Reflective Supervision in Infant Mental Health Practice (2 CE Hours)

Learning objectives
- List various models of infant mental health supervision in addition to reflective supervision.
- Understand reflective supervision’s origins and history through the infant mental health movement.
- Describe reflective supervision in the context of infant mental health intervention.
- Describe reflective supervision’s applicability in various infant mental health settings.

Introduction
Infant mental health supervision can provide a rich opportunity for mental health practitioners to further their self-awareness and clinical skills. Yet it can cause intense reactions that are universal among those being supervised as well as their supervisors, especially in the relatively new field of infant mental health. Supervision can uncover the brightest and darkest aspects of our work, ourselves and of one another. (Schafer, 2007).

In this course, four models of supervision that can be applied to infant mental health intervention will be discussed, with a primary focus on reflective supervision. While the field of infant mental health has identified reflective supervision as the preferred supervision form, in reality, strict adherence to any one supervision methodology can create its own set of issues. It is more normal to incorporate more than one supervision method into infant mental health practice, especially because infant mental health supervisors must wear many hats during tougher economic times.

William M. Schafer, PhD., clinical psychologist and past president of the Michigan Association for Infant Mental Health, has identified four primary infant mental health supervision models (Schafer, 2007) as:
- Administrative.
- Traditional.
- Relationship-based.
- Mindfulness.

While they will all be described here, the course will focus primarily on the relationship-based or reflective supervision approach by discussing its history, providing a more in-depth description and discussing its applicability in infant mental health settings. All of the models described here are helpful and needed in infant mental health practice.

Supervision models

Administrative supervision
Administrative supervision is the most commonly used supervision model in the workplace; administrative supervision encompasses reviews and assessments of a supervisee’s work performance. Dr. Schafer states, “In the world of infant-toddler services, administrative supervision is commonly concerned with the appropriateness of services offered, the timeliness and accuracy of documentation and reporting for the purposes of reimbursement, and the flow of paperwork and information necessary to keep the office functioning smoothly.” (Schafer, 2007).

Administrative supervision follows a logical format as it strives to pursue an orderly route to get the job accomplished. The goal is quality control. The roles of supervisor and supervisee are clear where the power clearly lies with the supervisor. Disciplinary action follows failure to follow clearly communicated directives. Transfer of information is the major change agent, and supervision proceeds by teaching, training and setting standards.

Relevance in infant mental health settings
While the relationship between supervisor and supervisee is not considered the central agent of change, administration supervision serves a primary purpose of keeping infant mental health program goals on course and maintaining orderliness with regard to timelines, record keeping and paperwork flow. Administrative supervision addresses the immediate issues relevant to financially supporting the work.

Traditional mental health supervision
Behavioral health supervision and psychodynamic supervision are two primary forms of traditional supervision; they differ within the behavioral health methodology in that there is less importance given to the role of internal personal conflict and external conflict with clients, supervisees and supervisors. Both forms of supervision assume that a task is too complicated to be scripted in advance and that the purpose of supervision is the development of a sophisticated set of skills and sensitivities in the supervisee. The change agent is a two-way exchange of experience and meaning.

Behavioral health supervision
Behavioral health supervision is generally a strength-based model that focuses on solution-focused communication between the supervisor and supervisee. It emphasizes conflict and pathology less and the natural inclination toward health and healing more.

During a behavioral health supervision session, strategies for creating solutions and offering better coping skills are discussed, as well as finding specific support and services, and building teamwork. The supervisor role models coaching and mentoring so that the supervisee will do the same with clients.

Psychodynamic supervision
Psychodynamic supervision has its roots in psychoanalytic practice and assumes that supervisors cannot teach people how to do their work by describing prescriptive steps to follow; the task is too complex to be prescribed. The supervisor helps the supervisee reach a deeper understanding after a supervisee has described what has occurred in treatment. Both discuss possibilities and possible courses of action.

Relevance to infant mental health settings
Traditional supervision requires the supervisor to listen intently to the supervisee and build on two-way, meaningful communication. The subsequent trust and intimacy that grows from these exchanges, with clearly defined boundaries, often contributes to a more psychologically safe work environment, encouraging role modeling these attributes with clients. In infant mental health settings, the relationship is the client (Paul and St. John, 1998) and therefore listening intently to caregivers and discussing possible solutions with immediate follow-up can instill confidence and promote growth. Both supervisees and client families understand that interventions are not required but instead are volunteered.

Relationship-based supervision
Relationship-based supervision (reflective supervision) emerged in the late 20th century, growing from infant mental health work. Other related terms include “reflective supervision” and “reflective practice.” Including relationship-based supervision, they all create a context and an interpersonal environment that permits self-reflection and professional use of self. (Eggbeer, Mann, Seibel, 2007) All three focus on the relationship between the client and client(s) and the relationship between the supervisor and supervisee. It assumes that all learning takes place within the context of a relationship. Therefore, the principal change agent is “reflection” as opposed to the tradition supervision change agents of “interpretation” or “reform.”

Reflective supervision assumes that a parallel process (Bertacchi and Coplon, 1992) occurs between the relationship of the supervisor and supervisee and the supervisee and the client family. It is assumed that change along either of these paths produces a similar change in the other. The distinction between authority and power in reflective supervision and traditional supervision is that in reflective supervision, the supervisor is still viewed as more experienced in the dyadic relationship but is not the expert who knows what to do. The supervisor places a larger burden on him/herself to be the knowing expert when practicing traditional supervision.

