may not commit to RS if they feel overwhelmed by the demands of their job.  One supervisee called this a *double-edged sword;* that is, she knew that RS was good for her clinical practice, however, she often felt pressured to reschedule or cancel supervisory meetings to address agency demands.

**A Model of RS – Variables that Impact the Supervisee's experience of RS**

Findings from Aim #1 of this study suggest that the development of the supervisory relationship and the supervisee's experience of RS is the culmination of a complex interplay between the identified constructs.  Taken together, these findings suggest an ecological model of supervisee experience of RS. (see Figure 8).  Using an ecological structure to organize the themes that emerged from this data provide structure to the RS experience.  This organizing model can be used to describe RS to new supervisees, new supervisors, and agency leadership; all of whom may be unfamiliar with these relationship-based concepts within a supervisory structure.

Figure 8

An Ecological Model of Reflective Supervision
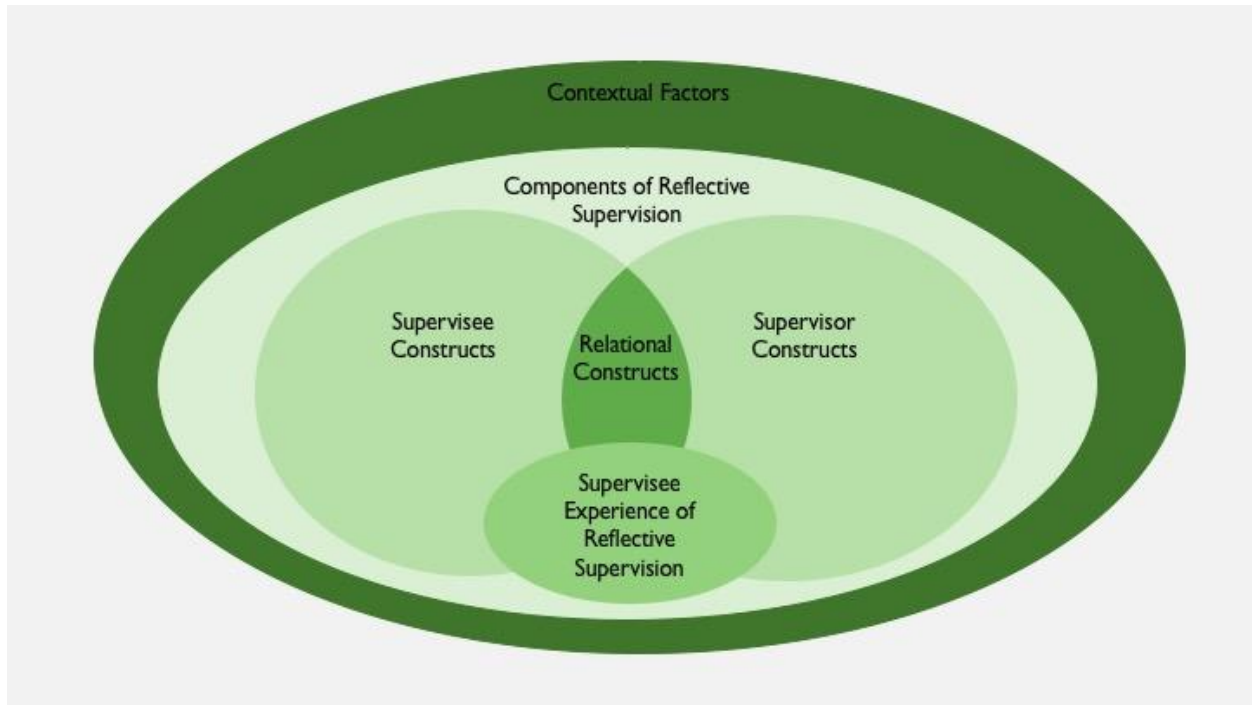


## Aim #2 – Professional Outcomes

As summarized in Figure 9 below, the participants in this study described several outcomes that they felt were impacted as a result of their engagement in RS. Data suggested that RS has the potential to impact professional outcomes, which were grouped under two themes: professional wellness and personal growth. Including personal growth outcomes within this aim reflects the clinical belief within IMH and social work that it is difficult to separate personal experiences from their professional role (Bernstein et al., 2013), and in fact, IMH professionals are supported, through RS, to reflect upon how the work connects to their personal experiences (Schafer, 2007; O'Rourke, 2011). That is, professionals who work in relationship-based ways with their clients offer themselves to the work and enter into relationships that impact them in deep, personal ways

(Siegel & Shahmoon-Shanok, 2010). Therefore, it is fitting that data from this study emerged that identified RS as impactful to both professional and personal growth.

Figure 9

Professional Satisfaction Outcomes from the Supervisee Perspective

| 2.1 Professional Wellness Outcomes | 2.2 Personal Growth Outcomes |
|---|---|
| • Burnout & vicarious trauma<br>• Employee engagement<br>• Professional development motivation<br>• Professional efficacy | • Empowerment<br>• Emotion regulation<br>• Reflective capacity |

**2.1 Professional wellness.** Supervisees in this study described aspects of professional wellness (or a lack thereof) that included experiences of burnout and vicarious trauma and practicalities of employee engagement such as job satisfaction, retention, and productivity. In addition, supervisees described how RS supported their professional growth and their motivation to continue their professional development, as well as the development of their feelings of professional efficacy.

Feelings of burnout and the impact of vicarious trauma was one theme related to professional outcomes that emerged from the data. Supervisees in this study connected lower levels of burnout and vicarious trauma to positive RS experiences. Experiences of burnout have been investigated extensively throughout the social work literature (Ben-Porat & Itzhaky, 2015; Travis, Lizano, & Mor Barak, 2015; Wagaman, Geiger, Shockley, & Segal, 2015), as social workers are viewed as being at high risk due to the nature of their jobs. In their study of child welfare workers, for example, Travis et al. (2015) found that work-family conflict, role ambiguity,

and role conflict impacted the rate of staff turnover in social work positions indirectly through feelings of burnout, which was measured by level of emotional exhaustion and depersonalization. Burnout has also been investigated as an outcome measure within the limited empirical RS literature. Watson, Bailey, et al. (2016) investigated the impact of RS on levels of burnout within a sample of early intervention professionals who received RS over the course of 18 months. The authors found no difference between pre and posttest for levels of burnout related to depersonalization and personal accomplishment. However, they did find that levels of emotional exhaustion *increased* over the course of RS. Similarly, using the same measure in sample of public child welfare workers, Boyas and Wind (2010) found that emotional exhaustion was significantly *higher* for those who received increased supervisory support. Results from the current study could provide an explanation for the seemingly counterintuitive results reported in these studies. In the Watson, Bailey, et al. study, participants reported viewing RS as having a positive impact on their work, yet also reported higher rates of emotional exhaustion. Supervisees in the current study have helped us to understand that as they engage in RS over time, they are better able to identify and acknowledge their emotional responses to the work and when they perceive RS as supportive, they can be fully honest about the challenges and difficulties that the work entails. It may be, therefore, that the supervisees in the prior studies felt safer and more confident in their work as a result of RS and were better able to articulate and answer honestly questions about their level of emotional exhaustion.

Data from the current study also suggest that characteristics related to employee engagement, such as job satisfaction are also impacted by RS. This finding is consistent with Frosch et al. (2018), who investigated levels of job satisfaction among early childhood interventionists who received RS over the course of 9 months. The authors found that participants

reported a positive impact of RS on their overall job satisfaction, as well as their capacity to cope with job stress.  Although no study to date has studied the influence of RS on professional motivation, Frosch and colleagues did find that 79% of the participants in their study reported that RS contributed positively to their overall commitment to IMH.

Lastly, these data suggest that RS promotes the supervisee's sense of professional efficacy. Many supervisees in this study noted that RS helped them to feel more confident in their capacity to intervene with families, to grow and develop in their work, and to move forward in their careers. Shea, Goldberg, & Weatherston (2016) investigated self-efficacy as it related to RS using their *Reflective Supervision Self-Efficacy Survey for Supervisees* (RSSESS; Shea et al., 2012).  This tool was also used by Frosch et al. (2018).  In both the Shea et al. and Frosch et al. studies, IMH professionals reported higher levels of self-efficacy after receiving supervision over the course of approximately 9 months.  Supervisees in this study described feelings of efficacy related to their work and the importance of feeling confident and competent when working with high-risk families. Themes that emerged from the current data are consistent with theoretical views of how self-efficacy promotes confidence and developmental growth.  Self-efficacy is the belief in our capacity to assert control over, impact, or change events that affect our lives (Bandura, 1992/1993). If we believe in our capacity to master a skill, we will engage in behaviors that promote that mastery.  Conversely, if we have a wish or a hope to attain a certain goal, a low sense of self-efficacy can negatively influence our attempts at reaching that goal.  A low sense of self-efficacy has been found to influence feelings of depression, anxiety, and feelings of helplessness (Schwarzer, 1992).

Self-efficacy has been investigated as it relates to being a student (Fortune, Lee, & Cavazos, 2005; Holden, Meenaghan, Anastas, & Metrey, 2002); being a parent (Conti, 2015; Gross

& Marcussen, 2017; Izzo, Weiss, Shanahan, & Rodriguez-Brown, 2000; Leerkes & Burney, 2007); and within professional environments (Ellett, Ellis, & Westbrook, 2007). Professional self-efficacy is important for professionals who work in the most vulnerable and high risk environments, like social workers and IMH professionals. Having a positive sense of self-efficacy is important to moderate feelings of helplessness and hopelessness that can often arise when working with disenfranchised and isolated populations (Harden, 2010; Harden et al., 2010). Also, levels self-efficacy can impact cognitive processes, such as complex learning and decision-making; motivational processes, such as how we interpret and deal with failures; and affective processes, such as how we cope with anxiety and stress (Bandura, 1992). For example, individuals with higher levels of self-efficacy tend to set higher goals for themselves and stay committed to them, even in the midst of challenge and failure (Bandura, 1993). These capacities are important in the work of IMH professionals, who are often expected to make quick decisions when working with a family in their home; who may experience failures connecting with a family; or who may feel high levels of stress in their jobs. Further exploring professional efficacy as it relates to IMH intervention and RS is an important area for future research.

**2.2 Personal growth outcomes.** Data also suggest that RS can support supervisees in their overall personal growth, specifically when their RS is perceived as valuable and helpful. Themes that emerged from this study related to personal growth included feelings of empowerment in their work, increased capacity to regulate their emotions, and an increase in their overall reflective capacity.

The theme that emerged in this study related to empowerment has not yet been investigated within the empirical literature related to RS. However, this theme is consistent with theories related to empowerment within social work practice (Gutierrez, Parsons, & Cox, 1998).

Empowerment is an important part of the social work field, as social workers advocate for and engage in interactions that promote empowerment within their clients. Theories related to empowerment in social work also stress that professionals themselves benefit from feeling empowered and that this sense of empowerment connects with aspects of self-care, which can be a buffer for feelings of burnout and high staff turnover (Lee & Miller, 2013). Based on data from this study, professional feelings of empowerment may be important to study in future research investigating RS.

In addition, themes emerged from this study related to the influence of RS on supervisees capacity to regulate their emotions and their overall reflective capacity. Supervisees connected an increasing capacity to regulate their emotions during stressful interactions with clients with their experiences in RS. Supervisees connected experiences in RS such as the opportunity to slow down and think deeply to their capacity to do the same when working with families. Similarly, supervisees described how RS supported their capacity to reflect upon their own experiences and emotional responses to their work. Through this reflection with their supervisor, they were able to become more aware of their responses and then use this awareness in their work. This use of self within relationship-based work is important as it has the potential to inform their understanding of the family and can help to guide them in their intervention (Heffron et al., 2005). In these ways, themes that emerged from this study are consistent with Schön's (1983) theory of the development of the reflective practitioner. That is, through increased emotional regulation and reflective capacity as a result of RS, the supervisee is shifting from a reflection-on-action focus to a reflection-in-action focus. This shift allows the supervisee to observe themselves and consider their experience while at the same time attending to the perspective and experience of the other, as well as their interactions (Heffron et al, 2005). In addition, the theme related to reflective

capacity is consistent with Shea et al.'s (2016) study with IMH specialists and supervisors who participated in an 8 session training program. The authors reported that from pretest to posttest, supervisees increased their use of reflective practice skills both in RS and in their work with families.

**Aim #3 – Practice Behavior Outcomes**

Lastly, summarized in Figure 10 below, the participants in this study described their perspectives of practice behavior outcomes that were impacted as a result of their engagement in RS. Data suggest that RS has the potential to impact these outcomes, which were grouped under one main theme: infant and family engagement.

Figure 10

Practice Behavior Outcomes from the Supervisee Perspective

**3.1 Infant and Family Engagement**

- Bringing up difficult things with families
- Becoming a better observer
- Developing relationships with families
- Perspectives & ideas
- Re-energizing to keep moving forward

Data suggest that RS supports the supervisee's capacity to bring up difficult situations and concerns with the families they are working with. They also described that the focus on infant and family content within RS helped them to become better observers of development, relationships, and family dynamics and supported their developing relationship with families. In addition, many supervisees in this sample stated that participating in RS, either group or individual, provided them

with multiple perspectives and ideas that helped them in their understanding of the infants and families they were working with. They also noted that having the opportunity and time to think deeply about these families helped them to shift and change their perspectives related to this high-risk population. Supervisees also described RS as helping them to feel re-energized in their work, which they described as feeling overwhelming and burdensome at times.

