ZERO TO THREE | LEARN

Beyond Reflection: Advancing Reflective Supervision/Consultation (RS/C) to the Next Level

A Professional Innovations Discussion Paper

January 2022

ZERO TO THREE, Professional Innovations Division

Authored by: Noelle Hause, Senior Manager of IECMH Professional Development & Sarah LeMoine, Senior Director, Professional Innovations Division, ZERO TO THREE

Published by
ZERO TO THREE
2445 M St NW, Ste. 600
Washington, DC 20037
(202) 638-1144
Toll-free orders (800) 899-4301
Fax: (202) 638-0851
Web: http://www.zerotothree.org

Suggested citation: Hause, N., & LeMoine, S. (2022). Beyond reflection: Advancing reflective supervision/consultation (RS/C) to the next level: A Professional Innovations discussion paper. ZERO TO THREE.

Foreword

Reflective practice can mean many things to many people. The phrase reflective practice is used frequently in and outside of the early childhood field. You may be familiar with similar or related terms such as reflective supervision, reflective capacity, reflective consultation, and reflective process. Definitions vary across disciplines. Most include continuous learning cycle application; retrospective examination; and a purpose to understand context, rationale, and/or intent of actions, behaviors, and beliefs.

In a sense, reflective practice is an acknowledgment that we don't have all the answers and that, in many cases, there can be multiple "truths" or possibilities to explore. An attitude of wondering and inquiry encourages curiosity; in reflective practice, there is no room for assumptions. Intentional reflective practice is an important aspect of professional growth, and it is a promising practice for increasing the quality and effectiveness of service delivery.

Reflective practice is a core early childhood professional practice, vital to our ability to effectively support young children and their families, and ourselves. Reflective practice is included across the foundational *ZERO TO THREE Competencies for Prenatal to Age 5 Professionals*™ (P-5 Competencies). The P-5 Competencies have a broad purpose of strengthening professional competence on shared fundamental concepts and to facilitate interdisciplinary partnerships and coordinated service delivery. All of ZERO TO THREE's professional offerings are framed by the core P-5 Competencies. This discussion paper, like the P-5 Competencies that frame it, is one of our efforts to support a shared understanding of what it takes to help young children succeed.

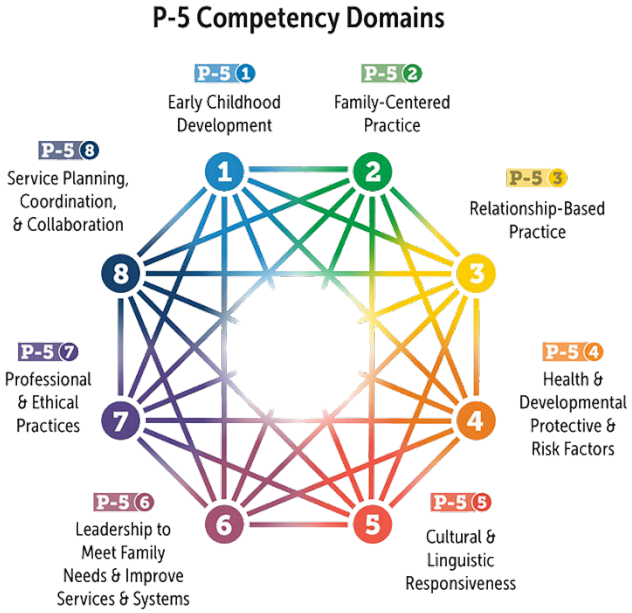
Our Invitation and Thanks

This paper focuses on reflective practice in the infant and early childhood mental health (IECMH) field, specifically reflective supervision/consultation. As you read this discussion paper, we encourage you to reflect on how the ideas and questions discussed might translate into your own professional practice–or perhaps how they already do. Participating in professional development and practice discussions are an important part of contributing to early childhood professions. We invite you to Continue With Us.

Thank you for prioritizing space to join us in "wondering" together and advancing opportunities for and with the early childhood workforce. Through self-awareness, reflective practice, and intentional action, we work together to make the world better for infants, toddlers, and their families.

Sarah LeMoine, Senior Director, Professional Innovations Division, ZERO TO THREE
prodevelopment@zerotothree.org | www.zerotothree.org/LEARN

P-5 Example Reflective Practice Attitudes & Skills



P-5 2 Family-Centered Practice

A2.2 Considers one's own biases through reflective practice and how such biases might influence guidance, services, and supports offered to each family. Is committed to addressing biases that may interfere with effective provision of supports and services for individual families.

P-5 3 Relationship-Based Practice

S3.5 Uses self-awareness and reflective practice to understand how one's own culture and values and those of the family may impact the development of a productive relationship. Examines one's own biases regularly and identifies areas to better support the unique needs of each family.

S3.7 Respects and supports the relationships between children, their families and caregivers, and among P-5 professionals through relationship-based practice using techniques such as reflective listening, asking questions to increase understanding, and modeling responsive interactions.

S3.8 Receives reflective supervision to refine and improve skills. Uses this learning to build more effective relationship-based practice personally and across the organization.

P-5 5 Cultural and Linguistic Responsiveness

A5.4 Reflects on one's own cultural values and attitudes through reflective practice to understand and appreciate those of others.

P-5 6 Leadership to Meet Family Needs and Improve Services and Systems

S6.1 Provides and receives reflective supervision to step back from the immediate, intense experience of hands-on work and take the time to wonder what the experience really means.

More information about the P-5 Competencies is available online at www.zerotothree.org/p-5.

Contents

INTRODUCTION

Reflective practice was once considered a complimentary and supportive tool for professionals in the infant and early childhood mental health (IECMH) field. Today, reflective practice is an established, necessary, and fundamental practice across all early childhood related sectors and disciplines—benefiting the health and well-being of infants, young children, families, caregivers, educators, supervisors, system administrators, policymakers, faculty, and researchers.