Reflective supervision requires that both the supervisor and supervisee enter into a mutual
relationship that requires them to be open and willing to risk self-disclosure. Moreover, self-disclosure from a supervisee is not immediately assumed to be an expression of personal pathology but reflective of entering into a relationship with a suffering client. Reflective supervision strives to create a developmental space in which growth and the unlocking of human potential can occur in the client family and the service provider (Schafer, 2008).

Reflective supervision acknowledges that the interaction between the supervisee and his/her client family is unique. Therefore, the supervisor’s role is to help but not instruct the supervisee to reach deeper recognition of the emotional issues of the client family and to move them beyond their inhibiting patterns of interaction. “The change agent (also) becomes the development of the relationships themselves, and the result is the expectation that all participants, including the client family, supervisor and supervisee, will experience both the joy and the terror of growth during the process.” (Schafer, 2007)

In contrast to administrative supervision, reflective supervision requires interventionists and their supervisors to assume a receptive posture that utilizes physical senses including voice, touch, sight, mind and body. Reflective supervision is not passive but is instead a centered approach to listening, observing, providing feedback and discussion. It also engages the supervisee and supervisor to be fully involved but does not ask the supervisor to be instructional or directive.

Relevance to infant mental health settings
Reflective supervision is a relationship-based supervision methodology that addresses the “intersubjective domain of self with others.” (Schafer, 2007) Reflective supervision creates a non-judging space where the dialogue moves on several different levels and challenges both the supervisor and supervisee to mutually grow through the supervision process. When mental health supervisors are careful about the quality of their relationships with supervisees, it ultimately affects parents and other adults to expand their capacity to nurture their young children.

Mindfulness practice
Based on Eastern psychology techniques, mindfulness practice has, as its core, the practice of maintaining presence even in the face of discomfort and pain, of tolerating states of not knowing, and of bringing compassion to all aspects of self and others. Presence – the experience of being internally still without resistance or judgment – is the ultimate healing source. Mindfulness practice, therefore, requires that one surrender the natural impulse to do and instead to maintain a stance of compassionate awareness for what “is.” The form of communication is less and less verbal.

Mindfulness practice requires courage on the part of the supervisor because it confronts the supervisor with his/her own powerlessness and admission that he/she is not the expert. This form of supervision appears to be more relevant to situations that involve certain death, irretrievable loss and chronic pain than to situations that are more easily changed or “fixed” and where supervisee and client family relationships do exist.

Relevance to infant mental health settings
The practice of “presence” offers advantages to supervisees who have a difficult time relating to client families and clients who are challenged to maintain a meaningful relationship and situations when mental health practitioners feel powerless to make a difference. These times can include working with families living on the margins of life, who suffer from chronic mental illness and substance abuse and who are impacted by homelessness, social apathy or domestic violence. Sometimes it is impossible to establish a relationship, and when this occurs, supervisors can utilize mindfulness practice to support and provide validation to their supervisees.

A closer look at reflective supervision
Reflective supervision in infant mental health is the process of examining with someone else the thoughts, feelings, actions and reactions evoked in the course of working closely with young children and their families. The purpose of reflective supervision is to assure quality services to infants, toddlers and their families. With supervisees, supervisors:

- Explore positive and negative reactions to the client family work.
- Encourage careful thinking and perspective talking as supervisees recount the work.
- Plan for future steps.

Key concepts within reflective supervision include:
- Reflective functioning or the capacity to have your own thoughts and feelings as well as the capacity to think about another person’s thoughts and feelings.
- Reflective dialogue or when conversation occurs around difficult discussion topics.
- The parallel process that occurs between the supervisor and the supervisee.

A sensitive supervisor will reflect on the supervisee’s concerns as well as her own. For example, starting a supervisor-supervisee relationship can be scary for both participants. When a supervisor, after listening to her supervisee’s trepidation, shares their mutual concerns aloud, a door or portal is opened for further exploration. The supervisor, then, is not pressured to provide the “right” answer, but rather to ask the supervisee how she thinks they should proceed. Through mutual discussion, they can agree on a process that works for both of them.

Background
The conviction that reflective supervision is key to effective infant-family work has firmly taken root during the past three decades. Beginning in the 1970s, mental health practitioners were concerned about the inner experiences of babies and toddlers in addition to the inner world of their parents. They wanted to understand the role that a baby’s relationships with important others played in healthy development. Infant mental health grew from their work. (Fraiberg, Adelson, Shapiro, 1975) In the 1980s, “self reflection” was written about and discussed as playing a key role in supervision as the field grew.

The infant mental health field covers many professionals working in diverse settings that touch the lives of infants, toddlers and their families. Some of these professionals include mental health, speech, occupational and physical therapists as well as professionals from other medical arenas, such as nurses. According to authors, Eggbeer, Mann and Seibel, (2007) professional activities over the 1980s focused on:

- Training individuals from single or multiple disciplines.
- Reaching those who work in programs and those who practice alone or in small groups.
- Educating those who either interact with children and families on a daily basis or see them intermittently.
- Preparing individuals who have advanced degrees in early childhood and other fields as well as those who have never taken a course nor held a baby.

The Zero to Three Network, the national association of infant mental health practitioners, began to identify four elements of training as important for all practitioners as they moved from pre-service preparation to practice in the emerging infant mental health field.