These data coincide with practice behaviors that have been identified as important throughout the RS clinical and theoretical literature (Fenichel, 1994; Shahmoon-Shanok et al., 1995; Shahmoon-Shanok et al., 2005; Weatherston, 2013; Weatherston et al., 2009; Weatherston & Paradis, 2011). That is, IMH health interventions are delivered within the relationship built between the professional and the parent, therefore this therapeutic relationship is essential to their implementation (Weatherston, 2000/2007/2010). Also, the capacity for observation has been put forth as one of the most essential skills of an IMH professional as well as within social work practice (Briggs, 1999; Burgess, 2005; Michigan Association for Infant Mental Health [MI-AIMH], 2014; Weatherston, 2000b/2005; Weatherston & Tableman, 2015). These practice behaviors coincide with the behaviors IMH professionals aim to support in parents who engage in IMH interventions. For example, IMH professionals support parents to become better observers of their babies so that they can better respond to their baby's needs (Weatherston, 2000b; Wightman & Weatherston, 2004). In addition, some IMH interventions are designed to strengthen the parent's reflective functioning (Roosa Ordway, McMahon, De Las Heras Kuhn, & Suchman, 2018; Slade et al., 2005; Suchman et al., 2010) so that they are better able to understand and take the perspective of their baby, responding to the needs of their infant instead of their own needs or desires. Furthermore, IMH interventions were developed to support parents and infants in their development of safe, trusting, and responsive relationships, that in turn add joy, warmth, and love

to their lives (Weatherston, 2007). Interestingly, supervisees in this study identified outcomes for themselves that mirror those they aim to support in their work with parents and families.

The data also suggest that these practice behaviors are connected to the professional wellness and personal outcomes described above. For example, data suggest that when supervisees feel confident and capable in their work, they may be better able to discuss clinical concerns with families, such as calling Child Protective Services, or confronting parents when they are engaging in high-risk behaviors such as substance abuse. Therefore, being able to address concerns with families may be influenced by an increased sense of professional efficacy. Further, if a supervisee feels empowered in their work, this may keep them energized during times when they are feeling overwhelmed.

Taken together, the outcomes found in this study draw attention to the potential of RS to advance the development of the IMH professional and enhance their work. Additionally, these data also suggest that these outcomes influence each other in dynamic and interconnected ways (see figure 11).

Figure 11

Supervisee perspectives of outcomes impacted by Reflective Supervision



## A Developmental Process of Understanding RS

Chapter Five also described additional themes that emerged from the data and were connected to the study aims. Data suggested that supervisees underwent a development process

in their understanding of RS which impacted their perception of its value to their work and their capacity to use it when working with families.  This process included three phases: 1) Entering into an experience of RS; 2) Exploring and discovering aspects of RS; and 3) Integrating RS into how they are.

**Entering into an Experience of RS.**  This phase is characterized by the newness of the RS experience for the IMH professional who is first entering the field.  Not only were they new to RS, but they were also new to their job as an IMH professional. They were learning new job responsibilities, meeting new people, and learning expectations of administrators.  At this stage, supervisees described that there were often focused on what to do with their client families and how to approach aspects of their job such as paperwork or community resources.  Early in RS, supervisees were also not sure of how to be with their supervisor, what their role was in RS, what they were expected to bring to supervisory meetings, and how their involvement in RS could benefit their work.  However, some supervisees in the study who were experienced in IMH and RS described an ongoing insecurity about their role in and confusion about how RS connected to their work.  A small portion of the study sample remained unconvinced that RS was worth their time.  They remained skeptical about it's worth and it's benefit to their professional role and the interventions they provide for families.  These data suggest that it is possible that the length of time a supervisee engages in RS and the work may not be the only influence on the development of their understanding of RS.

In addition to feeling worried about being new to the work and RS, supervisees described a desire to be seen as competent in their work and some supervisees described feeling additional worry when they did not understand RS or the expectation of their role in it.  Moreover, some supervisees described feeling caught when they knew the expectation in RS was to share

vulnerability and their emotional response to the work, yet they did not yet feel safe with their team or trust their supervisor.  A supervisor who is compentent in providing RS and who understands these competing feelings and this early experience in RS may help the supervisee navigate this early phase.

The themes that emerged from these data related to being new to RS and to their job, as well as developing new relationships with their supervisor and colleagues is parallel to the parent who is new to IMH intervention.  That is, parents new to IMH intervention may feel unsure about its benefits to their family.  They may want to focus on their concrete needs, such as finding a crib for their infant or finding a new job.  Early in the work, IMH professionals honor the parent's focus on these concrete needs, while at the same time continue to be consistent, predictable, and sensitive in their interactions (Fraiberg, 1980; Weatherston, 2000b).

**Exploring and Discovering Aspects of RS.**  Data suggested that this phase is characterized by a shift in needing concrete direction to understanding the importance of emotional support.  As they grow in their work with infants and families, supervisees noticed how RS provided them with a parallel experience.  They described that their experience of RS with their supervisor was a model of how they were with families, and in turn, how they could support parents to be with their babies.  They described that, when they initially entered into an experience of RS they were focused on figuring out what *to do*. Over time this changed from needing help *doing* to needing support in how they were *being* with families.  Furthermore, supervisees described that they began to use RS more intentionally over time.  They thought about what they wanted to bring to their supervisory meetings, what issues they were struggling with, and what they needed from their supervisor.

This shift from *doing* to *being with* parallels the early parenting relationship (Furman, 1998). The infant is an active partner in the continued development of the attachment relationship. As they develop, they are able to engage in proactive, intentional movements, that is, if they want something they are able to move their body in order to obtain it. Consistent, sensitive, and responsive caregiving helps the infant to regulate their emotions and aids in the development of a sense of self. The infant continues to need the parent as a support, but has increased capacities on their own. Data suggest that supervisees may go through a similar experience. Through a consistent, reliable, and sensitive relationship with their supervisor they developed a sense of confidence that they know what to *do*; while they looked to the supervisor for continued guidance on how to *be*.

**Integrating and Internalizing RS into How They Are.** Data suggest that this phase was characterized by how supervisees viewed, valued, and used RS within their work. Some supervisees in this study described experiences in their work with infants and families that paralleled their supervisory relationship. They were also able to hold multiple views of RS, for example, although they viewed RS as integral and essential to their work, it remained challenging. They identified times when RS was difficult, when there were disruptions in their relationships with their supervisors, and what happened when RS went wrong. They spoke with a level of confidence in their work and acknowledged their role in the RS relationship.

Taken together, these additional findings pointed to a developmental progression in how supervisees came to understand, value, and use RS in their work (see Figure 12).
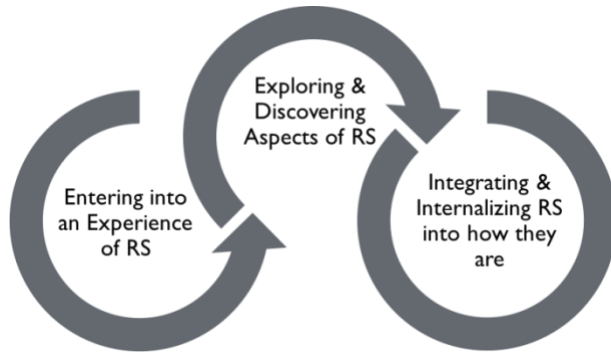
Figure 12. Process of Integrating Reflective Supervision

In summary, data suggest that when entering into RS, supervisees need time to build their understanding and awareness of how this type of supervision supports their work and what is expected of them as a supervisee. As this awareness builds, supervisees continue to explore and discover aspects of RS that support their work and the development of themselves as an IMH professional. Further, as supervisees began to understand RS and their role within it, they are better able to use RS in the present moment when with their supervisor and when with infants and families – thus becoming Schön's (1983/1987) Reflective Practitioner, moving from "reflection on action" to "reflection in action." The process of RS is non-linear, as supervisees noted that there may be times, even when they have reached the *integrating* phase, when they may be in the *entering into* phase, needing more concrete support from their reflective supervisor; or in the *exploring phase*, when they may be feeling particularly confused or challenged by a family or clinical situation. Furthermore, data also suggest that how supervisees understand and value RS can impact their level of engagement in RS, and subsequently how much they can then benefit from, learn from and use within their work.

**A Theoretical Model of the Supervisee's Experience of RS**

The evidence presented in this dissertation led to a developmental and ecological theoretical orientation toward the supervisee's experience of RS. That is, the supervisee's

understanding and use of RS in their work develops over time and quality of experience, and is impacted by the interaction between this process and the environments or settings where RS takes place. A theory of RS is proposed that considers the complex interplay between variables and the supervisee's understanding and use of RS. This theory also hypothesizes that the supervisee's level of understanding and integration of RS in their work will impact their attainment of the identified outcomes (see Figure 13).

Figure 13

A Theoretical Model of Reflective Supervision from the Supervisee's Perspective
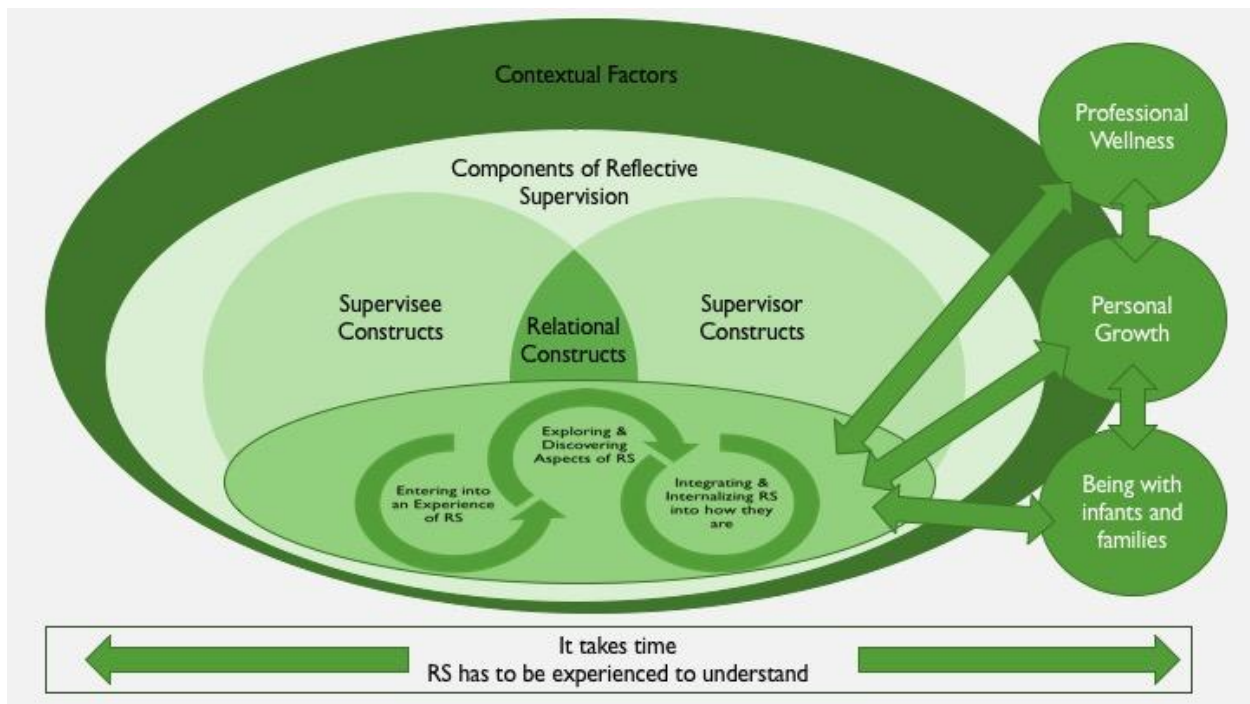


**An ecological view of RS.** Along with attachment theory and psychoanalytic theories of development, this study is supported by an ecological view of human development. Ecological theorists posit that human beings are influenced by their environment and use that knowledge to grow and change. In turn, their growth and change will influence the environment in new ways, thereby creating new ways to influence human development (Bronfenbrenner, 1979). Further,

humans are social creatures; that is, we need interaction and companionship with other human beings in order to thrive. Additionally, the ecological framework also includes different constructs within the understanding of human behavior – the individual cannot be understood without taking into account the family, community, society, and overall culture. These levels of influence are often viewed as individual systems that are embedded into larger systems, thereby creating a structure or context from which to understand the flow of influences and resources related to development (Bronfenbrenner, 1979).

The ecological systems framework infuses structure into the experience of RS, which is often viewed as complex and abstruse. The RS experience is impacted by and impacts a myriad of variables. As pictured in the theoretical model, the experience of RS is nested within supervisee, supervisor, relational constructs, and contextual factors. These then impact the professional, personal, and practice behavior outcomes through their effect on the experience of RS. For example, the supervisee's growth within the RS experience will impact their professional wellness, such as their sense of professional efficacy. As the IMH professional develops confidence and competence in their work, this will support and further impact their level of confidence within the RS relationship.

## Strengths and Limitations

### Study Strengths

This study is important to the field of IMH as its findings provide empirical support for the clinical and theoretical views of how RS supports the work of IMH professionals. In addition, this study adds new information to the field, as the data demonstrate the experience of RS to be a complex interaction between attributes of the individuals involved, the quality of their relationships, and the professional environment in which RS is implemented. Moreover, results

propose that the supervisee's understanding of RS and perception of its value in their work can impact their attainment of identified outcomes.

Furthermore, the diversity and size of the participant sample are strengths of this study. Much of the previous empirical research focused on early childhood educators or early intervention professionals. This research included diversity in professional discipline, level of education, and job title and program focus. The essential components and outcomes of RS identified cut across disciplinary perspectives and programmatic focus, thereby strengthening the results.