The growing appreciation for reflective practice has also brought complexity to its *how* and *who*. There now seem to be as many "ways of practicing" as there are disciplines, and as many "ways of being" as there are professionals practicing. This diversity allows for flexibility and responsiveness in meeting policy development, organizational, administrative, programmatic, and individual needs. The myriad of approaches has also resulted in interchangeable use of terminology and corresponding definitions, purpose, role expectations, and levels of benefit, leading to the belief that each reflective practice model is identical. This belief often leads to confusion for those who provide, receive, support, and fund reflective practice services. As a result, there is a need for advancing shared understandings, starting with recognizing and addressing the similarities and differences between reflective practice models. Furthermore, there is an opportunity to attend to foundational considerations in need of attention, examination, and as necessary, reconstruction, including exploration of cultural and racial identities; equity, power, and privilege; and ethical guidelines.

Purpose and Scope

The purpose this paper is to help advance reflective supervision/consultation (RS/C) by stimulating important dialogue amongst IECMH professionals. The paper invites this discussion by:

1. **examining definitions of reflective practice,** specifically reflective supervision/consultation (RS/C) as used in the IECMH field;

2. **recognizing the multilevel benefits of reflective-informed practice** for infants, young children, families, caregivers, educators, supervisors, system administrators, policymakers, faculty, and researchers and all other professionals working with and for families;

3. **considering RS/C foundational areas in light of emerging and urgent issues**, such as the need to prioritize the leadership and collaboration of diverse voices in actively exploring, examining, and, as necessary, adapting or reconstructing current reflective practice models; and

4. **identifying specific opportunities to advance RS/C,** with additional IECMH field discussion, exploration, and action.

PART 1: Defining Reflective Practice

While reflective practice is often associated with clinical interventions, the practice is beneficial and recommended for the broader early childhood field including early childhood education, administrative, and policy work.

In all sectors and disciplines, a reflective practitioner:

- pauses to reflect and intentionally plan for their work interactions—before, within, and after the moment *and* at regular intervals;
- contemplates the many working relationships, interpersonal interactions, and potential meaning of those interactions;
- looks back at their interactions to consider how they influenced those they worked with and how they were influenced by those they worked with; and
- then uses that insight to inform and guide future interactions.

In many ways, reflective practice is comparable to the nurturing, responsive, consistent, and supportive caregiving relationship necessary for a baby or young child to grow and thrive. Furthermore, this reflection may lead to a shift in a personal or professional stance as one seeks to find deeper understanding, meaning, balance, purpose, and direction (Alliance for the Advancement of Infant Mental Health, 2018, 2021).

What Is Reflective Practice in IECMH?

Infant and early childhood mental health (IECMH) "is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture" (ZERO TO THREE Infant Mental Health Task Force Steering Committee, 2001). The field of IECMH is inclusive of early childhood professionals from a wide range of sectors and disciplines who touch the lives of very young children and families. It is often described as "a multidisciplinary professional field of inquiry, practice, and policy, concerned with alleviating suffering and enhancing the social and emotional competence of young children" (Zeanah, 2018, p. 6).

While a clear consensus on a definition has not been reached, **reflective practice** is often described and used in the IECMH field as a process in which a person reflects on ones' own thoughts, feelings, and behaviors that arise when working with expectant parents; infants, young children, and their families; and professionals. This process is one of exploration, occurring in collaboration with other trusted individuals, paying close attention to the parallel process (Alliance for the Advancement of Infant Mental Health, 2018).

Reflective practice in the IECMH field is commonly referred to as reflective supervision/consultation (RS/C).

Reflective Supervision and Reflective Consultation

The terms **reflective *supervision*** and **reflective *consultation*** are frequently used interchangeably. **Reflective supervision and reflective consultation** both refer to "a collaborative relationship for professional growth that improves program quality and practice, . . . by cherishing strengths and partnering around vulnerabilities to generate growth" (Shahmoon-Shanok, 2009, p. 7).

The *Best Practice Guidelines for Reflective Supervision/Consultation* (Alliance for the Advancement of Infant Mental Health, 2018) distinguished between reflective *supervisors* and reflective *consultants* in this way:

reflective *supervisor*

- operates "within an agency or program"
- will "most likely address reflective, clinical/case, and administrative content"

reflective *consultant*

- contracted by an agency or program
- "hired to provide reflective consultation to an individual or group on behalf of the promotion of IECMH"

This paper focuses specifically on IECMH **reflective supervision/consultation** or simply, **RS/C**.

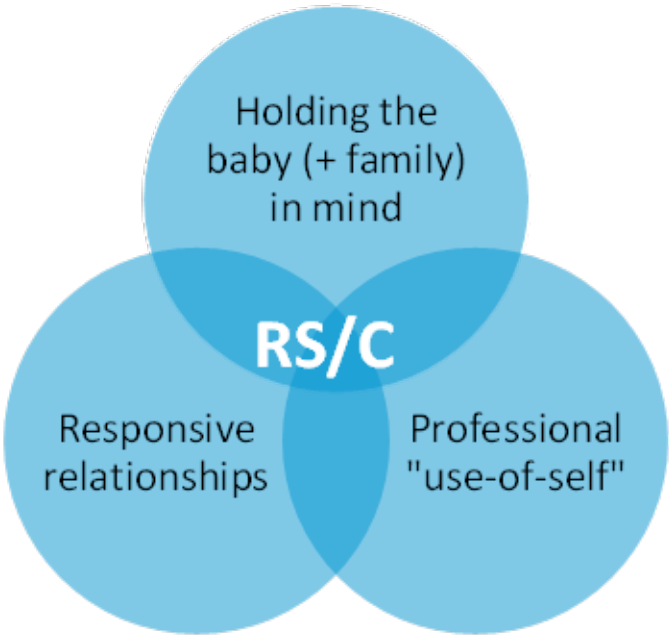
RS/C Tri-Focus Fundamentals

The IECMH field's work to define RS/C can be summarized in three, interconnected areas:

1. **Holding the baby in mind** means that the infant/young child is at the center of all work, inclusive of their family story and its specific context (Watson et al., 2016).