These include:

- Opportunities for direct observation and interaction with a variety of children less than 3 years old and their families.
- A robust knowledge base.
- Collegial support, within and across disciplines, throughout a practitioner’s life.
- Individualized supervision to allow reflection on all aspects of work with young children and families.

In the 1990s, the Zero to Three Network explored individual supervision more deeply. A multidisciplinary task force to study supervision as a “relationship for learning” identified its essential features as reflection, collaboration and regularity of occurrence. The key functions of supervision were to:

- Promote learning.
- Ensure a safe place for the expression of a full range of feelings elicited by work with babies and families.
- Provide an opportunity to discuss goals and measure progress towards achieving them.
- Bring content and process together in professional practice.
In 2000-2003, Early Head Start (EHS) National Resource Center undertook the Pathways to Prevention infant mental health initiative that involved 25 Early Head Start programs nationwide. Each program received help from a national infant mental health consultant to build its capacity to address infant mental health needs. This included an emphasis on either starting a system of reflective supervision or building upon an existing system. The project evaluation found that programs that elected to focus on enhancing their approach to supervision benefited from consultant support. (Mann, Boss and Randolph, 2007)

In addition, the Michigan Association of Infant Mental Health (MI-AIMH) now has developed infant mental health competencies that include a strong emphasis on understanding reflective supervision.

**Zero To Three**

Zero to Three is a national nonprofit, multidisciplinary organization that supports the healthy development and well-being of infants, toddlers and their families. The organization’s mission is to inform, educate and support adults who influence very young children’s lives. While there is no membership, professionals can access Zero to Three information through its website at http://www.zerotothree.org, receive a monthly eNewsletter, join the Zero to Three policy network, and subscribe to the Zero to Three Journal.

Zero To Three does not provide childcare, nor is it able to respond to individual parent questions. (The Early Head Start National Resource Center (EHS NRC) was created in 1995 by the Head Start Bureau and the Administration for Children and Families. Since its inception, the EHS NRC Center has been operated by Zero To Three in Washington, D.C.)

**The World Association for Infant Mental Health (WAIMH)**

The World Association for Infant Mental Health (http://www.waimh.org) is a nonprofit organization for scientific and educational professionals. Its central aim is to promote the mental well-being and healthy development of infants throughout the world, taking into account cultural, regional and environmental variations, and to generate and disseminate scientific knowledge. WAIMH seeks to facilitate increased knowledge about mental development and disorder in children from conception to age 3; disseminate scientific knowledge about services for care, intervention and prevention of mental disorders, and impairment in infancy; and disseminate evidence-based knowledge about ways to support the developmental transition to parenthood and the healthy aspects of parenting and care-giving environments. It also promotes international cooperation of professionals concerned with the optimal development of infants as well as the prevention and treatment of mental disorders in the early years, and aspects of research, education and interventions in all these areas.

**Advantages to reflective supervision**

There are many advantages to practicing reflective supervision in an infant mental health setting, including reducing stress and burnout in workers. Supervisees report that the support from their supervisees provides a sense of safety and openness and that they can rely on someone to support them when they are overwhelmed by the work and when a difficult decision needs to be made.

Reflective supervision also encourages staff to work through their own and their client families’ difficulties within the context of a non-judgmental supervision setting. In addition, it can provide a feeling of catharsis and replenish supervisees so that they can move beyond their internal conflicts and more carefully work with their families. Supervisors provide a sounding board for supervisees when they are naturally challenged by their own biases and situational inexperience.

Through reflective supervision, supervisees learn to understand empathy at different levels. For example, the supervisee experiences her supervisor’s empathy as she replays a tough session with a resistant parent. In turn, she is better able to express empathy for the parent, who she learns, is struggling with a recent addiction relapse.

Supervisees can also gain a deeper understanding of how their past and present experiences affect their world-view and personal beliefs. “As a result of being heard by a supervisor, a supervisee can better listen to client families and be curious about and discover the things that are important and meaningful to them about their children and themselves” (Heffron, Ivins, and Weston, 2005).

In addition, when working with client families, supervisees can sometimes lose sight of boundaries and forget the undeniable power of the unconscious mind. Through reflective supervision, supervisors can facilitate further awareness of how these issues fold together and how to best recognize and deal with them as they help families move forward.

Reflective supervision’s aim is to assure quality services to infants, toddlers and their families. Reflective supervision does so by facilitating an accepting and engaging relationship between the supervisee and parents. In turn, it benefits babies and toddlers by helping to support the capacities of their parents to provide nurturing care through the relationship they have with the infant-family professional (Eggbeer, Mann, Seibel, 2007).

**Barriers to reflective supervision**

The wide range of professionals who form the circle of infant mental health providers contributes to the lack of consensus about what the process of reflective supervision specifically entails or the qualifications of those who provide it. If one offers reflective supervision without personally experiencing it as well, it is not possible to provide the same form of supervision. Yet the infant mental health field is filled with nurses, early learning educators and others who have not had exposure to longer-term mental health training. The availability, quality and sequence of training for infant family professionals continues to be uneven (Eggbeer, Mann, Gilkerson, 2003) Sometimes infant mental health supervisors who are put into their positions because of their accomplishments lack the proven skills and knowledge required to be effective supervisors.