This study was carefully designed with attention to strategies to strengthen methodological rigor and trustworthiness. My immersion in the field of IMH and RS was important to inform the design and connect with IMH professionals, however it also posed challenges. My ongoing consultation with RS and psychoanalytic experts and meeting regularly with my coding partner and advisor helped to mitigate these concerns. These meetings provided me with a place to reflect and identify any potential biases, and ensured the trustworthiness of my analysis. These consultation meetings also aided in the development of the theoretical model, thereby creating a model that was informed by diverse perspectives of RS, psychanalytic thought, and IMH intervention.

**Study Limitations**

This study was subject to some limitations. First, this study was cross-sectional, that is, data were collected at only one time period. Studying RS at several time points will provide evidence to describe causal relationships between RS and identified outcomes. Also, although this sample did demonstrate some diversity within professional discipline and level of education, it was focused on professionals who work with infants and families, and therefore limits the generalizability of these results to other areas of social work. Furthermore, as the interest in the

individual interviews was so much higher than the interest in the focus groups, geographic constraints or focus group dynamics may have impacted the sample size. Perhaps IMH professionals did not want to attend a focus group to talk about their experiences in RS if they knew that colleagues from their own or other programs would also be in attendance. Lastly, although the study meets recommended sample size of 20 – 60 for grounded theory (Charmaz, 2014), certain themes found did not reach saturation. Saturation refers to a point during data analysis when no new codes or themes are identified (Charmaz, 2014). For example, the theme *issues of diversity*, was identified important to report, yet was a theme identified in later interviews. Therefore, including more participants may have assisted in this theme reaching saturation. The majority of the sample were Caucasian women. In addition, two African American and one Hispanic/Latina professional participated in the interviews. Therefore, the limited racial diversity within the study is a limitation.

## Recommendations for Future Research

This study supports existing research on RS and contributes ideas for future empirical research. First, this dissertation puts forth a theoretical model of RS that describes a developmental process that influences whether and how supervisees came to understand and use RS in their work. It will be important to further test this model using both qualitative and quantitative methodology. Additionally, the proposed model offers a jumping off point for research questions related to the impact of the identified levels of influence on the supervisee's experience of RS, and the subsequent influence on outcomes. Possible research questions include: 1) Are there differences in how supervisees score on outcome measures based upon their level of understanding of RS? 2) Are there differences in supervisee's scores on outcome measures based upon the format of RS,

such as group, individual, or both? and 3) Are there variables in the proposed model that predict the supervisee's level of understanding of RS and their attainment of outcomes?

Also, it would be important to study RS within a relational sample, that is, with both supervisors and supervisees. Currently, the majority of the existing research samples include only supervisors or only supervisees, even though RS is fundamentally a relational experience. Finally, there has been limited research investigating RS groups. This study identified the format of RS as an important variable in how supervisees come to understand and use RS in their work. Group RS is used throughout the state and the country, sometimes in tandem with individual RS, but often times as the only type of RS provided. It will be important to study the implementation of group RS and the unique experience a group provides. Finally, it is important to investigate RS using a longitudinal, experimental design. This will establish patterns of RS over time and establish RS as an evidence-based practice.

## APPENDIX A – DISCUSSION GUIDES

**1) Focus Group Discussion Guide**

| INTRO/WARM UP |
| --- |

You are asked to be open and honest in our discussion today. In order to maintain confidentiality, please do not mention names of supervisors, colleagues, or families you have seen. In addition, it is important that what is said in the focus group is not repeated outside of the focus group. It may feel uncomfortable, especially for those of you who are colleagues or who have the same reflective supervisor, to give feedback, especially if it is negative, about your supervisory experience. It is important that we all agree to maintain confidentiality and to be nonjudgmental in our responses to each other's thoughts and opinions.

Description of the project
I am interested in learning more about how IMH professionals experience and think about reflective supervision; and whether this experience changes over time. I am also interested in what professional outcomes you think are impacted by engaging in reflective supervision.

| Engaging in Reflective Supervision |
| --- |

What is it like to engage in reflective supervision?

What is reflection and what are the core components of reflection supervision?

> What does "reflection" mean to you?

> What does reflective supervision mean to you? What is reflective supervision with your supervisor like?

> What do you see as the most important part of reflective supervision?

How do you see your role in the reflective supervision relationship?

What are barriers to effective reflective supervision?

| Reflective Supervision & Professional Outcomes |
| --- |

What professional outcomes are influenced by reflective supervision?

How does reflective supervision support your professional development?

> How has this changed over time?

How do you see yourself using what you have experienced in reflective supervision with your client families?

How have you changed in your professional role since you have been receiving reflective supervision?

---

<div align="center">

**WRAP UP**

</div>

---

Any other experiences stand out to you about the reflective supervision process?

If you woke up tomorrow and all those barriers you mentioned were gone…what would reflective supervision look like for you?

If you could give advice to the leaders of your agency, your supervisor, or the infant mental health field, about how to best support practitioners doing work with infants and families, what would it be?

## 2) Individual Interview Discussion Guide

---

<div align="center">

**INTRO/WARM UP**

</div>

---

You are asked to be open and honest in our discussion today.  In order to maintain confidentiality, please do not mention names of supervisors, colleagues, or families you have seen.

<u>Description of the project</u>
I am interested in learning more about how IMH professionals experience and think about reflective supervision; and whether this experience changes over time.  I am also interested in what professional outcomes you think are impacted by engaging in reflective supervision.

---

<div align="center">

Engaging in Reflective Supervision

</div>

---

What is it like for you to engage in reflective supervision?

What do you see as the core components of reflection supervision?

Focus group participants have talked about "feelings of safety" as an essential part of engaging in reflective supervision.  Do you agree with this?
> How do the core components of reflective supervision foster feelings of safety?
> What other things add to the development of this feeling of safety?

How do you see your role in the reflective supervision relationship?

If you had to describe reflective supervision to a new colleague, what would you say?

If you had to describe reflective supervision to a friend who was not trained in a human service field, what would you say?

## Reflective Supervision & Professional Outcomes

Focus group participants have identified decreased burnout as an outcome of reflective supervision.

Do you agree?

Can you provide an example in your own work how reflective supervision impacted feelings of burnout?

What other outcomes do you think are impacted by reflective supervision?

Can you provide an example from your own work?

Focus group participants also discussed how they did not "buy into" reflective supervision right away. Did you experience this? When do you think you found yourself "buying into" reflective supervision?

Can you give an example from your own work of how you have used what you have experienced in reflective supervision with your client families?

## WRAP UP

Any other experiences stand out to you about reflective supervision?

If you could give advice to the leaders of your agency, your supervisor, or the infant mental health field, about how to best support practitioners doing work with infants and families, what would it be?

## APPENDIX B – DEMOGRAPHIC FORMS

### 1) Focus Group Demographic Form

| Demographics |
| --- |

What type of reflective supervision do you receive?

     Individual _____

     Group _____

     Both individual and group _____

How long have you been receiving reflective supervision?

     Individual _____ Years/Months

     All with the same supervisor? _____ Yes/No

     How many reflective supervisors have you had?_____

     I don't receive individual reflective supervision _____

     Group _____ Years/Months

     All with the same group supervisor? _____ Yes/NO

     How many group reflective supervisors have you had? _____

     I don't receive group reflective supervision _____

How often do you receive reflective supervision?

     Individual

          Weekly _____

          Biweekly _____

          Monthly _____

          Other _____

          N/A _____

     Group

          Weekly _____

          Biweekly _____

          Monthly _____

          Other _____

          N/A _____

Does your agency/program financially support reflective supervision?

          _____ Yes/No

Do you pay out of pocket for your reflective supervision?

_____ Yes/No

If yes, please circle if you pay for: individual, group, or both

Where do you meet for reflective supervision?  Check all that apply.  Please don't enter names.

|  | Individual | Group |
|---|---|---|
| Agency | | |
| Private home | | |
| Public location (library, etc.) | | |

What is your level of education?
  Para-professional _____
  Bachelor degree _____
  Graduate degree _____

What is your field of study?
  Education _____
  Nursing _____
  Psychology _____
  Social Work _____
  Other (please list) _____

Have you worked in other positions within your field of study before coming to infant mental health? _____ Yes/No

How long in those positions? _____ Years/Months

Does your current infant mental health position involve the use of infant-parent psychotherapy? _____ Yes/No

What is your intervention focus?
  Education (e.g. parenting, child development)
  Mental health (e.g. attachment-focus, trauma)
  Health/medical (e.g. maternal/infant health)
  Other _____

What is the average number of hours you spend providing home visits each week? _____

Supervisor characteristics:
  How long has your supervisor been providing reflective supervision? _____

  What is your supervisor's field of study? _____

  Does your supervisor receive her own reflective supervision?

                              Yes/No/I don't know

Did your supervisor hold a position where she did the same type of work you are doing
with high risk infants and families?
                    Yes/No
                    He/she still provides services to infants and families


## 2) Individual Interview Demographic Form

| Individual Interview Demographics Questionnaire |
| --- |

What type of reflective supervision do you receive?

Individual _____
Group _____
Both individual and group _____
I don't currently receive reflective supervision _____

How long have you been receiving reflective supervision?

Individual _____ Years/Months
All with the same supervisor? _____ Yes/No
How many reflective supervisors have you had?_____
Is your individual reflective supervisor (check all that apply):
_____ responsible for administrative oversight?
_____ an external consultant
_____ a past or current employee of your program?

Group _____ Years/Months
All with the same group supervisor? _____ Yes/NO
How many group reflective supervisors have you had? _____
Is your group reflective supervisor (check all that apply):
_____ responsible for administrative oversight?
_____ an external consultant
_____ a past or current employee of your program?

How often do you currently receive reflective supervision?
 Individual                                          Group
                Weekly _____              Weekly _____
                Biweekly _____              Biweekly _____
                Monthly _____              Monthly _____
                Other _____              Other _____
                N/A _____              N/A _____

Does your agency/program financially support reflective supervision?

_____ Yes/No

Do you pay out of pocket or have in-kind support for your reflective supervision?

_____ Yes/No

If yes, please circle if you pay for: individual, group, or both

Does your current infant mental health position involve the use of infant-parent psychotherapy?

_____ Yes/No

Where do you meet for reflective supervision?  Check all that apply.  Please don't enter names.

|  | Individual | Group |
|---|---|---|
| My Agency | | |
| Home | | |
| Public location (library, etc.) | | |
| Over the phone | | |
| Virtually (Skype, etc.) | | |
| Private office/practice | | |
| Other | | |

| What is your level of education? | What is your field of study? |
|---|---|
| Para-professional _____ | Education _____ |
| Bachelor degree _____ | Nursing _____ |
| Graduate degree _____ | Psychology _____ |
| | Social Work _____ |
| | Other (please list) _____ |

Are you Hispanic/Latino? _____ Yes/No

What is your race?  Select all that apply:
____ American Indian or Alaskan Native        ____ Native Hawaiian or other Pacific Islander
____ Asian                                    ____ White
____ Black or African American                ____ Prefer not to answer

Do you currently provide reflective supervision? _____ Yes/No

Supervisor characteristics:

How long has your supervisor been providing reflective supervision?

less than a year _____
1 to 5 years _____
5 or more years _____
I don't know _____

What is your supervisor's field of study? _____

Does your supervisor receive their own reflective supervision?

_____ Yes/No/I don't know

Does your supervisor either currently or in the past do the same type of work you are doing with high risk infants and families?