2. Recognizing the importance of and attention to **responsive relationships** is supported by the RS/C dyad's exploration of the parallel process focusing on the balance of attention to multiple perspectives and patterns of repeated relationship and interaction themes (Watson et al., 2016). This dyad forms the reflective alliance in which exploration of ambiguity is supported, judgment and problem solving are suspended, and a "holding space" is created.

3. Attending to one's **professional "use-of-self"** includes building and sustaining self-awareness of one's experiences, culture, family, and other identity aspects, and interactions with the family, to bi-directionally inform relationships (Derman-Sparks & Edwards, 2019; Watson et al., 2016).



Importantly, these fundamentals occur within and through ongoing consultant-consultee or supervisor-supervisee dialogue. Dialogical reflection—improvised or created in the moment—deepens the connection "as together they [consultant and consultee/supervisor and supervisee] develop their history and knowledge of one another and of the children and families in their conjoined care" (Heller & Gilkerson, 2009, p. 12).

RS/C Topline: Why, How, and What

Why It Matters

RS/C is important because it offers regular and protected opportunities for its participants to reflect and think more deeply about their work, "using ones' emotions as data to explore the network of relationships surrounding an infant or young child", especially when strong feelings arise (Paradis et al., 2021, p. 69). This practice includes how professionals approach, collaborate with, and support infants, young children, families, and other professionals. It can be a critical part of surfacing one's own biases and ways of being that might be similar to or different from the families served. RS/C also includes how working with others influences professionals' own ongoing practice and scope of work. It assists participants in recognizing that each family member also enters and maintains relationships with others in ways that are influenced by early relational experiences of their own primary caregivers.

How It Happens

The focus of RS/C is not specifically on characteristics or behaviors of the consultant/supervisor, consultee/supervisee, client, or any other individual or system. Nor is there focus on the identification of solutions. Rather, the focus is on how the dyad (consultant/consultee or supervisor/supervisee) or the consultant and group members (when provided in a group setting) collaborate to understand and attend to specific aspects of the work done by the consultee(s) or supervisee(s) and the myriad of relationships that the work encompasses. This is referred to as "the space between the two" (Watson et al., 2016, p. 15). It is not about judging either participant or rushing to "fix" a problem, but on understanding what is occurring in their work together.

What It Takes

In addition to the core knowledge, skills, and attitudes included in the ZERO TO THREE P-5 Competencies (see examples on p. 5), it takes specialized capacities to successfully engage in RS/C. Keeping the baby at the center of this work requires a curious stance and the ability to recognize the potential risks and resiliencies that each person in the caregiver network brings in support of the baby (ZERO TO THREE, 2021). Understanding the experiences that each person (including self) brings, and noticing feelings, thoughts, and behaviors, requires a balance of attention (Michigan Association for Infant Mental Health, 2017). It also requires a regard and tolerance for ambiguous space, where one often sits in the middle of uncomfortable and sometimes confusing feelings, information, and relationship interactions (Hause, 2020).

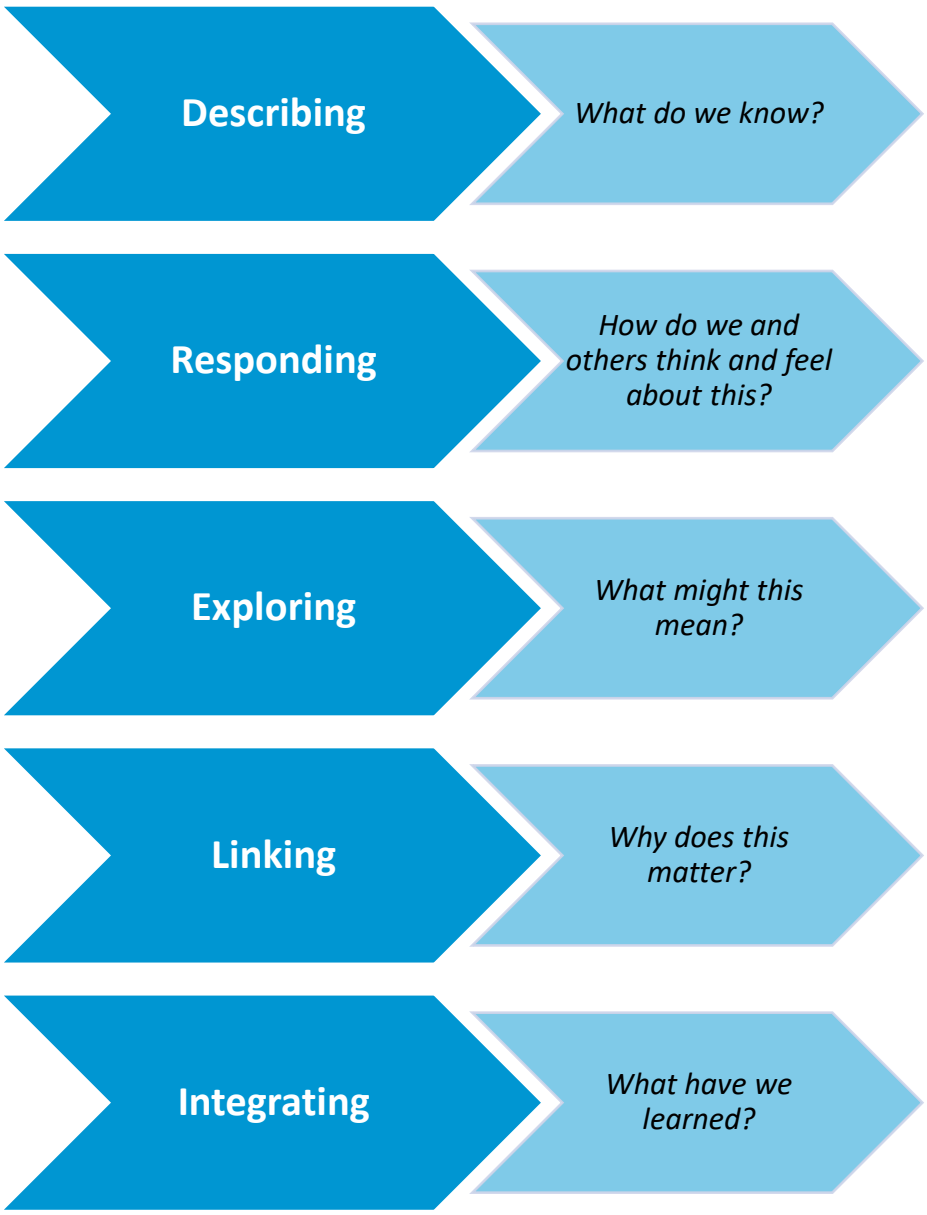
RS/C Definition Through Process Measurement and Evaluation