Some questions about the method remain:

- How does reflective supervision interface with performance evaluations? For example, how can they be quantified to reflect treatment outcomes and completion of job responsibilities?
- How does differential power play out in the supervisory relationship? For example, supervisors are seldom given the performance task of providing only reflective supervision without goals and objectives, paper work and other performance timelines. How does this dual role play out within the context of a birth-to-5 mental health setting? Can the supervisor continue to perform her administrative duties with staff if she simultaneously engages in reflective exploration?
- What degree of confidentiality is shared during supervision? Supervisees often fear that their supervisor will not keep the content of the discussion private or will use it to make later managerial decisions regarding them.
- What is the essential therapeutic nature of reflective supervision? For example, one of the most frequent objections to reflective supervision is that it appears to be psychotherapy with the supervisee. The most commonly reported fear is that supervision may open up feelings and conflicts that it cannot contain or resolve. (Shafer, 2007) An unspoken fear within both supervisors and supervisees is, “Do I want to reveal myself to someone with whom I work?” Supervisors must be willing to risk meeting their supervisees in the spirit of equal openness.
- How will reflective supervision be established and maintained in my organization where the pace of the work and the lack of space prohibit the length of time and privacy needed for reflective supervision?
- How can my organization afford to pay a trained mental health clinician to provide supervision? Early data has supported that not using reflective supervision entails serious costs in terms of quality of services and staff turnover. But many child welfare organizations that survive month to month on slender budgets and short-term solutions to long-term problems see the costs of providing reflective supervision as prohibitive.
Relating to client families from the reflective supervision perspective
Providing infant mental health intervention services to client families while receiving relationship-based supervision prompts supervisees to examine themselves from a different perspective than if they were receiving administrative supervision.

Working with client families creates a dual relationship that builds upon a relationship with a supervisory. Infant mental health specialists must draw on the strengths of their client families, rather than focus on their deficits. When they are together with a mother, father, and yet-to-be-born baby or a baby or toddler, there are at least four key players in the room. All are important and all have strengths as well as equal but different kinds of knowledge. The specialist’s presence is powerful in that room, and the things she/he wants to learn about that family are the very same things they need to know about themselves.

(Cardone, Gilkerson, Wechsler, 2007)

Remember, within the field of infant mental health, the relationship is the client. Therefore, it’s not uncommon to reflect with one’s supervisor on the following questions about:

Personal life story
Our lives affect how we approach our work, and so the relationship between self and others can be examined through reflective supervision. Questions that prompt deeper self-examination may include:

- How do I define myself and the way I approach my work? For example, have I been a parent or a parent-surrogate?
- How do I define myself and the way I approach my work? For example, have I been a parent or a parent-surrogate?
- How does my having been a birth mother, stepmother, mother-in-law, aunt or having no children affect how I approach my work?
- If my own child is a teenager and I’m involved with a teenage mother, how do I relate to my client and her family?
- If I’m a single, working mother, how do I feel about my clients who are struggling with being single and working as well?
- If I have no children, how do I feel about working with mothers and their babies?
- Do I have a personal trauma history? Does that affect how I work with trauma survivors?
- Am I strongly influenced by my spirituality and/or my religious convictions when I interface with my client families?

Working within the infant mental health setting
These questions focus on where personal instincts lay with regard to the art of engaging children and their families. For example, one question might be, “Am I drawn to a particular age when working with children and families?” Others could include:

- Do I feel more comfortable and confident around toddlers than babies, or more comfortable around babies?
- Do I struggle with understanding how mothers relate better with their babies than their toddlers?
- Am I having difficulty understanding an adolescent mother with her toddler because they appear to exhibit the same behaviors?
- Does my own age affect how my client families relate with me? For example, a young infant mental health specialist might relate more easily with a teen mother, but an older specialist might be able to share wisdom that is more easily heard by a teen mom.
- How do I hold my emotions in check and set boundaries with client families? Is it different from a solution-focused approach?
- How much emotion can I safely share with my supervisor? Will she/he hold what I say against me and see my emotions as a form of pathology?
- What strengths and resources do I bring to my work?

Personal relationships and work
How do family, friends and co-workers help me define myself within my work setting? This question prompts further questions that might include:

- Who helps bring out my strengths in the workplace as well as in my personal life?
- How do my personal relationships affect how I approach my work?
- How do I regulate and contain my emotions with client families when someone in my personal life is struggling with an emotional issue? For example, how am I affected in my work if one of my siblings is unable to be a birth parent?
- How assertive am I in the workplace based on my earlier family relationships?
- How does my work culture promote support for infant mental health work? For example, do I struggle with informing co-workers and supervisors more than my client families?
- How does my work culture support me as a supervisor when I must assume a dual administrative and reflective supervision role?
- How do my relationships with my own teenage children affect my relationships with my teen mothers?

Framing, mirroring and responsive listening
Reflective supervision is a strength-based approach to infant mental health supervisory work. Communicating through reflection provides an avenue to reframe circumstances that bring out authentic and more centered responses from supervisees because reflection does not “corner” the supervisee nor demand the perfect answer. Reflective supervision relies on unfolding information without jumping to conclusions. In turn, the supervisee is provided a portal or opening from which to think about and ponder, rather than an immediate answer that may or not be the best. What supervisors do in way of mirroring, framing and listening responsively to supervisees guides supervisees to do the same with their clients.