_____Yes, my supervisor is still working directly with families

_____No, my supervisor is not currently working with families but did in the past

_____ No, my supervisor never worked directly with infants and families

## APPENDIX C – DEMOGRAPHIC TABLES

### Focus Group and Individual Interviews Demographics

|  | Focus Group (n=24) | | Individual Interview (n=26) | | Total (n=50) | |
|---|---|---|---|---|---|---|
|  | n | % | n | % | n | % |
| **Level of Education:** |  |  |  |  |  |  |
| Para-Professional | 1 | 4.0 |  |  | 1 | 2.0 |
| Associate Degree | 1 | 4.0 | 1 | 3.8 | 2 | 4.0 |
| Bachelor Degree | 4 | 16.0 | 2 | 7.7 | 6 | 12.0 |
| Graduate Degree | 17 | 72.0 | 23 | 88.5 | 40 | 80.0 |
| **Use of IPP in your work?** |  |  |  |  |  |  |
| Yes | 15 | 64.0 | 15 | 57.7 | 30 | 60.0 |
| No | 6 | 24.0 | 11 | 42.3 | 17 | 34.0 |
| **Field of Study** |  |  |  |  |  |  |
| Education | 3 | 12.0 | 1 | 3.8 | 4 | 8.0 |
| Nursing |  |  | 1 | 3.8 | 1 | 2.0 |
| Psychology/Counseling | 5 | 20.0 | 6 | 23.1 | 11 | 22.0 |
| Social Work | 14 | 60.0 | 16 | 61.5 | 30 | 60.0 |
| Other | 1 | 4.0 | 2 | 7.7 | 3 | 6.0 |
| **Race:** |  |  |  |  |  |  |
| Hispanic/Latino(a) |  |  | 2 | 7.7 | 2 | 7.7 |
| American Indian/Alaska Native |  |  |  |  |  |  |
| Asian |  |  |  |  |  |  |
| Black/African American |  |  | 2 | 7.7 | 2 | 7.7 |
| White |  |  | 17 | 65.4 | 17 | 65.4 |
| Prefer not to answer |  |  |  |  |  |  |

**Features of RS Received by Participants**

| | Focus Groups (n=24) | | Individual Interviews (n=26) | | Total (n=50) | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Type of RS | | | | | | |
| Individual only | 0 | 0 | 4 | 15.4 | 4 | 8.0 |
| Group only | 7 | 29.2 | 3 | 11.5 | 10 | 20.0 |
| Both individual & group | 16 | 66.7 | 19 | 73.1 | 35 | 70.0 |
| Not currently receiving RS | 1 | 4.2 | 0 | 0 | 1 | 2.0 |
| | | | | | | |
| Agency Financial Support | | | | | | |
| Yes | 23 | 92.0 | 24 | 92.3 | 46 | 92.0 |
| No/pay out of pocket | 1 | 4.0 | 2 | 7.7 | 3 | 6.0 |
| Subsidized/In kind | 1 | 4.0 | 4 | 15.4 | 1 | 2.0 |
| | | | | | | |
| Features of Individual RS | | | | | | |
| Quantity | | | | | | |
| Weekly | 12 | 50.0 | 11 | 42.3 | 23 | 46.0 |
| Biweekly | 1 | 4.2 | 5 | 19.2 | 6 | 12.0 |
| Monthly | 3 | 12.5 | 7 | 26.9 | 10 | 20.0 |
| Meeting place | | | | | | |
| At Agency | 15 | 62.5 | 20 | 76.9 | 35 | 70.0 |
| Over the phone | 6 | 25.0 | 3 | 11.5 | 9 | 18.0 |
| Public location (i.e. library) | 2 | 8.3 | | | 2 | 4.0 |
| Private home | | | 1 | 3.8 | 1 | 2.0 |
| Virtual platform | | | 1 | 3.8 | 1 | 2.0 |
| | | | | | | |
| Features of Group RS | | | | | | |
| Quantity | | | | | | |
| Weekly | 0 | 0 | 1 | 3.8 | 1 | 2.0 |
| Biweekly | 10 | 41.7 | 12 | 46.2 | 22 | 47.8 |
| Monthly | 14 | 58.3 | 9 | 34.6 | 23 | 46.0 |
| Meeting place | | | | | | |
| At Agency | 19 | 79.2 | 20 | 76.9 | 39 | 78.0 |
| Over the phone | 1 | 4.2 | | | 1 | 2.0 |
| Public location (i.e. library) | 4 | 16.7 | | | 4 | 8.0 |
| Private home | 2 | 8.3 | | | 2 | 4.0 |
| Virtual platform | | | 1 | 3.8 | 1 | 2.0 |

**Information about Reflective Supervisors**

| | Focus Groups (n=24) | | Individual Interviews (n=26) | | Total (n-50) | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Individual Supervisor Role | | | | | | |
|   Administrative | 14 | 58.3 | 16 | 61.5 | 30 | 60.0 |
|   External Consultant | 2 | 8.3 | 7 | 26.9 | 9 | 18.0 |
|   Group Supervisor Role | | | | | | |
|   Administrative | 1 | 4.2 | | | 1 | 4.2 |
|   External Consultant | 19 | 79.2 | 22 | 84.6 | 41 | 82.0 |
| Supervisor's Field of Study | | | | | | |
|   Psychology/Counseling | 7 | 32.0 | 4 | 15.4 | 11 | 22.0 |
|   Social Work | 12 | 44.0 | 17 | 65.4 | 29 | 58.0 |
|   I don't know | | | 3 | 11.5 | 3 | 6.0 |
| Time providing RS | | | | | | |
|   Less than one year | 1 | 4.0 | 2 | 7.7 | 3 | 6.0 |
|   1 – 5 years | 2 | 8.0 | 7 | 26.9 | 9 | 18.0 |
|   More than 5 years | 14 | 56.0 | 11 | 42.3 | 24 | 48.0 |
|   I don't know | 7 | 28.0 | 5 | 19.2 | 12 | 24.0 |
| Supervisor receive RS? | | | | | | |
|   Yes | 13 | 52.0 | 18 | 69.2 | 31 | 62.0 |
|   No | 1 | 4.0 | 1 | 3.8 | 2 | 4.0 |
|   Don't know | 10 | 40.0 | 6 | 23.1 | 15 | 30.0 |
| Did or Does the same work? | | | | | | |
|   Yes & is currently | 9 | 36.0 | 7 | 26.9 | 16 | 32.0 |
|   No, but did in the past | 15 | 60.0 | 18 | 69.2 | 32 | 64.0 |

**Average length of time receiving reflective supervision & number of supervisors**

|  | Mean *(SD)* | Range Minimum | Maximum |
|---|---|---|---|
| Individual RS |  |  |  |
|   Length of time receiving | 51.31 months *(54.98)* | 6 months | 20 years |
|   Number of supervisors | 2.06 *(1.24)* | 1 | 6 |
| Group RS |  |  |  |
|   Length of time receiving | 45.96 months *(43.57)* | 6 months | 17 years |
|   Number of supervisors | 1.73 *(.98)* | 1 | 5 |

## APPENDIX D – QUALITATIVE MEMOS

**Memos related to the development of the theoretical model:**

**March 26:** Two of the EHS home visitors were very open about their positive response to RS, with one additional saying that she too believes it is very positive, but also shared that she finds it very difficult. One of the them then said that she took a while to get it, to fully understand its importance to her work. When she did get it, she realized how essential it has become. I think this is an important point. So, I need to listen for this theme in the next group. We talked briefly about what happened for her, when she "got it." But I would like to learn more about this…if I hear this theme again I'd like to try to remember to ask things like: how did you know when you got it? when you understood it's importance? what happened that helped you understand?

**April 27**: They [focus group participants] talked about how hard RS is, how they didn't buy into it at first, and how it took feelings of trust, safety, and confidence to integrate it into their thinking and to use it their work. Some said that they still don't share their authentic responses to being with families, that they still don't feel safe in their supervisory relationships; but they can appreciate how it supports their work with families. So far, it seems like the feeling of safety as the amount of time they have been in RS is important to consider.

**June 30**: I was struck when it seemed like almost all participants said or agreed with statements like: "this didn't always happen" or "it wasn't always like this" or "it took a minute for me to feel comfortable." Is there a process that the supervisee goes through? Something that needs to happen in order for them to understand, feel, or acknowledge that RS is impactful and important to their work? In the [location] group, the new person who had only been there 6 months disagreed with fellow participants who were talking about how RS supports their work. She said, "I'm not experiencing that right now. I just am trying to figure out my job."

**June 30**: The [location] group also talked about changes in their supervision, and how they would revert back to being less willing to be vulnerable when there was a change in their supervision. The differences in supervisee intrinsic qualities also came up for me in the [location] group - two participants were really different in how they talked about their response to RS. One who said, "I'm really resistant to reflective supervision" and the other saying, "Really? I feel like I just fell right in step with the whole thing." The [location] group elucidated the many variables that have the potential to impact this process…such as a change in supervisor, the type of work that the supervisee does, or the supervisee's history of caregiving relationships.

**June 30**: These RS supervisory relationships are so intimate and when they are handled with great care, they can be amazing. However, when they are handled in ways that are not thoughtful or judgmental, or when supervisors aren't offering themselves in ways that model vulnerability, they can feel hurtful to the supervisee. Because [name] has had the experience of what she perceived as really good RS in the past, she has an understanding of what she needs from it and how to get it, even if it is from someone other than her current supervisor. She has a level of confidence related to RS, yet this new supervisory experience has been difficult and is impacting her work. On the other hand, [name] is stuck…she has been receiving RS for six

years, hasn't had it any other way, with any other supervisor. She doesn't view it as fitting with her job responsibilities, and she hasn't connected with her supervisor in a way that gives her the "felt sense" of being held and heard. She can intellectually understand that this is a helpful way of debriefing or venting about her job and clients, but she isn't experiencing an emotional connection

**August 14**: The amount of time it took to embrace reflective supervision varied among the supervisees. For some, they still had not yet embraced it, so they were in the early stages of this timeframe. For others, they had an understanding of it, but there were still aspects of their work and themselves that were holding them back or that were still resistant. And still others who had fully embraced it, with a full understanding of the "good, the bad, and the ugly" of reflective supervision.

> Things that seem to impact this timeframe include:
> Supervisee "temperament"
> Length of time receiving reflective supervision
> Supervisor qualities
> Group vs individual
> How reflective supervision was introduced to them
> Whether their reflective supervisor is also their administrative supervisor
> Previous supervisory experiences (reflective and others)

Parallel to this timeframe to embrace reflective supervision is also a developmental process in terms of what the supervisee needs from reflective supervision. As the supervisee progresses in their "embracing" of the reflective supervision process, they are also developing in their work as a professional and their relationships with clients. In this way, what the supervisee needs from reflective supervision will change/shift over time.

**Memos focused on my responses to the content and bracketing**

**April 20:** I'm worried about being able to get something from this…really feeling like I'm not doing anything, that I'm doing it wrong, that I won't be able to do this. Really feeling like an imposter today. What am I doing and why am I doing this? Will I really add something to the field?

It is funny that as I say that it maps onto what [the focus group participant] was saying just now… that RS helps her to know that when it feels like she's not doing anything, she really is doing a lot.

Just a thought…the other thing she said was that she would benefit from more structure. That also maps onto what I'm feeling…needing more structure, that I lost my structure/routine when the fire happened. That I feel very unstructured and muddled with this data…where do I go from here? I could use some consistency, too.

**July 21:** For this participant, being in group and in individual with people she doesn't trust seems to make her feel sad. And it is both about the other, but also about herself. She can't be

genuine in these relationships…and that feels uncomfortable for her. Because her default is to be genuine within all of her relationships. This makes me think about my relationship with…there isn't trust in that relationship and I don't believe that she can accept my perspective because she doesn't trust me, either. She gets defensive…maybe I do, too. We both add to the quality of our relationship – which hasn't been very positive.

**August 1:** When [interviewee] talked about not feeling effective in her work, and having to be reminded by her supervisor and colleagues how important she is to families, it made me think about the case presented yesterday in group…[Name's] case. There are a lot of strengths in the family, the caregiver is very present & nurturing, but there is a lot of identified risk…the baby's drug & alcohol exposure, the family relationships, grandma's view of herself as mother, her relationship with her daughter. [Name] talked a lot about how great the grandmother is and how she wasn't sure about what to do, she didn't think she was helping them very much. I tried to stay focused on [Name's] perspective and her new-ness to the work…But it was hard because I did see lots of risk…. Anyway, what we talked about instead was [Name's] presence, of someone there to be a witness to the joys of their relationship and to witness and be excited about the baby's progress. I worried, though, about how slow this process can be! I had to be present to Name's emotional response, but I was feeling restless…like, hurry up because this baby is at risk!

**August 6:** I am feeling pretty angry/disappointed/shocked because of what [the interviewee] said about her supervisor. Because I know who this supervisor is, and because I facilitated this RS group over to that supervisor about 7 years ago…I'm really having a lot of feelings.

This was a hard interview. I think part of it was because she wasn't giving me a whole lot to work with. I think I got out as much as I could with her…but I don't know. I wonder about our personal connection. I was thinking about that. Did she feel a bit weird because of that? Did she think I was going to tell people that I interviewed her? I really got the sense that she was holding something back. It made me wonder why she wanted to do this interview in the first place. I think I would have rather she just lay out how negative she finds it. I'm holding a bit of frustration with her and a lot with her supervisor!

**Memos when transcribing individual interviews:**

**Re: an IMH home visitor:** She describes this "breath" that she takes before talking. She describes her view of being careful about her words. It was obvious on the recording, as there was lots of silence. During the interview, when she was right in front of me, it was also obvious that I needed to wait, that she had something to say and I didn't want to interrupt her thought. Sometimes she would get off topic a bit…or tell stories, but they most often would demonstrate the point of what she was trying to say.

I'm thinking now that what she is really underscoring is the idea of being seen and known. When a supervisor can demonstrate this…the supervisee can bring her full, genuine self. And be able to receive "her stuff back" as the supervisor reflects it to her. I also don't think a supervisor would be very good at handing "her stuff back" in a way that she can receive it, if the supervisor doesn't see or know the supervisee.

The deeper parts of RS will not really be reached if there is not a sense of knowing between the supervisor and supervisee.

**RE: an Early Childhood Educator:** She also brings up not wanting to bring home what she is experiencing…people at home don't really understand…it is important to have someone who understands the work they are doing. The reflective supervisor can be that person, but also this is a benefit of the group setting, too, I think.

She is 4 years into her teaching, and she is young, but she is really able to express her thoughts pretty eloquently about her experience. I love her thought about teachers needing to be available for students, and then teachers need someone to confide in. She is basically talking about "holding" and "containing" without even knowing it! She said: "This feels heavy, so we need help to carry it."

**RE: an HFA home visitor:** She talks about how they just sort of "clicked" at the beginning, that she just made her feel really comfortable. I'm wishing now that I had asked more about this…what was it that the provider did to help her to feel comfortable? If this is dyadic, is it that idea that she was willing to engage and the supervisor was there to respond…they were both ready to enter into a relationship?

**September 23:** Listening & transcribing the last couple, especially [name] & [name], have reminded me how incredibly important RS is to these clinicians. And how powerful this experience can be for the families that they work with. Their capacity to talk about how RS connects to their work is incredible to me. I have also been thinking about when Nichole asked me about how they talk about it connecting to their families…their work with families. And I told her they didn't talk about it in so many words…but I was wrong. They most certainly did. I don't know why I didn't include those terms in my codes for the focus groups. We used the parallel process…but it didn't make it as clear as it is now. In these individual interviews they are very eloquent in describing the parallel process in a clear way.