There have been significant efforts to build a research foundation for RS/C. Process measurement and evaluation efforts contribute to defining and strengthening RS/C models and practice. A variety of tools have been created in an effort to measure both consultant/supervisor and consultee/supervisee reflective practice capacity—for self and each other (Ash, 2010; Heller & Ash, 2016; Weatherston, 2012), sense of self-efficacy (Shea et al., 2020), and the degree to which reflective practice skills are used (Heffron, 2013; Shea et al., 2012).

The Reflective Interaction Observation Scale (RIOS; Watson et al., 2016) is an evaluation tool designed to (a) assess the reflective relationship dyad and (b) define and operationalize the process of RS/C by "identifying and demonstrating the unique components which differentiate it from other forms of relationship-based professional development" (p. 15) and other models of reflective practice. This tool lays out five core elements for reflective consultants/supervisors:

1. Seek to **understand the family story,** which includes what is currently known about the infant's/young child's environment, focusing on the people who provide the relational context for social and emotional development.
2. **"Hold the baby in mind"** so that their attention always "cycles back to the baby and the baby's experience and well-being" (p. 16).
3. Intentionally attend to one's own **professional "use-of-self."** Through the reflective process of slowing down, observing, listening, and understanding their own lived experiences, including aspects of culture, race, privilege, and power, professionals are in a better position to examine thoughts, feelings, and behaviors that may be evoked when working with expectant parents, babies, young children and their families, and other professionals, and set boundaries in accordance with their scope of work.
4. Recognize the **parallel process.** When reflective practice participants feel seen and heard, they can provide the same support to families and caregivers, who in turn can embrace the experience of the baby, providing the nurturing, supportive care needed for the baby to grow and thrive.
5. Form a **reflective alliance**. The reflective consultant/supervisor provides a supportive "holding space" for professionals to examine their own lived experiences, their feelings and thoughts about these experiences, and how these experiences may influence or be influenced by the relationship interactions of those with whom they work. Their focus is on "forming a partnership to explore the experience of the supervisee and to ensure that the work is firmly grounded in infant mental health principles and theory" (Watson et al., 2016, p. 17).

Together, the reflective consultant/supervisor and consultee/supervisee engage in the collaborative tasks of:



In addition to helping to define RS/C, process measurement and evaluation are essential to documenting and tracking its benefits.

PART 2: Benefits of RS/C

When professionals, in all levels of service, participate in RS/C, they are afforded space to explore their own responses and feelings, contemplate their professional "use-of-self," be intentional in their decision-making and policy development, and provide consistent and compassionate support to staff.

Benefits of RS/C include:

- increased reflective functioning (Shea, 2020; Tomlin et al., 2009);
- promotion of professional development (Gilkerson & Kopel, 2005; Paradis et al., 2021);
- increased meaning and job satisfaction, and reduced burnout (Harrison, 2016);
- increased insight (Virmani & Ontai, 2010); and
- help to address and mitigate secondary trauma (Osofsky, 2009; Paradis et al., 2021).

The field of IECMH is currently experiencing a workforce crisis, in nearly all states, at all levels of the service continuum from promotion to prevention, assessment, diagnosis, and treatment. The above listed benefits of RS/C directly address many of the root causes for this shortage of professionals, including consistently devastating staff turnover. In addition to supporting the retention of current service providers, RS/C supports increasing the quality of their work as well, which directly benefits young children and their families.

Taking a "Deeper Dive" Into the Parallel Process

As discussed in Part 1 of this paper, the meaning of "holding the baby in mind" is to regularly attend to and understand the baby's internal experience (Watson et al., 2016). This occurs while also balancing all other relationships and can be difficult amidst the cascading macro to micro effects of the following (and their multidirectional influences on each other):

Individuals working in a variety of disciplines and roles can experience the benefits of a regular, carefully planned, and co-regulated space, to freely explore one's feelings, thoughts, and behaviors, without fear of judgment, admonishment, or intrusive problem solving. The attuned support of RS/C is akin to the nurturing, consistent, and responsive support a primary caregiver provides for the baby and exemplifies the parallel process.