Framing supervisee or client responses invites everyone to problem-solve or hypothesize together. Saying, “Let’s think about this together,” opens up a world of possible discussions. Mirroring from supervisors lets supervisees know they are taken seriously and sends the message that they are safe to voice what they may think would be the unspeakable. (Cardone, Gilkerson, Wechsler, 2007). By repeating what they hear, supervisors validate and make room for their supervisees to speak their thoughts. For example, a supervisor might respond to a supervisee’s comment, “I’m tired of chasing down my client just to be told that I’m unwanted,” by saying, “I know you’ve been working really hard to make that connection and you’re tired.”

Sometimes supervisors simply listen without commenting and by doing so create a still space where further ideas and feelings can come to light. For those who are wrestling with their thoughts, silence extends an invitation to spend more time examining those thoughts.

How reflective supervision is utilized in various infant mental health settings
Reflective supervision has been effective in a variety of settings. For example, it can be utilized in an early learning environment where infant mental health specialists are often asked by parents and early learning educators to assess babies and toddlers, and then inform and refer client families for follow-up intervention.

Home-based infant mental health intervention is another environment that has been shown to provide a portal to assess and intervene on behalf of children and their families. Early Head Start In-Home programs provide these types of services.

In addition, programs that provide prenatal support services such as Healthy Start have been very effective in getting early infant mental health intervention to newborns. Adolescent mother programs provide opportunities to assess for infant mental health intervention as well.

Reflective supervision has also been effectively used in child welfare settings to prevent child abuse where family and/or group sessions are provided for client families.

Early learning settings
Early learning settings provide an opportunity for early learning educators to build and sustain long-term relationships with families, especially when there is early involvement. Through parent and parent group interaction as well as the day-to-day contact with children and their parents, opportunities arise to inquire, observe and increase trust between all the players. Early learning educators can earn credibility with their client families when they demonstrate and build upon their relationships while maintaining self-awareness of the power they bring to those relationships.
The supervisor and the supervisee in these settings are often working together and sharing similar duties. The supervisor often knows and interacts with the supervisee’s client families. So there are certain cautions supervisors must take to avoid superimposing their own communication styles on their supervisees. The following case illustrates this challenge.

Veronica and Milton
Veronica is Milton’s supervisor in an early learning setting where they work with young children ages 6 months to 4 years old. Veronica has been an early childhood educator for more than 10 years, and Milton is a new educator after retiring from the military after 20 years. Veronica has been using reflective supervision with Milton since his employment began six months ago.

Milton, on the other hand, has been struggling with reflective supervision because he has yet to recognize its value. He has observed Veronica role modeling it with other workers within their early learning setting. Milton cannot relate to her since he used to work in the military. Veronica has been challenged to recognize that Milton has a different presentation style than she and that his humor is a huge strength when he relates to the families in his own way. In fact, they like his directness and relate well to his feedback.

In this setting, Veronica has an opportunity to explore Milton’s and her own different communication styles through the reflective supervision approach. Lately, when they meet for supervision, Veronica has taken more time to get to know more about Milton and his earlier professional background. In his former job, he came from a military world where introspection could cost precious time when a life-or-death decision had to be made and where humor offset some of the intense pressures he faced.

In addition, recently, Veronica has become more direct with Milton and even said he might think reflective supervision was for “bleeding heart liberals.” She and Milton had a good laugh, and the ice was broken. Veronica went on to ask Milton how and when he knew to use his great sense of humor with a center family, and she acknowledged that the families in the center warmed up to him when he was direct and fun to be around. She wondered aloud with Milton how that might help to relieve some of the stress their families suffered.

Assessment and infant mental health intervention within an early learning environment
When early learning environments enhance their services by providing an infant mental health assessment and intervention program, they should be mindful of creating separate physical space for doing this work.

Infant mental health spaces may be separate or included in the layout of the early learning center, but ideally, they should include an office with locked file cabinets and technical equipment space, family session room and an assessment or playroom with two-way mirrors and the capacity to video and audio record. The early learning center play area itself provides assessment opportunities through observation regarding a child’s socialization and gross and motor skills. But it cannot be the only space for administering assessments, interventions and private discussions.

An early learning center infant mental health environment enhances the local community. Local, state and federal funders also are looking more favorably on early learning environments that are guided by infant mental health evidence-based practices. In addition, the ability to observe supervisees in their own setting and then provide more immediate feedback because of shared learning space is an additional advantage.

Home-based infant mental health
Parallel processes and parallel struggles for the supervisee and client family as well as the supervisee and supervisor can abound when services are provided within an in-home infant mental health setting. Yet opportunities for growth on the part of all the players are abundant.

Because of the in-home, one-on-one intervention format, an in-home infant mental health setting can focus more intensely on the connection between supervisee and client family. Often, the client family has experienced a degree of psychological and physical isolation that has contributed to the problems within the parent-infant/baby/toddler relationship. Because of their isolation, parents may project larger-than-life expectations onto the infant mental health specialist. In turn, the complexity of client family issues may seem overwhelming to the supervisee, and she/he may project exaggerated expectations onto the supervisor as well.

In addition, with an in-home setting, the issue of trust can become a focal point as the client family and even the supervisee come face to face with their trust issues. As a result, resistance can emerge, including within the supervisee-supervisor relationship, particularly when a client is especially resistant to accepting support from the specialist. When these times occur, the supervisee can feel overwhelmed and ask the supervisor to “fix” the situation as demonstrated by the following scenario.