These two IMH home visitors are relatively new to the work, but they were able to describe their experience in such beautiful ways. But what about the EHS home visitor who was just stuck? Who had been in an RS group for six years and she didn't have words to describe her experience. What makes these professionals have such different responses to RS?

## APPENDIX E – FINAL CODES AND DESCRIPTIONS

**Aim #1 – Components of RS: Final Codes and Descriptions**

| Essential Components of RS | | |
|---|---|---|
| Main Theme | Codes | Description |
| 1) Importance of feeling safe | | Psychologically safe to share difficult feelings and experiences. |
| 2) Importance of trust | | Trusting the other is an essential component. This comes through confidentiality, non-judgmental responses, and an openness to the supervisee's perspective. Again, this is parallel to the work. |
| 3) Consistency & Predictability | | Having a consistent and predictable time…and that both the supervisor and the supervisee keep those times. |
| 4) Non-judgmental responses | | This code is used when they talk about feeling judged by their supervisor or by their colleagues in group. This is also when they feeling like the supervisor and their colleagues are able to listen to their story with openness and an ear to the emotional content. |
| 5) Being present - supervisee & supervisor | | Being intentional about being present, listening, thoughtful. This also includes challenges to being present - such as when in group and hearing difficult family stories that aren't your own cases. This code is used when supervisees are talking about the importance of being present - whether you are the supervisee themselves, the supervisor, when they are in a group and have to be present for colleagues…or when colleagues need to be present for them. |
| Supervisee Constructs | | |
| Main Theme | Codes | Description |
| 1) Expectations of RS & previous experiences of supervision | 1A. Expected something different | This code refers to times when the expectations of RS that supervisees bring do NOT match their experience. This could be that they thought RS would be more administrative, but it is more focused on emotions. Or it could be that they thought it would be more |

| | | focused on emotional responses, but their supervisor stays with concrete of administrative responses. |
|---|---|---|
| | 1B. Not sure what to do or what to expect | Supervisees who don't know what to expect from RS, either what it is going to be like, or what the expectations for their role/behavior are. |
| 2) Understanding of RS & perception of value | 2A. Not knowing what it is | Some supervisees start RS with really no idea of what it is supposed to be and how it is supposed to support their work in a different way than their "regular" supervision. |
| | 2B. Not knowing benefits | Don't have an understanding of what the benefits of RS would be. Don't know what it is and therefore don't know the benefits. |
| | 2C. Uncertainty – feel thrown in | This code refers to the experience of some supervisees who felt as if they were "thrown in" to RS or that they were told to go to these meetings without any reason why or what it is. This code seems to be connected to feelings of uncertainty and resistance. |
| | 2D. Perceptions of value | This group of codes refers to the supervisee's perspective of the value of RS. Perceptions of value related to RS can impact how the supervisee engages in RS, whether they attend RS meetings consistently, and whether they find RS helpful and a productive use of their time. |
| | 2D1. Change over time | This code refers to the experience the supervisee has over time related to how they value RS. Perceptions of value change over time and experience with both the work and an RS relationship. |
| | 2D2. Understanding RS helps see value | Supervisees note that when they have a better understanding of RS they can see how it connects to their work and how valuable it can be to their work with infants and families as well as in their view of themselves as a professional. |
| | 2D3. Not valued, no time for it | When RS is NOT valued, supervisees (and others such as supervisors and agencies) don't make time for it. Or they may schedule other things over the |

| | | RS time, or they don't consistently attend RS meetings. |
|---|---|---|
| 3) Perceptions of Admin/Reflective Balance | 3A. Balanced | These codes capture a feeling that the admin/reflective relationship is balanced. That the supervisor is able to address administrative needs in ways that both use a reflective stance, but also allow for reflective growth on the part of the supervisee. |
| | 3A1. Feel safe | The supervisee doesn't worry about backlash, therefore can talk about difficult topics with their supervisor. Feel safe enough to share times where they may have made mistakes or times when they were not sure. |
| | 3A2. Supervisor takes reflective stance | Supervisor takes a reflective stance on admin tasks. |
| | 3B. Unbalanced | From the supervisee's perspective, the admin/reflective supervisor is unable to find a balance between administrative tasks and time for reflection and thinking about cases and emotional response. |
| | 3B1. Paperwork preoccupation | Supervisee worries about paperwork performance. Feels pressure from the supervisor or the agency to get the paperwork done at the detriment of the reflective process. Also captures times when the supervisor is focused on paperwork and unavailable for reflection. |
| | 3B2. Time management | There are times when the supervisor is focused on administrative things and there is not time to discuss cases deeply or in a reflective way. The supervisor is not able to manage time so that both the admin and the reflective agenda are addressed. |
| 4) Perception of Supervisee Role | 4A. Be prepared | This code refers to the responsibility of the supervisee to attend RS sessions prepared. Especially if it is a group and they are due to present a case, or in individual where they are expected to bring thoughts and observations about families. If supervisees don't prepare or |

| | | |
|---|---|---|
| | | don't bring observations/issues to RS, it is difficult to find ways to use RS strategies. |
| | 4B. Be receptive & open | It is part of the supervisee role to be open to feelings of vulnerability and to be receptive to hearing and using what comes out of RS. Being receptive to the reflections of the supervisor, but also receptive to their own reflective thoughts that might be a result of deeper discussion and reflection about their emotional response. |
| | 4C. Capacity to show up | Show up, be present, be there |
| | 4D. Takes effort | This code refers to the active role that supervisees need to take in RS. Being a supervisee takes thought, preparation, and effort. This is not a type of supervision where the supervisee just receives what the supervisor is telling them. They are an active part of this supervisory relationship and have a role in creating it. It can often be difficult and take a lot of effort. |
| 5) Intrinsic Qualities | 5A. Level of comfort w vulnerability | RS demands a level of vulnerability. Some supervisees are comfortable sharing their emotional responses, where others are cautious or fearful. |
| | 5B. Comfortable sharing emotions | Supervisee expresses comfort with vulnerability and reflection |
| | 5C. Putting up walls | Supervisees may be resistant to reflection or feelings of emotional vulnerability. They resist by putting up walls and refusing to share. |
| 6) Experiences of trauma | | Brings up past experiences of trauma or experiences of secondary/vicarious trauma |
| Supervisor Constructs | | |
| Main Theme | Codes | Description |
| 1) Level of experience and skill | | Supervisees want supervisors who understand the work they are doing and have experience with infant mental health intervention, etc. They also want supervisors who are skilled in reflective supervision, have training, and, if group facilitators, are able to |

| Main Theme | Codes | Description |
|---|---|---|
| | | facilitate/hold/understand group dynamics. Supervisors who are able to present feedback in ways that take into account their relationship with the supervisee/group so that the supervisee is able to hear and integrate that feedback into their own perspectives. |
| 2) Support Supervisee's Professional Development | | Supervisor demonstrates trust in the professional judgment and abilities of the supervisee. Allows the supervisee time to discuss their perspective of their work and come to their own answers about how to move forward. Again, this is a parallel to infant-parent relationships. This is like Secure Base caregiving behaviors. |
| 3) Asking questions VS giving answers | | The importance of asking reflective questions that allow for the supervisee to come to some conclusions on their own. |
| 4) Reflective capacity | | Supervisor demonstrates the capacity to reflect themselves, they can wonder, think, express emotional responses, and acknowledge times when they don't know or feel helpless |
| 5) Capacity for perspective taking | | Supervisor demonstrating capacity to take the perspective of the supervisee. Being curious about their experience and withholding judgment. |
| 6) Capacity to contain emotions | | RS supervisors who underscore the difficult nature of the work and acknowledge the emotional stressors supervisees experience can help them to feel more confident in their work. This is like Safe Haven caregiving behaviors. Supervisees feel like someone is taking care of them…has their best interests at heart. Statements could also be coded when supervisees felt like the supervisor was not able to support their emotional responses. |
| Relational Constructs | | |
| Main Theme | Codes | Description |
| 1) Quality of the supervisory relationship | | This code captures the supervisee view of the relationship between themselves and the supervisor. This refers to either |

| | | the individual supervisor or the group consultant. Relationship dynamics could include feeling comfortable, feeling awkward, the supervisor talking about their own problems or cases, feeling vulnerable with admin supervisor, or fit between supervisor & supervisee. |
|---|---|---|
| 2) Sharing vulnerability | | RS - group or individual - means that supervisees and supervisors share their feelings associated with their work. This can be difficult and can bring up feelings of vulnerability. Sharing vulnerability can also deepen the relationships between colleagues & supervisors/supervisees. |
| 3) Mutual availability | 3A. Availability of supervisee | The capacity of the supervisee to make themselves both physically and emotional available for RS. |
| | 3B. Availability of supervisor | Supervisor was either available…they had regular times to meet or supervisor had an "open door" policy. OR the supervisor was not available…for example maybe they are a consultant that is only at the agency once or twice a month. This includes both physical availability & emotional availability or presence. |
| | 3C. Being held in mind by the supervisor | The sense of the supervisor's nurturance and their interest in the supervisee's wellbeing. That the supervisor cares about them and remembers what they have told them. |
| 4) Disruptions in the supervisory relationship | | When supervisees talk about difficult experiences or disruptions in their relationships with their supervisors. This disruption, if not discussed and resolved, could impact their ongoing relationship. |
| Contextual Factors | | |
| Main Theme | Codes | Description |
| 1) Agency Support of RS | | The supervisee's perspective of how their agency supports the implementation of RS.  Such as providing time for RS, or demands on the supervisor that cuts into their |

| | | capacity to provide consistent RS. |
|---|---|---|
| 2) Format of RS | No option | This code refers to supervisees who note that they didn't have an option for either individual or group…they weren't asked what they preferred, they were just assigned. |
| | Prefer combo | This code refers to supervisee statements that note that they prefer to have both individual and group. They note that they each serve different purposes and each support engagement in the other. |
| | Prefer individual | This code refers to supervisees who note that they prefer group RS to individual. This preference can impact the level of their engagement in individual RS. |
| | Prefer group | This code refers to supervisees who note they prefer individual over group and that this can impact their engagement in group RS. |
| | Structure | This code captures comments related to structure of the RS. Supervisees note that they appreciate certain structure within either their individual or group RS. Structure can impact how they engage in and what they can receive from RS. |
| 3) Issues of Diversity | | Diversity within the RS relationship - differences in race, culture, age, geography, experience & how supervisees use RS to address issues of bias, equity, privilege |
| 4) Resource Limitations | Cost | RS can be expensive if their agency doesn't pay for it. Any mention of the cost of RS, especially if they have to pay for it out of pocket. |
| | Demands of job | This can include time, paperwork, family needs, risks. Needs of children in the classroom, or relationships with parents. Time outside of the classroom is precious, as teachers don't often have time to plan, etc. Home visiting demands include time, unforeseen crises, paperwork |
| | Time | Sometimes it can feel like there isn't |

| | | enough time to get everything done. |
| --- | --- | --- |

**Aim #2 – Professional Satisfaction Outcomes: Final Codes and Descriptions**

| Professional Wellness Outcomes | | |
| --- | --- | --- |
| Main Theme | Codes | Description |
| 1) Burnout & vicarious trauma | | Levels of burnout in their work, capacity to "leave work at work", to not feel overwhelmed - this can be impacted by experiences of vicarious trauma. |
| | 1A. Lifts burden | This code refers to the experience of sharing a family's story, or sharing emotional responses with another person VS reflecting only on our own. Through the experience of sharing these difficult feelings, there is a feeling of heaviness that is lifted. This connects to the parallel process…now that their emotional load is lightened, or shared, they are able to share more of themselves with families. |
| 2) Employee engagement | 2A. Job satisfaction | Feeling satisfied in their job and in their work. |
| | 2B. Productivity | Able to meet the requirements of the agency related to productivity. |
| | 2C. Retention | They remain in IMH or in that particular position. Decreased turnover is a benefit to agencies and programs. |
| 3) Professional development motivation | | This code refers to statements made that identify how RS supports their motivation to move ahead in their career. This is different from professional efficacy. This code refers to motivation to become a supervisor, or motivation to apply for MIAIMH endorsement. |
| 4) Professional efficacy | | Feeling as if they are "enough" to do the work. Having a professional sense of efficacy in that they have confidence that they will be able to be successful in their attempts at intervention. |
| | | |
| Personal Growth | | |
| Main Theme | Codes | Description |

| 1) Empowerment | | RS allows for supervisees to generate thoughts, insights, and solutions on their own. This is shift from the supervisor telling the supervisee what to do to allowing the supervisee to come to their own conclusion. |
|---|---|---|
| 2) Emotion regulation | | RS allows for supervisees to receive emotional support through their experience of sharing vulnerability and being heard and validated. This allows them to be able to go out to home visits and be able to be fully present and available to the families they are working with. |
| 3) Reflective capacity | | Increased self-awareness and reflective capacity. |