RS/C has a unique focus on the shared, intentional exploration of the parallel process. *Parallel process* refers to the way in which one relationship affects and is affected by other relationships (Alliance for the Advancement of Infant Mental Health, 2018; Emde, 1991; Heller & Gilkerson, 2009; Tomlin et al., 2014; Weatherston, 2005; Weatherston et al., 2010). It "describes the interlocking network of relationships between supervisors[/consultants], supervisees[/consultees], families and children" (Heffron & Murch, 2010), as well as administrators and policymakers.

Individuals working in a variety of early childhood disciplines and roles can benefit from RS/C.

Take, for example, the following scenario:

An **IECMH clinical reflective supervisor** meets with a **supervisee** (an IECMH consultant in home visiting) for reflective supervision. While exploring a particular family story, the clinical reflective supervisor learns that the supervisee is frustrated with the parent. She states, “I thought she (baby’s mom) wanted help. She just won't try the strategies that I've recommended. I don't think I'm the right consultant for her.” The supervisee is struggling with how to move forward with services.

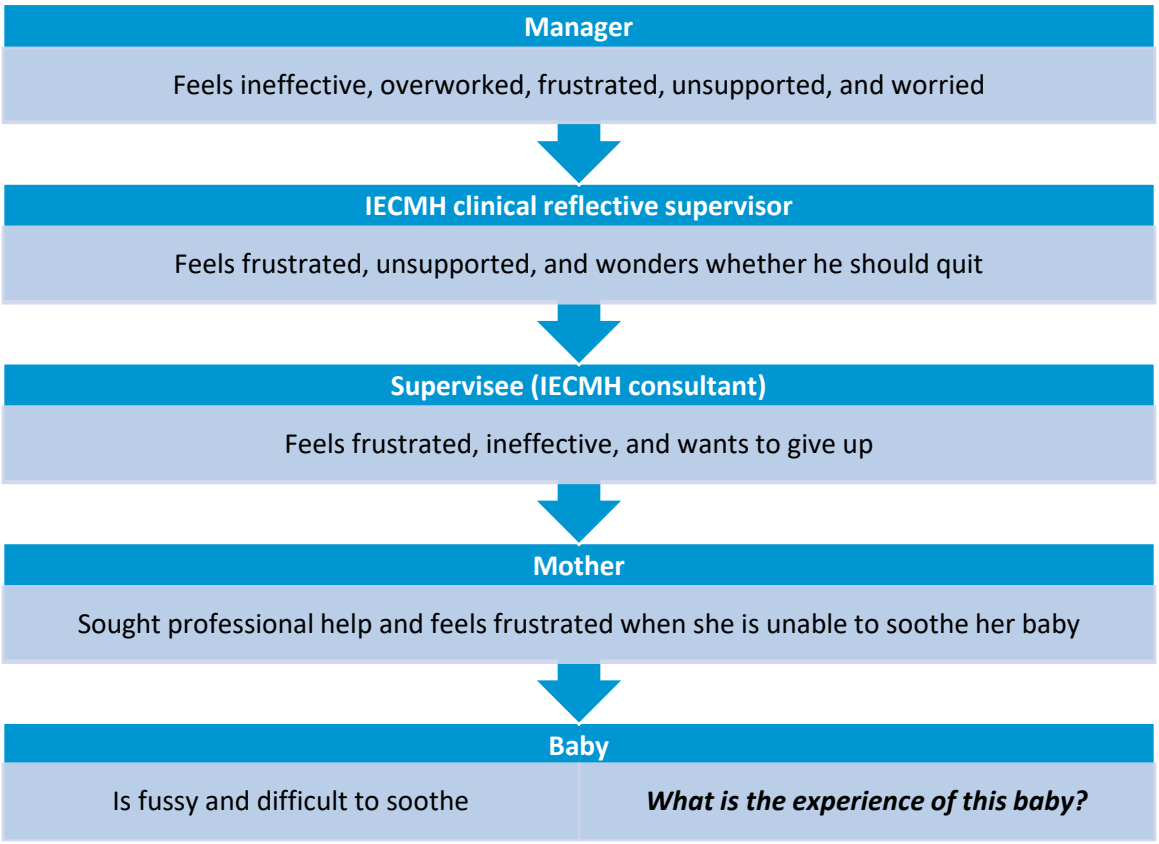
This is not the first time that this supervisee has expressed frustration, ineffectiveness, and a desire to transition or close a family case file. The clinical reflective supervisor feels a tightening in his stomach and a growing frustration with this supervisee. He believes there is more to the story and has grown accustomed to her tendency to want to quit when she becomes frustrated. He silently reminds himself that it is up to him to form a reflective alliance with this supervisee and provide a supportive holding space so that she can examine her own experiences and feelings about her interactions with this mother, rather than tell her what to do.

As he is reflecting, he recognizes how much easier it would be to support this supervisee if he himself were receiving support. But due to budget cuts, he has very little time to process situations with his management team. It is just not a priority. “Come to think of it,” he ponders, “RS/C has not really been recognized in my organization as a necessary or prioritized practice. I wish we had a policy in place for everyone to receive RS/C in the organization.” This lack of prioritization of RS/C often leaves him feeling frustrated and,

at times, he questions whether this is the right position for himself. Furthermore, he is aware that his own **manager** often feels stressed, so he does not want to burden her. Simultaneously, he is not aware that his manager feels ineffective, overworked, frustrated, unsupported, and worried about funding programs. She is hoping that she will not have to cut programs this year.

As the IECMH clinical reflective supervisor turns his attention back to the supervisee, she reports that the **mother** is often frustrated with her baby. And, not surprisingly, the IECMH clinical reflective supervisor learns the **baby** is fussy and difficult to soothe much of the time. He wonders what it is like to be this baby and how he will support the supervisee in understanding the mother's experience, so that she can, in turn, help the mother understand the experience of her baby.

The parallel process highlights the similarities across all individuals and relationships and how these relationships impact and influence the experiences of the people involved.