Janet and Ruth
Janet is Ruth’s reflective supervision supervisor. Ruth is an experienced licensed mental health therapist and new to the infant mental health field. She is providing in-home mental health services through the community’s Early Head Start program and struggling with a parent client’s ambivalence and resistance to receiving her support.

Her client, Emma, has a history of drug and alcohol abuse and has been mostly abandoned by her baby’s father, who has been intermittently involved with her since he learned of her pregnancy. The young mother has lived alone with her baby in a trailer in a small rural community since her prenatal stay at the county’s drug and alcohol rehabilitation center. Having no means of personal transportation, she must rely on family members and friends to take her to her recovery groups and other appointments.

Start-up for all parties involved has been challenging. In the early stages of their supervision experience, when Emma canceled their sessions, Ruth canceled her supervision with Janet. When Janet asked her about the cancellations, Ruth said there was nothing to discuss when she hadn’t met with her client. Janet was tempted at those times to share her frustration with Ruth, but instead chose to discuss the issue of Emma’s ambivalence about receiving Ruth’s support. Bringing the ambivalence issue to light clarified for Ruth that it would be okay to wonder (aloud) with Emma about what it must be like to experience help from someone she barely knew. The follow-up conversations between Ruth and Emma validated that difficult discussions could occur without retribution or blame, and over time, Emma became more reliable about letting Ruth know her schedule. Ruth, in turn, shared her appreciation for Emma’s consideration, and also began to meet regularly with Janet regardless of whether she’d met with Emma the same week.

The issue of trust was reflected within the parallel infant mental health process as well. Emma was concerned that family members would attempt to gain custody of her infant daughter, and her stress level was extremely high. Staying sober and caring for and nurturing her child challenged Emma, who was reluctant and ashamed to admit she needed help. Emma was apprehensive that Ruth, the same age as her mother, would judge her and collude with her family to take her baby away. Ruth reassured Emma and attempted to give her advice. When Ruth did share advice, Emma appeared bored and distracted. As Emma’s fears that her child would be taken away grew, Ruth’s did as well. She reported to Janet that she was worried that Emma would experience an addiction relapse. She asked Janet to provide some answers.

Janet was tempted to give Ruth advice, but restrained herself. Instead she focused on listening to Ruth’s concerns and wondered aloud whether Ruth had doubts about Emma’s capacity to mother. Ruth responded that she hadn’t given it much thought, but admitted she thought Emma was very immature. Janet went on to reflect that Ruth’s anxiety appeared to grow with Emma’s. Janet’s anxiety rose as well. She wondered whether she was up to the task of supervising Ruth, but didn’t immediately share these specific concerns. Instead, she continued to listen and asked Ruth more about her fears for Emma. As Ruth and Janet both reflected on and
discussed those fears, Ruth’s anxiety diminished considerably when Janet reassured her that the baby’s safety was something that Ruth knew how to consistently monitor.

As Janet followed Ruth’s lead, Ruth learned to follow her young client’s as well.

As Emma became aware that Ruth was on “her side,” she disclosed more of her fears and began to ask for help when it came to understanding why her infant daughter responded in certain ways to her parenting. Janet supported Ruth’s plan to tell Emma that she saw Emma gaining confidence as a parent, which helped create parent-child inroads and growing trust between Ruth and Emma.

Neonatal and newborn settings

Neonatal settings provide expectant and new parents with an opportunity to explore their infant’s development and to identify and address their expectations about becoming parents. Currently, there are a number of evidence-based curriculums available to infant mental health specialists who work within these settings. The curriculum normally incorporates reflection into the material through:

- Greeting, connecting and reconnecting with parents.
- Asking about and validating parental observations.
- Reflection on the neonatal experience and infant behavior.
- Creating a pattern of behavior that can continue after the birth of the baby and into the future.

Jennifer and Sarah

Sarah is Jennifer’s supervisor in a community mental health center where weekly neonatal groups are held. Jennifer is a newly licensed mental health professional with no previous work experience except for her internship through graduate school. Sarah has been at the center for a short time herself but brought several years experience to her new job, especially in working with neonatal and early intervention programs.

As the supervisor and supervisee became acquainted, Jennifer shared almost immediately that she was grappling with feeling uncomfortable around her client parents because she’d never been pregnant or close to being married. Sarah reflected on Jennifer’s apparent concern for her clients and noted it was a concern that everyone felt and experienced. Jennifer’s response was relief.

Throughout the following weeks of supervision, Sarah followed Jennifer’s lead as Jennifer explored her internal and external responses within the context of her work with her families. The parallel process emerged as Sarah invited Jennifer to invite her clients to “see what was happening for them” with regard to their babies’ womb activity and other developments. At the same time, Sarah was nonverbally inviting Jennifer to reveal her own responses to them.

In addition, in supervision, Sarah provided further elaboration to Jennifer’s feedback. For example, if Jennifer reflected on one mother’s negative response to breast-feeding, Sarah would note that there are many maternal responses to breast-feeding, and that sometimes breast-feeding isn’t a good fit for a mom and baby.