## Aim #3 – Practice Behavior Outcomes: Final Codes and Descriptions

| Infant and Family Engagement | | |
|---|---|---|
| Main Theme | Codes | Description |
| 1) Bringing up difficult things with families | | How RS helps the professional to be brave in their work and talk about difficult things with families. To be present, available, and aware of concerns. To not ignore concerns, but to address them head on in ways that are helpful and clinically connected to the family's experience. |
| 2) Becoming a better observer | | Slowing down and having to present cases in RS supports the supervisee's growth as an observer of development and relationships. |
| 3) Developing relationships with families | | Use RS to think about the family situation and find ways to intervene. Help families to identify needs and how to address them. To help them to understand how their experiences in their own childhood are influencing how they are now. To find relationships that are supportive vs. negative. |
| 4) Perspectives and ideas | | RS provides time to discuss families and therefore receive ideas and different perspectives on what might be going on in the family. These can assist |

| | | the supervisee in how they are engaging in treatment. |
|---|---|---|
| 5) Re-energizing to keep moving forward | | The support received in RS is re-energizing and helps to keep supervisees going in their jobs. This code also connects to the outcome of retaining staff. |

**Additional finding – Categories of Supervisee Development in RS**

| Entering into an experience of RS | | |
|---|---|---|
| **Main Theme** | **Codes** | **Description** |
| 1) Building an awareness of RS | 1A. Don't understand | Didn't understand what RS was in the beginning, unsure of their role. Thought it would be more about problem solving. OR supervisees who are still in the early phase - they are looking for more concrete information, more problem solving. |
| | 1B. Difficult to remain present | When it is unclear why the supervisee is engaging in RS and how it connects to their work, it is difficult to remain present and alert. |
| 2) Learning the work AND learning RS | 2A. Administrative in the beginning | Supervisees describe their understanding as needing to bring an agenda, to ask the right questions about families. |
| | 2B. Unsure of their role in RS & on the job | Early in RS, supervisees are often not sure of how to be with their supervisor, what their role is, what to bring. This can feel uncomfortable. |
| | 2C. Want to be seen as competent in their work | Supervisees worry about being new to the job and new to RS. They are not only learning a new job, meeting new people, learning expectations of administrators; but they also are being expected to engage in this new form of supervision that they may never have experienced before. |
| 3) Need concrete guidance | 3A. Administrative in the beginning | At this stage, supervisees are often focused on what to DO with their families and how to approach aspects of their job such as paperwork, community resources, etc. This also includes their role and expectations of them in RS. |

| | 3B. Need confidence building | Supervisees describe their understanding as needing to bring an agenda, to ask the right questions about families. |
| --- | --- | --- |
| | 3C. Need scaffolding to help with next steps | This may include reflective questions from the supervisor that assist the supervisee in describing their observations and experiences when with the infant and family. |
| 4) New relationships | 4A. Importance of developing relationships with families | Supervisees are engaging in new relationships with infants and families that often take time and care in developing. As they are learning the work, they are also engaging in several new relationships. |
| | 4B. Supervisory relationship development | It is important, just as in any relationship, that the supervisee become comfortable with the supervisor. This takes time. |

**Exploring and discovering aspects of RS and themselves**

| Main theme | Code | Description |
| --- | --- | --- |
| 1) Becoming more intentional about RS | 1A. RS has to be experienced | To understand and define RS, it has to be experienced. |
| 2) Growth in RS parallels growth in the work | 2A. Can see connections to work | They can see how RS connects to their work. They have experienced the support from their supervisor and have an understanding of why sharing their emotional response can be helpful in their ongoing work with high-risk infants and families. |
| 3) Shift from concrete skills to emotional support | 3A. Help me share emotions | They continue to need help identifying and sharing their emotional response in supervision. They need support bringing observations and emotions to supervision and help connecting them to their work experiences. |
| | 3B. Self-discovery | Supervisees describe new realizations about themselves, both as IMH professionals, as well as how they are as people within relationships. |

**Integrating and internalizing RS into how they are**

| Main theme | Code | Description |
| --- | --- | --- |

| | | |
|---|---|---|
| 1) I'm experienced in the work…but still need emotional support | | Doubting their capacity to do the job. Feeling doubt or unsure in their decision-making even though they have experience in the work. |
| 2) Perception of self as instrument of change | | A deeper view of relationship based work that demonstrates the supervisees understanding of themselves and the relationship they develop with the family as the essential instrument of change within IMH intervention. |
| 3) Using RS in work with infants and families | | This code focuses on how supervisees notice the connection of engaging in RS and how they are with families. They give specific examples of their work with families and note how their experiences in RS connect. This code also notes that when supervisees feel a bit more proficient at their work with infants and families, they have a better idea of how RS connects. |

# REFERENCES

Alexander, L., Gallen, R. T., Salazar, R., & Shahmoon-Shanok, R. (2012). Fighting fires with reflective supervision in a state early intervention system: Trading an axe for Mr. Rogers' slippers. *Zero to Three, 32*(6), 32-38.

Ainsworth, M. D., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*(10), 49-67.

Azzi-Lessing, L. (2013). Serving highly vulnerable families in home-visitation programs. *Infant Mental Health Journal, 34*(5), 376-390. doi: 10.1002/imjh.21399

Barron, C., & Paradis, N. (2010). Infant mental health home visitation: Setting and maintaining professional boundaries. *Zero to Three, 30*(6), 38-43.

Bandura, A. (1992). Exercise of personal agency through the self-efficacy mechanism. In R. Schwarzer (Ed.), *Self-efficacy: Thought control of action,* p. 3-38. London, UK: Routlege.

Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational Psychologist, 28*(2), p. 117-148.

Beam, R. J., O'Brien, R. A., & Neal, M. (2010). Reflective practice enhances public health nurse implementation of Nurse-Family Partnership. *Public Health Nursing, 27*(2), 131-139. doi: 10.111/j.1525-1446.2010.00836.x

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

Beddoe, L., Karvinen-Niinikoski, S., Ruch, G., & Tsui, M. S. (2015). Towards an international consensus on a research agenda for social work supervision: Report on the first survey of a Delphi study. *The British Journal of Social Work*, *46*(6), 1568-1586.

Behar-Horenstein, L. S., & Niu, L. (2011). Teaching critical thinking skills in higher education: A review of the literature. *Journal of College Teaching and Learning*, *8*(2), 25.

Benoit, D., & Coolbear, J. (1998). Post-traumatic feeding disorders in infancy: Behaviors predicting treatment outcome. *Infant Mental Health Journal, 19*(4), 409-421.

Ben-Porat, A., & Itzhaky, H. (2015). Burnout among trauma social workers: The contribution of personal and environmental resources. *Journal of Social Work*, *15*(6), 606-620.

Bernstein, V. J., Lewis, M. L., Daniher, K., Murphy, K. (2013). Stepping stones: Relationships, resiliency, and reflective practice. *Zero to Three, 34*(2), 64-71.

Bertacchi, J. & Coplon, J. (1992). The professional use of self in prevention. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A source book,* (84-90). Washington, DC: ZERO TO THREE.

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

Bigelow, A. E., MacLean, K., Proctor, J., Myatt, T., Gillis, R., & Power, M. (2010). Maternal sensitivity throughout infancy: Continuity and relation to attachment security. *Infant behavior and Development*, *33*(1), 50-60.

Bogo, M. & McKnight, K. (2006). Clinical supervision in social work: A review of the research literature. In L. Shulman & Safyer, A. (Eds.), *Supervision in counseling: Interdisciplinary issues and research*, 49-67. Binghamton, NY: The Haworth Press, Inc.

Bowlby, J. (1969). *Attachment and Loss, Vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base, 2nd Edition.* New York: Basic Books.

Boyas, J., & Wind, L. H. (2010). Employment-based social capital, job stress, and employee burnout: A public child welfare employee structural model. *Children and Youth Services Review*, *32*(3), 380-388.

Brandell, J. R. & Ringel, S. (2004). Psychodynamic perspectives on relationship: Implications of new findings from human attachment and the neurosciences for social work education. *Families in Society, 85*(4), 549-556.

Brandt, K. (2014). Transforming clinical practice through reflection work. In K. Brandt, B. D. Perry, S. Seligman, & E. Tronick (Eds.), *Infant and early childhood mental health, 293-307.* Washington, D. C.: American Psychiatric Publishing.

Braun, V. & Clarke, V. (2006). Using thematic analysis in Psychology. *Qualitative Research in Psychology, 3*, 77-101.

Briggs, S. (1999). Links between infant observation and reflective social work practice. Journal of Social Work Practice, Vol. 13(2), pp. 147-156.

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard university press.

Burgess, Gloria A. (2005). Intimate uncertainty: Reflections on infant observation in Psychoanalytic training. *Canadian Journal of Psychoanalysis,* Vol. 13(2), pp. 273-281.

Carpenter, J., Webb, C., Bostock, L., & Coomber, C. (2012). Effective supervision in social work and social care. *Bristol: Social Care Institute for Excellence, Research Briefing 43*. Retrieved from:

http://www.drugsandalcohol.ie/18661/1/SCIE_briefing43_Effective_supervision.pdf

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), *The handbook of attachment, 2ⁿᵈ edition* (pp. 3-22). New York, NY: The Guilford Press.

Cearley, S. (2004).  The power of supervision in child welfare services.  *Child & Youth Care Forum, 33*(5), 313-327.

Charmaz, K. (2014).  *Constructing grounded theory, 2ⁿᵈ Edition.*  Los Angeles: SAGE.

Chow, A. Y. M., Lam, D. O. B., Leung, G. S. M., Wong, D. F. K., & Chan, B. F. P. (2011).  Promoting reflexivity among social work students: The development and evaluation of a programme.  *Social Work Education, 30*(2), 141-156.  doi: 10.1080/02615479.2011.540377

Collins, A., Seely Brown, J., & Holum, A. (1991).  Cognitive apprenticeship: Making thinking visible.  *American Educator, 15*(3), 6-11.

Collins-Camargo, C., Sullivan, D. J., Washeck, B., Adams, J., & Sundet, P. (2009).  One state's effort to improve recruitment, retention, and practice through multifaceted clinical supervision interventions.  *Child Welfare, 88*(5), 87-107.

Conti, R. (2015). Compassionate parenting as a key to satisfaction, efficacy and meaning among mothers of children with autism. *Journal of autism and developmental disorders*, *45*(7), 2008-2018.

Counts, J. M., Gillam, R. J., Perico, S., & Eggers, K. L. (2017).  Lemonade for Life: A pilot study on a hope-infused, trauma-informed approach to help families understand their past and focus on the future.  *Children and Youth Services Review, 79,* 228-234.

Creswell, J. W. (2013).  *Qualitative inquiry & research design: Choosing among five approaches.*  Los Angeles, CA: SAGE.

Davies, D. (1999).  *Child development:  A practitioner's guide.*  New York, NY: The Guilford Press.

Davys, A. M. & Beddoe, L. (2009).  The reflective learning model: Supervision of social work

students.  *Social Work Education, 28*(8), 919-933.

Davys, A. M. & Beddoe, L. (2010).  *Best Practice in Supervision: A Guide for the Helping*

*Professions.*  London: Jessica Kingsley Publishers.

Dewey, J. (1910).  *How We Think.*  New York, NY: 2005 edition Barnes & Noble.

Doehrman, M. J. (1976). Parallel process in supervision and psychotherapy.  *Bulletin of the*

*Menninger Clinic, 40,* 1-104.

Dunst, C. J. (2007). Early intervention for infants and toddlers with developmental disabilities. In

S. L. Odom, R. H. Horner, M. E. Snell, & J. B. Blacher (Eds.), *Handbook of*

*developmental disabilities*, pp. 161-180.  New York, NY: The Guilford Press.

Eggbeer, L., Mann, T. & Seibel, N. (2007). Reflective supervision: Past, present, and future.

*Journal for ZERO TO THREE, 28*(2), 5-9.

Ellett, A. J., Ellis, J. I., & Westbrook, T. M. (2007). A qualitative study of 369 child welfare

professionals' perspectives about factors contributing to employee retention and

turnover. *Children and youth services review*, *29*(2), 264-281.

Emde, R. N. (1991). The wonder of our complex enterprise: Steps enabled by attachment and the

effects of relationships on relationships. *Infant Mental Health Journal*, *12*(3), 164-173.

doi:10.1002/1097-0355(199123)12:3<164::AID-IMHJ2280120304>3.0.CO;2-4

Emde, R. N. (2009).  Facilitating reflective supervision in an early childhood development

center.  *Infant Mental Health Journal, 30*(6), 664-672.  DOI: 10.1002/imhj.20235

Fenichel, E. (1992).  *Learning through supervision and mentorship to support the development*

*of infants, toddlers and their families: A source book.*  Arlington, VA: ZERO TO

THREE.

Fonagy, P. (2002).  Understanding mental states, mother-infant interaction, and the
development of the self.  In J. M. Maldonado-Duran (Ed.), *Infant and toddler mental
health: Models of clinical intervention with infants and their families* (57- 76).
Washington, DC: American Psychiatric Publishing, Inc.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002).  *Affect regulation, mentalization and
the development of the self.*  New York: Other Press.

Fortune, A. E., Lee, M., & Cavazos, A. (2005). Achievement motivation and outcome in social
work field education. *Journal of Social Work Education*, *41*(1), 115-129.

Foulds, B. & Curtiss, K. (2002).  No longer risking myself: Assisting the supervisor through
supportive consultation.  In J. J. Shirilla & D. J. Weatherston (Eds.), *Case studies in
infant mental health: Risk, resiliency, and relationships,* (pp. 177-186).