RS/C for Leadership and Policymakers

It is important for leaders of programs, organizations, and systems to have the opportunity to experience RS/C so they too can stay connected to the experience of the infant/young child, family, and their staff. In the article "The Value of Reflective Supervision/Consultation in Early Childhood Education," the authors call attention to the parallel process in all levels of service. "When program leaders (including administrators, supervisors, and managers) receive reflective support, they are better prepared to offer the same to their staff, who in turn are better prepared to provide reflective support to the caregivers, families, infants, and young children they serve" (Paradis et al., 2021, p. 72).

How could the previous scenario be different if…

Manager	
If she felt effective and supported...	Would she be able to support the IECMH clinical reflective supervisor?
IECMH clinical reflective supervisor	
If he felt supported...	Would he decide to stay in his job? Would he experience an increase in patience with the IECMH consultant?
Supervisee (IECMH consultant)	
If she felt the patience of her IECMH clinical reflective supervisor...	Would she still feel like giving up? Would she have more compassion and patience for this mother?
Mother	
If she felt seen, heard, and known by this patient and understanding IECMH consultant...	Would she be more available to consider the perspective of her baby and, as a result, be more patient herself?
Baby	
If the mother is more patient...	How would this change the experience for the baby?

In their article “The Intersection of Leadership and Vulnerability: Making the Case for Reflective Supervision/Consultation for Policy and Systems Leaders,” Schmelzer and Eidson (2020) asserted that it is beneficial “for leaders of programs, organizations, and systems to have the opportunity to experience RS/C, in order to advance this systematic awareness on behalf of babies and the adults who care for them.”

The authors make the argument for an expansion and more comprehensive parallel process that includes leaders and administrators of programs, organizations, and systems. They assert many reasons for why this current gap in professional support exists, including financial cost, lack of published articles and research regarding the value of RS/C in systems and policy, and the idea that RS/C may feel uncomfortable and foreign for those in leadership positions.

Leadership and policymakers carry heavy responsibilities, contribute to important decision-making, experience complex feelings, and tend to be many levels removed from the experience of the infant/young child. RS/C would support them in asking themselves, for nearly every decision, "How will this impact the infants, young children, and families we are serving?” In addition, another way of conceptualizing “the baby” in policy and systems work is to consider that “the baby represents, among other things, vulnerable persons or populations who do not yet have a voice, but whose needs are clear” (Schmelzer & Eidson, 2020).

PART 3: Foundational Considerations

The Diversity-Informed Tenets for Work With Infants, Children and Families' state that:

> *Working with infants, children, and families* ***requires*** *all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on our lives in order to provide diversity-informed, culturally attuned services* (Irving Harris Foundation, 2018).

It is incumbent upon all individuals, organizations, and systems of care working with infants, children, and families, to intentionally focus on, and seek to understand, one's own identity in all its facets independently, as well as in relation to others. The practice of RS/C must explicitly address and provide direction and space for such work.

At the heart of the RS/C relationship is a shared journey of self-awareness and discovery. This journey is strongly influenced by the lens through which the consultant/supervisor and consultee/supervisee make meaning of relationships and experiences. The relationship is strengthened as the dyad mutually explores issues and the parallel process with regard to the infant/young child, family, and the practitioner (Stroud, 2010).

An important aspect of professional "use-of-self" is cultural humility, which can be defined as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client [or supervisee]" (Hook et al., 2013, p. 354). Cultural identity is multifaceted and encompasses a "space where people's multiple cultural locations intersect." This intersection is referred to as the construct of an "ecological niche" (Harrell, 2014) and exists within a broader social and ecological framework (Bronfenbrenner, 1989), implying that we must recognize and act upon the reality that there are as many cultural identities as there are infants/young children, families, and professionals. *Preparing Competency-Based Learning for Infant and Early Childhood Mental Health Endorsement: Training Guide and Self-Assessment* (Alliance for the Advancement of Infant Mental Health, 2021) acknowledged that "by holding space for a shared understanding that each of us has had unique racial and cultural experiences, we can in turn, be open to learn and relate to others" (p. 17). Holding a stance of cultural humility can contribute to the development of a strong reflective alliance.

Best Practice Guidelines for Reflective Supervision/Consultation called out the importance of "increasing self-awareness by identifying and addressing personal biases" within the context of a safe "relationship for learning" (Alliance for the Advancement of Infant Mental Health, 2018, p. 7). It emphasized that this "increased self-awareness is critical to the provision of culturally responsive services." However, this model "was created by practitioners from the dominant

culture based on literature from scholars who also come from the dominant culture" (Paradis et al., 2021). Thus, the question arises, is simply having an "opportunity" to take time and explore one's cultural, racial, and other identities within the context of reflective supervision or consultation "good enough"?

Reflection alone on these issues is not enough to positively impact practices, organizations, systems, and policies to advance social justice. RS/C can and should support its participants in moving through an intentional and ongoing cycle of reflection to on/in/after action. Leaders and other professionals can elevate the need for and benefit of RS/C in supporting diversity-informed and culturally attuned services. Without intentional action, current practices, organizations, systems, and policies are unlikely to change and meet the needs of diverse babies, toddlers, and families.

Equity, Power, and Privilege

Reflective supervisors and consultants work to promote a shared understanding or reflective alliance, which optimally includes confidentiality; safety; recognition of assumptions, bias, privilege, and power; and the promise to hold space for thoughts, emotions, and experiences with those with whom they work. It is hoped that by creating such a space, participants can use the time to explore and examine their own thoughts, emotions, and experiences to the extent that they are willing and able. This can be difficult as "Confronting and exploring emotionally charged subject matter while maintaining an atmosphere of compassion and empathy for the anxiety, pain, ambivalence, and anger that can accompany the topic of race" (Harrell, 2014, p. 85), for instance, "…can trigger strong affective and defensive reactions" (Tummala-Narra, 2009). This give and take of safe and brave spaces is central to the reflective alliance between the consultant/supervisor and consultee/supervisee (Alliance for the Advancement of Infant Mental Health, 2021; Arao & Clemens, 2013). While the dyad may strive for an equilibrium of safety and bravery, there remains a tension between the two. This tension leads us to the question: Can comfort coexist in the presence of "genuine dialogue on diversity and social justice issues" (Arao & Clemens, 2013, p. 136), if there is to be true growth and change?