Sarah also wondered whether Jennifer could hold deeper conversations with parents about how they were feeling about becoming parents and whether they felt pressure to experience certain feelings and respond to people’s congratulations in certain ways. Jennifer responded by disclosing to Sarah that she understood how some of her clients would be hesitant to answer those questions. As Sarah and Jennifer reflected on and explored Jennifer’s comments, Sarah showed Jennifer what she could do with her clients as well. Sarah essentially created a safe space to talk with Jennifer about difficult subjects, thereby helping Jennifer do the same with her clients. (Cardone, Gilkerson, Wechsler, 2007)

Jennifer also explored modeling by speaking to babies within and outside of the womb when she sat with families. As she gained confidence, she used her voice and tone to soothe and coax them when the babies were especially active and when they were quiet as well. For example, her comments might be, “You are a wonderful busy baby, and your mommy loves you so much,” or “Speaking softly to you is something you like, isn’t it baby?”

Sarah had encouraged Jennifer to build upon her strengths from the beginning of their supervisory relationship and had followed Jennifer’s lead along the way. That gave Jennifer the tools she needed to begin her infant mental health career and build positive relationships with new parents and their children.

Child welfare settings to prevent child abuse

Reflective supervision within the child welfare setting can improve work with children and families because it builds upon the existing skills of the mental health professional to create a different connection pathway with their clients. The mental health professional-client relationship has a tremendous influence on how well therapy will go. The quality of a relationship with client families is crucial to the success of an intervention. When utilizing reflective supervision, these relationships take under consideration what mental health professionals know but are not necessarily attentive to all the time: how clients experience them.

Mental health professionals can fall into patterns of identifying mistakes within families that have entered the child welfare system and then pointing out what can be done differently and better, providing instruction and directive guidance. Reflective supervision within the child welfare environment explores mistakes without exploiting them and promotes sensitivity to nuances in addition to interaction. Themes can travel further than just what the next case management treatment goal is and how to achieve it.

When topics that include issues of loneliness, oppression, fears and losses are discussed, doors open to understanding and knowing clients at a different, more humanistic level because everyone shares these feelings. For example, how can mental health professionals guide client families to deal with anger if they have not dealt with their own? Reflective supervision with their supervisors can promote self-disclosure on the part of supervisees about all of these issues in order to be more sensitive to a client family’s journey.

While utilizing reflective supervision, supervisors guide supervisees to become adept at working with families within the child welfare system. Most of the time, these families are forced by a court order into mental health counseling, and many have never been given the tools to become aware of, identify and communicate their feelings, worries and needs. These families relate more to instincts that in many instances have kept them alive. When they encounter a non-authoritarian authority figure, it can be disorienting for a time, but they usually instinctively relate to the listening and warm approach that reflective supervision promotes. It is an approach that leads supervisees to have more meaningful conversations with their clients, which can include different kinds of questions and reflections about why people are motivated to their actions.

Sometimes supervisors must simply be witness to their supervisees’ processes, or the process of discovery does not become the supervisee’s own. Supervisors within reflective supervision become the secure base from which supervisees can verbally explore their work with their families without necessarily needing a response from their supervisors. Other times, supervisees require more guidance or reflection, but just as often supervisors can be effective by being still and listening as supervisees explore their feelings and thoughts. Interrupting or in some way intruding in the process can disrupt the self-discovery that occurs during the supervision hour. When individuals are allowed to continue thinking about and exploring their own ideas without interference from another or the imposition of another agenda, the knowledge gained is their own. It comes from within. It is implicitly rather than explicitly derived. (Weigand, 2007)

Again, as the supervisor models listening and reflection, so, too, the supervisee learns to listen and reflect with client families who are searching to find their way toward healthier parenting. For example, when time is taken to ask and reflect on family rituals and cultural celebrations, parents are able to examine their relevance to their parenting. They are better prepared to make decisions about how they want to proceed as new parents and what pathways are more advantageous for them and their children.

The following scenario illustrates this point:
Lawrence and Mary

Lawrence is Mary’s reflective supervision supervisor within a mental health early intervention program that provides in-home services to children birth to age 3. The program is part of a larger organization that also provides case management for children who have entered the child welfare system. All of the program’s families have been ordered into treatment by a court and referred by case managers working within the same environment.

Mary is 20 years older than Lawrence and has several more years experience as a licensed mental health therapist. Lawrence, while younger, has been involved in the infant mental health movement for more than six years and has introduced their entire program to reflective supervision, a new form of supervision for Mary. Due to constraining factors within the mental health reimbursement arena, she has favored using solution-focused therapy with families and has become rather impatient with the idea of receiving reflective supervision from Lawrence.

When they met for the first time, she tactfully shared with Lawrence that she didn’t think his supervision would be effective considering the transient nature of their client population and the time it took to listen to families “meander” over their issues. Lawrence acknowledged her comments and wondered aloud if they could work together to utilize both solution-focused therapy and reflective supervision into their discussions.

Soon, Mary began working with a family that had been ordered into treatment by a court after the parents were arrested for drug involvement. Their 3-month-old son remained in the care of his parents, but wraparound services were initiated, including in-home mental health counseling for the entire family. The young couple had both grown up in the child dependency system and both were very dependent on the other because their birth families were distant and/or seldom available to provide support. They spent their nights and weekends drinking alone together or with friends while their baby was exposed to marginally safe environments and often neglected when they were partying. The couple partied when their baby was exposed to marginally safe environments and often neglected when they were partying.