Fraiberg, S. (1980).  *Clinical studies in infant mental health: The first year of life.*  New York,
NY: Basic Books.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975).  Ghosts in the nursery: A psychoanalytic
approach to the problems of impaired infant-mother relationship.  *Journal of American
Academy of Child Psychiatry, 14*(3), 387-421.  Retrieved from:
http://www.dvrcv.org.au/sites/default/files/Fraiberg-Ghosts-in-Nursery.pdf

Frosch, C. A., Varwani, Z., Mitchell, J., Caraccioli, C., & Willoughby, M. (2018).  Impact of
reflective supervision on early childhood interventionists' perceptions of self-efficacy,
job satisfaction, and job stress. *Infant Mental Health Journal, 39*(4), 385-395.  doi:
10.1002/imhj.21718

Furman, E. (1982). Mothers have to be there to be left. *The Psychoanalytic study of the
child*, *37*(1), 15-28.

Furman, E. (1998). *Self-control and mastery in early childhood: Helping young children grow.* Madison, CT: International Universities Press.

Gatti, S. N., Watson, C., & Siegel, C. (2011). Step back and consider: Learning from reflective practice in infant mental health. *Young Exceptional Children, 14*(2), 32-45. doi: 10.1177/1096250611402290

Ghosh Ippen, C., Rosa Noroña, C., & Thomas, K. (2012). From tenet to practice: Putting diversity-informed services into action. *Zero to Three, 33*(2), 23-28.

Gibbs, G. R. (2007). *Analyzing Qualitative Data.* Los Angeles, CA: SAGE.

Gibbs, J. A. (2001). Maintaining front-line workers in child protection: A case for refocusing supervision. *Child Abuse Review, 10,* 323-335. DOI: 10.1002/car.707

Gilkerson, L. (2004). Irving B. Harris distinguished lecture: Reflective supervision in infant-family programs: Adding clinical process to nonclinical settings. *Infant Mental Health Journal, 25*(5), 424-439. doi: 10.1002/imhj.20017

Gilkerson, L. (2015). Facilitating attuned interactions: Using the FAN approach to family engagement. *ZERO TO THREE*, *35*(3), 46-48.

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

Goodman, S. H. & Brand, S. R. (2008). Infants of depressed mothers: Vulnerabilities, risk factors, and protective factors for the later development of psychopathology. In C. H. Zeanah (Ed.), *Handbook of infant mental health, 3rd edition,* pp. 153-170. New York, NY: The Guilford Press.

Greacen, T., Welniarz, B., Purper-Ouakil, D., Wendland, J., Dugravier, R., Saïas, T., & Tereno, S. (2017). Best practice in individual supervision of psychologists working in the French

CAPEDP preventive perinatal home-visiting program: Results of a Delphi consensus process. *Infant Mental Health Journal, 38*(2), 267-275. doi: 10.1002/imhj.21630

Gross, C. L., & Marcussen, K. (2017). Postpartum depression in mothers and fathers: The role of parenting efficacy expectations during the transition to parenthood. *Sex Roles*, *76*(5-6), 290-305.

Gutierrez, L. M., Parsons, R. J., & Cox, E. O. (Eds.) (1998). *Empowerment in social work practice: A Sourcebook*. Pacific Grove, CA: Brooks/Cole Publishing Co.

Harden, B. J. (2010).  Home visitation with psychologically vulnerable families: Developments in the profession and in the professional.  *Journal for Zero to Three, 30*(6), 44-51.

Harden, B. J., Denmark, N. & Saul, D. (2010).  Understanding the needs of staff in Head Start programs: The characteristics, perceptions, and experiences of home visitors.  *Children and Youth Services Review, 32,* 371-379.

Harrison, M. (2014). *A Qualitative Study Exploring Early Childhood Interventionists' Experiences of Ongoing Participation in a Reflective Consultation Program* (Unpublished doctoral dissertation). University of Minnesota, St. Paul, MN.

Harrison, M. (2016). Release, reframe, refocus, and respond: A practitioner transformation process in a reflective consultation program.  *Infant Mental Health Journal, 37*(6), 670-683.

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

Heffron, M. C., Ivins, B., & Weston, D. (2005).  Use of self: Essential learning processes for relationship-based work.  *Infants and Young Children, 18*(4), 323-336.

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

Heffron, M. C., Reynolds, D., & Talbot, B. (2016). Reflecting together: Reflective functioning as a focus for deepening group supervision. *Infant Mental Health Journal, 37*(6), 628-639.

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

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

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

Hepburn, K. S., Perry, D. F., Shivers, E. M., & Gilliam, W. S. (2013). Early childhood mental health consultation as an evidence-based practice: Where does it stand. *Zero to Three*, *33*(5), 10-19.

Hinshaw-Fuselier, S., Zeanah, P. D., & Larrieu, J. (2009).  Training in Infant Mental Health.  In C. H. Zeanah, (Ed.), *The handbook of infant mental health, 3rd edition* (533-548).  New York: The Guilford Press.

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: the Circle of Security intervention. *Journal of consulting and clinical psychology*, *74*(6), 1017.

Holden, G., Meenaghan, T., Anastas, J., & Metrey, G. (2002). Outcomes of social work education: The case for social work self-efficacy. *Journal of Social Work Education*, *38*(1), 115-133.

Izzo, C., Weiss, L., Shanahan, T., & Rodriguez-Brown, F. (2000). Parental self-efficacy and social support as predictors of parenting practices and children's socioemotional adjustment in Mexican immigrant families. *Journal of Prevention & Intervention in the Community*, *20*(1-2), 197-213.

Johnston, K., & Brinamen, C. F. (2012). The consultation relationship-from transactional to transformative: Hypothesizing about the nature of change. *Infant Mental Health Journal, 33*(3), 226-233. doi: 10.1002/imhj.21332

Kadushin, A. (1992). What's wrong, what's right with social work supervision. *The Clinical Supervisor, 10*(1), 3-19.

Kadushin, A. & Harkness, D. (2014). *Supervision in social work*. New York, NY: Columbia University Press.

Knott, C., & Scragg, T. (Eds.). (2016). *Reflective practice in social work*. London, UK, Learning Matters: SAGE.

Larrieu, J. A. & Dickson, A. B. (2009). Reflective practice in infant mental health training and consultation. *Infant Mental Health Journal, 30*(6), 579-590. doi: 10.1002/imhj.20230

Lawrence, J. (2005). Addressing diversity in higher education: Two models for facilitating student engagement and mastery. *Higher education in a changing world, Proceedings of the 28th HERDSA Annual Conference, Sydney, 3-6 July 2005,* 243-252.

Lee, J., & Miller, S. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society: The Journal of Contemporary Social Services*, *94*(2), 96-103.

Leerkes, E. M. & Burney, R. V. (2007). The development of parenting efficacy among new mothers and fathers. *Infancy, 12,* 45-67.

Letourneau, N. L., Stewart, M. J., & Barnfather, A. K. (2004). Adolescent mothers: Support needs, resources, and support-education interventions. *Journal of adolescent health*, *35*(6), 509-525.

Lewis, M. L., Rosa Noroña, C., McConnico, N., & Thomas, K. (2013). Colorism, a legacy of historical trauma in parent-child relationships. *Zero to Three, 34*(2), 11-23.

Lieberman, A. F. & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment.* New York, NY: The Guilford Press.

Lietz, C. A. (2009). Critical thinking in child welfare supervision. *Administration in Social Work, 34*(1), 68-78. doi: 10.1080/03643100903432966

Lietz, C. A. (2013). Strengths-based supervision: Supporting implementation of family-centered practice through supervisory processes. *Journal of Family Strengths*, *13*(1), 6.

Lietz, C. A., & Julien-Chinn, F. J. (2017). Do the components of strengths-based supervision enhance child welfare workers' satisfaction with supervision? *Families in Society: The Journal of Contemporary Social Services*, *98*(2), 146-155.

Low, C. M., Newland, R., Silver, R. B., Parade, S., Remington, S., Aguiar, S., & Campagna, K. (2018). Measuring reflective supervision within home visiting: changes in supervisors' self-perception over time. *Infant Mental Health Journal*, *39*(5), 608-617.

Mann, K., Gordon, J., MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Sciences Education, 14*, 595-621.

Many, M. M., Kronenberg, M. E., & Dickson, A. B. (2016). Creating a "nest" of emotional safety: Reflective supervision in a child-parent psychotherapy case. *Infant Mental Health Journal, 37*(6), 717-727.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, *4*(1), 107-124.

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

McGuigan, W. M., Katzev, A. R., & Pratt, C.C. (2003). Multi-level determinants of retention in a home visiting child abuse prevention program. *Child Abuse & Neglect, 27*, 363–380.

Michigan Association for Infant Mental Health (2014). Endorsement Competency Guidelines. Southgate, MI: MI-AIMH.

Michigan Association for Infant Mental Health (MI-AIMH; 2016a). Best Practice Guidelines for Reflective Supervision/Consultation, handout. https://mi-aimh.org/reflective-supervision/best-practice-and-consultant-competencies/

Michigan Association for Infant Mental Health (MI-AIMH; 2016b). Endorsement numbers. Retrieved from: https://static1.squarespace.com/static/5884ec2a03596e667b2ec631/t/58e661f59de4bb38c2222c42/1491493365294/2016+Endorsement+numbers+FINAL.pdf

Mikus, K. C., Benn, R., & Weatherston, D. (1994).  Parallel process.  *Zero to Three, 15*(3), 35-40.

Mor Barak, M. E., Travis, D. J., Pyun, H., & Xie, B. (2009).  The impact of supervision on worker outcomes: A meta-analysis.  *Social Services Review, 83*(1), 3-32.

Munro, E. (2010). Learning to reduce risk in child protection. *British Journal of Social Work, 40*(4), 1135-1151.

Munro, E. (2012).  The Munro review of child protection: Progress report: Moving toward a child centered system.  Retrieved from:

http://dera.ioe.ac.uk/14556/3/the_munro_review_of_child_protection_progress_report__ _moving_towards_a_child_centred_system_Redacted.pdf

Munson, C. E. (2012).  Handbook of clinical social work supervision, 3rd edition.  Binghamton, NY: The Haworth Social Work Practice Press.

Muzik, M., Rosenblum, K. L., Alfafara, E. A., Schuster, M. M., Miller, N. M., Waddell, R. M., & Kohler, E. S. (2015). Mom Power: preliminary outcomes of a group intervention to Improve mental health and parenting among high-risk mothers. *Archives of women's mental health*, *18*(3), 507-521.

Nair, P., Schuler, M. E., Black, M. M., Kettinger, L., & Harrington, D. (2003). Cumulative environmental risk in substance abusing women: early intervention, parenting stress, child abuse potential and child development. *Child abuse & neglect*, *27*(9), 997-1017.

National Association of Social Workers (2017).  *Code of Ethics of the National Association of Social Workers.*  Retrieved from:

https://www.socialworkers.org/LinkClick.aspx?fileticket=ms_ArtLqzeI%3d&portalid=0

Noble, C., & Irwin, J. (2009). Social work supervision: An exploration of the current challenges in a rapidly changing social, economic and political environment. *Journal of Social Work*, *9*(3), 345-358.  doi: 10.1177/1468017309334848

O'Farrelly, C., Lovett, J., Guerin, S., Doyle, O., & Victory, G. (2017). Enhancing Infant Mental Health Using a Capacity-Building Model. *Infants & Young Children*, *30*(4), 269-287.

Olds, D. L., Holmberg, J. R., Donelan-McCall, N., Luckey, D. W., Knudtson, M. D., & Robinson, J. (2014).  Effects of home visits by paraprofessionals and by nurses on children: Follow-up of a randomized trial at ages 6 & 9 years.  *JAMA pediatrics, 168*(2), 114-121.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, *8*(3), 1-21.

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

Osofsky, J. D. (2009).  Perspectives on helping traumatized infants, young children, and their families.  *Infant Mental Health Journal, 30*(6), 673-677.  doi: 10.1002/imhj.20236

Padgett, D. K. (2008).  *Qualitative methods in Social Work research.*  Thousand Oaks, CA: SAGE.

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

Patton, M. Q. (2002).  *Qualitative research and evaluation methods, 3rd edition*.  Thousand Oaks, CA: SAGE.

Pawl, J. (1994).  On supervision.  *Zero to Three, 15*(3), 21-29.

Pawl, J. H., & John, M. (1998). *How you are is as important as what you do ... In making a positive difference for infants. toddlers. and their families*. Washington, DC: Zero to Three.

Peled-Avram, M. (2017). The role of relational-oriented supervision and personal and work-related factors in the development of vicarious traumatization. *Clinical Social Work Journal, 45,* 22-32.

Perry, D. F., & Conners-Burrow, N. (2016). Addressing early adversity through mental health consultation in early childhood settings. *Family Relations*, *65*(1), 24-36.

Phillips, D. A., & Shonkoff, J. P. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. National Academies Press.

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). *The circle of security intervention: Enhancing attachment in early parent-child relationships.* New York, NY: The Guilford Press.

Proulx, G. (2002). Learning to see her son: A baby and his mother. In J. J. Shirilla & D. J. Weatherston (Eds)., *Case studies in infant mental health: Risk, resiliency, and relationships* (pp. 15-26). Washington, DC: ZERO TO THREE.

QSR International Pty Ltd. (2012). NVivo qualitative data analysis soft- ware (Version 10). Burlington, MA: Author.

Ramey, C. T., & Ramey, S. L. (1998). Early intervention and early experience. *American psychologist*, *53*(2), 109.

Ringel, S. (2003). The reflective self: A path to creativity and intuitive knowledge in social work practice education. *Journal of Teaching in Social Work, 23*(3/4), 15-28. doi: 10.1300/j067v23n03_03

Rogers, R. R. (2001).  Reflection in higher education: A concept analysis.  *Innovative Higher Education, 26*(1), 37-57.