Even with the best intentions, power dynamics and privilege differentials exist within these relationships, in part due to inherent distinctions in roles and scope of work. In addition, the professionals and influential leaders who determine the practice, research, policy, procedures, and funding priorities that inform RS/C guidelines are typically members of the dominant culture, which can create power imbalances within the relationships. Notably, this is parallel to power differentials or invisible barriers experienced between administrators, supervisors, service providers, educators, and the families with whom they work.

In the *ZERO TO THREE Journal* article "Honoring Diversity Through a Deeper Reflection," Stroud (2010) noted that it was the supervisor's/consultant's responsibility to open the conversations to address power, privilege, and prejudice. Stroud outlined important issues for supervisors/consultants, to raise within the RS/C relationship. These issues include:

- the unspoken power differential of the supervisor-supervisee or consultant-consultee relationship
- issues of difference or sameness related to culture, religion, gender, language, and any other diversity issue that exists within the supervisor-supervisee or consultant-consultee relationship
- ways in which power and prejudice have influenced the interpersonal development of the supervisee/consultee
- ways in which power and privilege are addressed within the supervisor-supervisee or consultant-consultee relationship and between the supervisee/consultee and the family with whom they provide services
- comfort level of supervisee/consultee in bringing up issues of sameness and difference within the context of their relationship with the family
- ways in which power and prejudice have shaped the family (or families) with whom the supervisee/consultee is currently working (Stroud, 2010)

A reconstruction of the RS/C model should align more closely with the *Diversity-Informed Tenets for Work With Infants, Children and Families* (Thomas et al., 2019); be guided by diverse professionals who provide and receive RS/C; respect and integrate nondominant bodies of knowledge; and create pathways for more equitable access to "members of the workforce who come from historically marginalized groups" (Paradis et al., 2021, p. 73).

Ethical Guidelines

RS/C helps an individual examine one's own emotional responses and critically think about how one might provide services to clients in an ethical way. However, ethics of the RS/C process itself have not been explicitly articulated, explored, documented, reviewed, or researched. While there have been questions about who can provide RS/C and with whom they can provide it, many reflective consultants follow and rely on ethical guidelines established within their own professions such as social work, counseling, and psychology. These professions include some common standards for ethical practice including confidentiality and mandated reporting. However, there have been no formal ethical guidelines set forth to address one's professional stance and scope of work as a reflective supervisor or consultant in the field of RS/C.

Dual Roles

Reflective supervisors, if simultaneously providing clinical and/or administrative supervision, carry an extra responsibility to assure trust and safety as they hold additional inherent power and privilege in the supervisor-supervisee relationship. While this power may not be recognized as such, it is present, nonetheless. Professionals who receive reflective supervision and their employee evaluations from the same person may be hesitant in sharing their true thoughts, emotions, and experiences for fear of being judged or evaluated based on revealing their internal states and personal experiences with discrimination, oppression, and other types of interpersonal stress and trauma. Issues such as classism and racism can make an already complex dual role even more complicated and can make it difficult to ascertain whether a supervisee is receiving maximum benefit or not.

While there is an inherent power differential in any consultative relationship, external reflective consultants may mitigate supervisor/supervisee power differentials in RS/C by providing anonymity and by not contributing to performance evaluations. However, Speilmann (2021, pg. 64), posed the question "…what happens when an organization does not have the resources to support this model? There must be a place between all or nothing." In many cases, with sensitivity and planning around this issue, the reflective practice experience can still be beneficial. The reflective supervisor must exhibit both the qualities of an effective administrator and the qualities of a reflective partner in the RS/C relationship. It is preferable that separate meetings are scheduled to address each of these roles. Supervisors may find a need to share concerns that may arise related to the supervisees' "direct service and/or the intersection of personal and professional development" (Alliance for the Advancement of Infant Mental Health, 2018, p. 8).

In addition to following ethical guidelines within one's own discipline, workplace policies, scope of work, job responsibilities, and ethical considerations for the growing field of RS/C should be explored, developed, applied, and researched.

Ethical considerations for the growing field of RS/C should be explored, developed, applied, and researched.

Mental Health Crisis Preparedness

Other kinds of serious ethical dilemmas may present themselves during RS/C. RS/C is not meant to replace clinical or administrative supervision, nor is it meant to replace psychotherapy or counseling. For example, there may be times when a consultee/supervisee experiences a significant mental health issue or personal crisis. *What should a reflective consultant/supervisor do if the person they are supervising or consulting expresses suicidal ideations? How will the reflective consultant or supervisor recognize mental health concerns and how can they best connect individuals to helpful services?* While it is not the consultant's/supervisor's role to be that individual's psychotherapist, counselor, or physician, it is imperative that the consultant/supervisor recognize the crisis as such, understand one's scope of work, and actively guide the consultee/supervisee to an identified trusted support.

Mental health preparedness should be a competency for consultants and supervisors who provide RS/C. Later, in keeping with the consultant's/supervisee's scope of work, the dyad can focus on how the individual's personal concerns may be impacting their work.