Drinking and using drugs had become a ritual. The couple had also been ordered to undergo random drug testing as well, and when Mary met them, they were extremely angry about their perceived harsh intervention plan. Mary wanted to get them started by pointing out how close they were to losing their son and that attacking one treatment goal at a time was their solution to the problem. But she remembered what Lawrence had said about planning “together,” and instead wondered aloud whether she and the family could work together to come up with some ideas of how they envisioned a family life that didn’t involve drugs or alcohol.

Soon she recognized that the couple had no idea what a functional family life meant. So she began to sit with the entire family and reflect with them on what their baby needed in way of nurturing and care. She also explored with the couple how it felt when life was calm. Their response was that it was boring. This led to further discussions about what life must have been like for them when they were growing up. Mary wondered aloud whether when they were younger and life was calm, chaos followed immediately after.

As time passed, she noticed that when the young mom cuddled her child, her husband became irritated and anxious. She took her concerns to her next reflective supervision session with Lawrence. She was feeling impatient with the father and wanted to direct him to hold his child while his wife relaxed. She felt frustrated with the dad because he seemed so self-absorbed. “Didn’t he get it?” she said. He was setting himself up to lose his family. On top of everything else, the young man smoked around his child!

Lawrence listened and responded only after Mary had finished venting her feelings. He waited several more seconds and sighed deeply. He then said, “I’m wondering what it must feel like to watch someone sabotage his life?” Mary sat quietly for a long while and then disclosed, “I feel helpless to make it different for him.”

The couple did eventually separate, but Mary was able to make inroads with the baby’s mother and build a lasting relationship with the young woman and her child. Mary and Lawrence continue to discuss her preference for using solution-focused therapy and how it could be folded into the supervision work they experienced together.

Reflective supervision as a group process

Many early intervention programs utilize reflective supervision through group supervision. There are advantages to processing infant mental health work in a group setting. The obvious advantage is that it’s a time saver. Meeting once a week for two hours uses valuable time efficiently, but also brings a richer context to the group supervision dynamic.

For example, when one group member risks self-disclosure, the group response is supportive rather than critical. Feelings are honored, not criticized. The environment is shaped to create a place to explore feelings about working with client families and wonder aloud how certain family struggles can affect relationship building or otherwise inhibit the work experience.

Sometimes group members may be challenged to rescue another member from the pain he or she is feeling with regard to a client family by offering expert advice or feedback. Reflective supervision doesn’t ask that. What it does is to provide a space for the worker to be a witness to his or her own personal self-discovery. It is the person’s own exploration unlike anyone else’s.

Summary

Reflective supervision is not the only supervision approach used within infant mental health settings. Administrative, traditional and mindful supervision serve to guide and organize infant mental health specialists as well. However, reflective supervision continues to be the preferred supervision methodology within the infant mental health field.

Reflective supervision had its beginnings in the 1970s and grew in the 1980s as the issue of training within the infant mental health movement came to light. Reflective supervision is an internal process rather than a superimposed process and challenges both the supervisor and supervisee to explore their own responses regarding the relationship building that occurs with client families and even between themselves. A parallel process happens as a result.

Reflective supervision has been difficult for many mental health supervisors to grasp, because by its very nature, it doesn’t promise pat results or identify succinct treatment goals before the supervision begins. Yet, in a 2002-2003 Pathways to Prevention study of 25 Early Head Start programs, evaluation outcomes revealed that programs benefited from receiving consultation from infant mental health consultants who focused on building capacity for reflective supervision.

Reflective supervision is used in a variety of early intervention settings that include early learning centers, in-home and center-based Early Head Start programs, child dependency systems, prenatal and infant health systems and young parent programs. Many state and local funders are now recognizing reflective supervision as enhancing mental health early intervention.

Glossary

Zero to Three Network provides a glossary of technical words or terms used in infant mental health work and reflective supervision:

Parallel process – Parallel process refers to how the interaction between supervisee and supervisor mirrors, or is parallel with, the interaction between the supervisee and client. The concept of parallel process is related to the psychoanalytic concepts of transference and counter-transference.

Presence – Presence is the experience of being internally still without resistance or judgment, and remaining accepting and open, regardless of the experience.

Use of self – The professional “use of self” refers to how we understand and use our thoughts, feelings, values and behaviors in our work with children and families.

Reflective functioning – Reflective functioning is the capacity to have your own thoughts and feelings as well as the capacity to think about another person’s thoughts and feelings.

(Final examination questions on next page)
1. The most commonly used supervision mode in the workplace is?
   a. Administrative supervision.
   b. Behavioral health supervision.
   c. Reflective supervision.
   d. Traditional supervision.

2. Traditional supervision requires the supervisor to be?
   a. Instructional.
   b. An intense listener.
   d. Less involved.

3. The Zero to Three Network, the national association of infant mental health practitioners, began to identify four elements of training as important for all practitioners as they moved from pre-service preparation to practice in the emerging infant mental health field. These include all of the following except:
   a. Opportunities for direct observation and interaction with a variety of children less than 3 years old and their families.
   b. Risk self-disclosure in professional practice.
   c. Collegial support, within and across disciplines, throughout a practitioner’s life.
   d. Individualized supervision to allow reflection on all aspects of work with young children and families.

4. The Early Head Start National Resource Center (EHS NRC) was created in?
   a. 1950.
   b. 1970.
   c. 1995.
   d. 2008.

5. Traditional supervision continues to be the preferred supervision methodology within the infant mental health field.
   a. True
   b. False