Roosa Ordway, M., McMahon, T. J., De Las Heras Kuhn, L., & Suchman, N. E. (2018). Implementation of an evidenced-based parenting program in a community mental health setting. *Infant Mental Health Journal*, *39*(1), 92-105.

Rosenblum, K. L., Dayton, C. J., & Muzik, M. (2008).  Infant social and emotional development: Emerging competence in a relational context.  In C. H. Zeanah (Ed.), *Handbook of infant mental health, 3rd Edition,* p. 80-103.  New York, NY: The Guilford Press.

Ruch, G. (2000).  Self and social work: Towards an integrated model of learning. *Journal of Social Work Practice, 14*(2), 99-112.  doi: 10.1080/02650530020020500

Ruch, G. (2007).  Reflective practice in contemporary child-care social work:  The role of containment.  *British Journal of Social Work, 37,* 659-680.  doi: 10.1093/bjsw/bch277

Sameroff, A. (1993).  Models of development and developmental risk.  In *Handbook of infant mental health*, p. 3-13.  New York, NY: The Guilford Press.

Schafer, W. (2007).  Models and domains of supervision and their relationship to professional development.  *Zero to Three, 28*(2), 9-16.

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

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

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant mental health journal*, *22*(1-2), 201-269.

Schwarzer, R. (Ed.) (1992). *Self-efficacy: Thought control of action*. London, UK: Routlege.

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

Siegel, D. J., & Shahmoon-Shanok, R. (2010). Reflective communication: Cultivating mindsight through nurturing relationships. *Zero to Three, 31*(2), 6-14.

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

Shahmoon-Shanok, R., & Geller, E. (2009). Embracing complexity across disciplines: Reflective supervision and postdegree training integrate mental health concepts with speech-language therapy and graduate education. *Infant mental health journal*, *30*(6), 591-620.

Shahmoon-Shanok, R., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995). *Reflective supervision: A relationship for learning.* Washington DC: ZERO TO THREE.

Shahmoon-Shanok, R., Lapidus, C., Grant, M., Halpern, E., & Lamb-Parker, F. (2005). Apprenticeship, transformational enterprise, and the ripple effect: Transferring knowledge to improve programs serving young children and their families. In K. M. Finello (Ed.), *The handbook of training and practice in infant and preschool mental health* (453-486)*. San Francisco: Jossey-Bass.

Shea, S. E. & Goldberg, S. (2016). Training in reflective supervision: Building relationships between supervisors and infant mental health specialists. *Zero to Three, 37*(2), 54-62.

Shea, S. E., Goldberg, S., & Weatherston, D. J. (2016). A community mental health professional development model for the expansion of reflective practice and

supervision: Evaluation of a pilot training series for infant mental health professionals. *Infant Mental Health Journal, 37*(6), 653-669.

Shea, S. E., Weatherston, D. J., & Goldberg, S. (2012). *Reflective supervision self-efficacy scale for supervisees (RSSESS).* Unpublished assessment tool.

Sheridan, M., & Nelson, C. A. (2009). Neurobiology of fetal and infant development. In C. H. Zeanah (Ed.), *Handbook of infant mental health*, *3rd edition* (pp. 40-58). New York, NY: The Guilford Press.

Shirilla, J. J. & Weatherston, D. J. (Eds.) (2002). *Case studies in Infant Mental Health: Risk, resiliency, and relationships.* Washington, D. C.: Zero to Three.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., ... & Committee on Early Childhood, Adoption, and Dependent Care. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232-e246. Retrieved from www.pediatrics.aappublications.org

Simpson, T. E., Robinson, J. L., & Brown, E. (2018). Is reflective supervision enough? An exploration of workforce perspectives. *Infant Mental Health Journal, 39*(4), 478-488. doi: 10.1002/imhj.21719

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal mental health. *Zero to Three*, *22*(6), 10-16.

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

Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005). Minding the baby: A reflective parenting program. *The psychoanalytic study of the child*, *60*(1), 74-100.

Spieker, S. J., & Bensley, L. (1994). Roles of living arrangements and grandmother social support in adolescent mothering and infant attachment. *Developmental Psychology*, *30*(1), 102.

Sroufe, L. A. (2005). Attachment and development: A Prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*, 349-367. doi.org/10.1080/14616730500365928

Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, W. A. (2009). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York, NY: Guilford Press.

Sroufe, L. A., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*(4), 1184-1199.

Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York, NY: Karnac.

Stroud, B. (2010). Honoring diversity through a deeper reflection: Increasing cultural understanding within the reflective supervision process. *Zero to Three, 31*(2), 46- 50.

Suchman, N. E., DeCoste, C., Castiglioni, N., McMahon, T. J., Rounsaville, B., & Mayes, L. (2010). The Mothers and Toddlers Program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot. *Attachment & Human Development*, *12*(5), 483-504.

Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child development*, *75*(5), 1435-1456.

Tomlin, A. M., Sturm. L., & Koch, S. M. (2009).  Observe, listen, wonder, and respond:  A preliminary exploration of reflective function skills in early care providers.  *Infant Mental Health Journal, 30*(6), 634-647.  doi: 10.1002/imhj.20233

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

Travis, D. J., Lizano, E. L., & Mor Barak, M. E. (2015). 'I'm so stressed!': A longitudinal model of stress, burnout and engagement among social workers in child welfare settings. *The British Journal of Social Work*, *46*(4), 1076-1095.

Turner-Daly, B. & Jack, G. (2017).  Rhetoric vs. reality in social work supervision: the experiences of a group of child care social workers in England.  *Child and Family Social Work, 22,* 36-46.

Urdang, E. (2010).  Awareness of self: A critical tool.  *Social Work Education, 29*(5), 523-538.  doi: 10.1080/02615470903164950

Van Doesum, K. T., Hosman, C. M., & Riksen-Walraven, J. M. (2005). A model-based intervention for depressed mothers and their infants. *Infant Mental Health Journal*, *26*(2), 157-176.

Virmani, E. A., & Ontai, L. L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health  Journal, 31*(11), 16-32.  DOI: 10.1002/imhj.20240

Virmani, E. A., Masyn, K. E., Thompson, R. A., Conners-Burrow, N. A., Mansell, L. W.  (2013). Early childhood mental health consultation: Promoting change in the quality of

teacher-child interactions. *Infant Mental Health Journal, 34*(2), 156-172. DOI: 10.1002/imhj.21358

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University Press.

Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social work*, *60*(3), 201-209.

Watkins, C. E. (2011). Celebrating psychoanalytic supervision: Considering a century of seminal contribution. *Psychoanalytic Review, 98*(3), 401-418.

Watson, C. L., Bailey, A. E., & Storm, K. J. (2016). Building capacity in reflective practice: A tiered model of statewide supports for local home-visiting programs. *Infant Mental Health Journal, 37*(6), 640-652.

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

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

Watson, C., Neilsen Gatti, S., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. In E. Nwokah & J. Sutterby (Eds.) *Early Childhood and Special Education: Advances in early education and day care, Volume 18,* 1-26. Bingley, UK: Emerald Group Publishing.

Weatherston, D. (2000a). Infant mental health assessment through careful observation and listening. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *WAIMH Handbook of infant mental*

*health, Volume Two, Early intervention, evaluation, and assessment,* p. 119-155.  New

York, NY: John Wiley and Sons, Inc.

Weatherston, D. (2000b).  The infant mental health specialist.  *Zero to Three, 21,* 3-10.

Weatherston, D. J. (2001).  Infant mental health: A review of relevant literature.

*Psychoanalytic Social Work, 8*(1), 39-70.

Weatherston, D. (2005).  Returning the treasure to babies.  In K. Finello (Ed.), *The handbook of*

*training and practice in infant and preschool mental health* (3-30). San Francisco, CA:

Jossey-Bass.

Weatherston, D. (2007).  A home-based infant mental health intervention: The centrality of

relationships in reflective supervision.  *Zero to Three, 28*(2), 17-22.

Weatherston, D. (2010).  Perspectives – Infant mental health home visiting strategies: From the

parent's point of view.  *Zero to Three, 30*(6), 52-58.

Weatherston, D.J. (2013). Reflective practice: Look, listen, wonder, and respond. *Zero to Three*

*Journal, 33*(3), 62–64.

Weatherston, D. & Barron, C. (2009).  What does a reflective supervision relationship look like?

In S. S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision.*

Washington, DC: ZERO TO THREE.

Weatherston, D. J., Kaplan-Estrin, M., & Goldberg, S. (2009). Strengthening and recognizing

knowledge, skills, and reflective practice: The Michigan Association for Infant Mental

Health competency guidelines and endorsement process.  *Infant Mental Health Journal,*

*30*(6), 648-663.

Weatherston, D. J. & Paradis, N. (2011).  Defining professional competency in the infant  mental

health field.  *Journal of Zero to Three, 31*(6), 52-59.

Weatherston, D. & Tableman, B. (2015). *Infant mental health home visiting: Supporting competencies/reducing risk, Manual for Early Attachments: IMH Home Visiting®.* Southgate, MI: Michigan Association for Infant Mental Health.

Weatherston, D., Weigand, R., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *Zero to Three, 31*(2), 22-30.

Weigand, R. (2007). Reflective supervision in child care: The discoveries of an accidental tourist. *Zero to Three, 28*(2), p. 17-22.

Wightman, B., & Weatherston, D. (2004). The awakening of relationships as a baby joins a family: Observations and reflections. *Zero to Three*, *24*(3), 30-37.

Wightman, B., Whitaker, K., Traylor, D., Yeider, S. Hyden, V., Weigand, B. (2007) Reflective practice and supervision in child abuse prevention. *Journal for ZERO TO THREE, 28*(2), 29-33.

Wilkins, D., Forrester, D., & Grant, L. (2017). What happens in child and family social work supervision? *Child and Family Social Work, 22,* 942-951.

Wilson, G. (2013). Evidencing reflective practice in social work education: Theoretical uncertainties and practical challenges. *British Journal of Social Work, 43,* 154-172. doi: 10.1093/bjsw/ber170

Wimpenny, K., Forsyth, K., Jones, C., Evans, E., & Colley, J. (2006). Group reflective supervision: Thinking with theory to develop practice. *British Journal of Occupational Therapy, 69*(9), 423-428.

Winnicott, D. M. (1960). The theory of the parent-infant relationship. *The International Journal of Psychoanalysis, 41,* 585-595.

Woodford, M. S. (1999).  Home-based family therapy: Theory and process from "Friendly Visitors" to multisystemic therapy.  *The Family Journal, 7*(3), 265-269.  doi: 10.1077/1066480799073010

Yip, K. (2006).  Self-reflection in reflective practice: A note of caution.  *British Journal of Social Work, 36,* 777-788.  doi: 10.1093/bjsw/bch323

Zeanah, C. H. & Zeanah, P. D. (2009).  The scope of infant mental health.  In C. H. Zeanah, (Ed.), *The handbook of infant mental health, 3rd edition* (5-21).  New York: The Guilford Press.

**ABSTRACT**

**A QUALITATIVE STUDY OF INFANT MENTAL HEALTH SUPERVISEES' VIEWS OF REFLECTIVE SUPERVISION**

by

**CARLA CARINGI BARRON**

**May 2019**

**Advisor:**  Dr. Carolyn Dayton

**Major:**  Social Work

**Degree:**  Doctor of Philosophy

The infant mental health (IMH) field has identified reflective supervision (RS) as a clinically-supported, best-practice supervisory strategy to support professionals working with high-risk infants and their families, yet there is a paucity of empirical evidence to corroborate this view. This dissertation used a qualitative, cross-sectional, grounded theory design to investigate supervisee perspectives of RS. Semi-structured focus groups and individual interviews with 50 IMH professionals who were receiving reflective supervision were collected and analyzed with the goal of developing a deeper understanding of how supervisees operationalized RS and whether and how it impacted outcomes. Supervisees described essential components of RS as feeling safe within the RS relationship, developing trusting relationships with their RS supervisor, consistency and predictability of the RS sessions, nonjudgmental responses from their supervisors, and the commitment of both the supervisor and supervisee to be present and emotionally available to the RS experience. Data also suggest a number of variables that influence the supervisee experience of RS. These variables include: supervisee and supervisor constructs, relational constructs, and contextual factors such as agency support of RS. Four professional wellness outcomes, including burnout and professional efficacy and three personal growth outcomes including reflective

capacity were described as influenced by RS. Supervisees described five practice behaviors influenced by RS, including the capacity to bring up difficult topics with families and becoming better observers of family dynamics. In summary, supervisees described that when they feel safe and trust their reflective supervisor, they feel more comfortable expressing their vulnerability and sharing difficult experiences within RS. This promotes growth in their capacity to be reflective about, and responsive to, their professional and personal needs, as well as the needs of the families they serve. Furthermore, data suggest a developmental and ecological theoretical perspective of the supervisee's experience in RS. Their experience and understanding of RS results from a complex interaction between qualities and characteristics of the individuals and the settings in which RS is implemented. This theoretical model expands our understanding of RS by including the supervisee perspective and offers a way to organize the RS experience. Results from this study will inform future RS training, provision, and access through empirical research and implementation recommendations.

**AUTOBIOGRAPHICAL STATEMENT**

Carla Barron was born and raised in the Metropolitan Detroit area, where she currently lives with her husband and two children. She has worked in the infant mental health field for over 20 years. Along with being a career-long reflective supervisee, she provides reflective supervision to infant mental health professionals, facilitates trainings, and supports students. She is interested in continuing her research on reflective supervision in order to learn more about how to best support professionals in the important work they do with infants and families.