Scope of Work

Understanding ones' scope of work is essential to RS/C. For example, an early childhood educator who serves as a home visitor may have some understanding (or knowledge) of IECMH yet cannot provide mental health services—just as an IECMH provider on an early intervention transdisciplinary team cannot provide occupational therapy services. What if a disciplinary action is initiated by an individual's professional regulatory body and a representative from that group then reaches out to the reflective consultant/supervisor for information? How will the relationship be defined and protected?

Professional boundaries must be established with informed consent between the RS/C dyad. Clarity of RS/C models, roles, qualifications, and demonstrated competencies will help not only those who want to provide RS/C, but those who are seeking it, as well.

PART 4: Opportunities to Advance

This discussion paper illuminates five urgent areas of opportunity to advance, which require further IECMH field commitment and exploration (see "Continue With Us" in the Appendices for ways to join us in pursuing these opportunities through existing efforts, and in exploring the need and feasibility of new ones).

1

Clarify definitions of reflective practice (including RS/C) models.
This will assist professionals in improving their understanding and increasing their reflective practice competencies within their field and scope of work.

- Develop field consensus on RS/C statements of practice, including a description of the model—with defined essential elements;
- adopt an RS/C discipline-specific reflective practice framework, which includes recommended and promising practice guidelines; and
- provide materials, professional development, and onboarding/orientation training.

2

Prioritize RS/C for all early childhood professionals (educators, home visitors, mental health providers, supervisors, system administrators, policymakers, faculty, and researchers). To improve quality and outcomes of IECMH and other disciplines working with infants/young children and their families, RS/C can be used as a strategy to improve:

- reflective practice capacity—for self and each other,
- meaning and insight, and
- job satisfaction…

…while simultaneously mitigating secondary trauma and reducing burnout.

The parallel process is powerful.

3 Diversify cultural and racial representation, contributions, and leadership.

- The current model of RS/C must be examined and adapted or reconstructed to represent and fully integrate the voices and experiences of all infants/young children and their families, and professionals.
- Intentional space must be created for individuals to increase their self-awareness; consider how their own cultural and racial narratives influence their work (how they show up for others); consider how others' cultural and racial narratives influence their work; and identify and address their own personal biases.

4 Recognize transparent attention to equity, power, and privilege as an essential RS/C element.

Statements of practice should intentionally call attention to:

- brave versus safe space—and the intersection of the two,
- the underlying premise of "do no harm",
- engaging consultees at their level of readiness,
- importance of exploring cultural and racial identity, and
- roles and "scope of work" aspects of the relationship.

Administrators, supervisors, and external consultants must receive their own RS/C.

5 Develop ethical guidelines for RS/C to address:

- dual relationships,
- mental health preparedness,
- demonstrated competencies of reflective consultants/supervisors,
- scope of work, and
- limitations and professional boundaries.

CONCLUSION

Reflective practice provides the opportunity to slow down, notice, review, assess, analyze, and adjust ones' thoughts, emotions, behaviors, and practice in response to their work. This framework uses (a) self-awareness and (b) exploration of cultural identity, diversity, power, privilege, and bias to help individuals learn from the past to inform future work, and it is valued by those who hope to:

- gain insight;
- inform next steps;
- improve relational skills;
- gain professional development; and
- overall, increase positive outcomes for infants, young children, and the adults who care for them.

For many people, reflective capacity is a natural activity–for others, it is a skill that must be developed. Nonetheless, continuous participation in reflective practice through RS/C is essential for one to navigate the everchanging intrapersonal and interpersonal dynamics that surface during one's work.

The importance of knowing that there are multiple models of reflective practice, including RS/C, is not that any one model is better than another, but that reflective practice serves different purposes based on how it is defined and applied within each profession. To gain the most benefit from reflective practice within one's respective profession requires clear and intentional models.

IECMH professionals represent a variety of disciplines including psychology, psychiatry, pediatrics, social work, and counseling. Additional disciplines providing services to and in support of infants, young children, and their families may include early childhood education, early intervention, home visiting, occupational therapy, physical therapy, speech therapy, child welfare, and primary care. The beneficiaries of RS/C span the full range of the social ecological system, from babies to policymakers, and include family members, direct service providers, administrators, and researchers.

There are unique features that set RS/C apart from other reflective practice models, and it is important to acknowledge that there remain gaps in information that address inclusive practices and ethics, given the growth and evolution of RS/C as a profession. "The evidence is building to support a long-held belief that RS/C is not just an effective practice in the early childhood education sector, but an imperative for both the professionals and the infants and young children in their care" (Paradis et al., 2021, p. 73).

This paper is an urgent invitation to more closely examine the definition, purpose, delivery (inclusive, equitable, and accessible), benefits, and foundational considerations of RS/C and to create opportunities for necessary change.

APPENDICES

Continue With Us

IECMH continues to be a ZERO TO THREE priority, as it has been since the organization's inception in 1977. We invite you to continue the discussions raised in this paper with us and to pursue the opportunities presented. Together, we can advance RS/C to the next level, benefiting infants, toddlers, families, and early childhood professionals.

Discuss

- Share, discuss, and network with your colleagues around the globe on ZERO TO THREE's Member Connect. Not a member yet? Join now to network with other professionals, access research and findings, and level-up your professional development.

- Contact us directly at prodevelopment@zerotothree.org.

Learn

- Partner with us for flexible, scalable IECMH professional development. Let us help you build the learning experiences that are right for you. Email us at prodevelopment@zerotothree.org.

    - Build and expand capacity with a growing body of empirical evidence and clinical practice. The IECMH Training Series provides a menu of options to build knowledge and competence in key IECMH areas from foundations and theoretical perspectives to reflective supervision, and more. Join Virtual Member Events for a sample of this series or create your own training package by combining different topics and formats to meet the needs of your team.

    - Enhance your ability to approach diagnosis from an IECMH perspective. *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–5) provides a developmentally sensitive, relationship-based, and contextually grounded system of diagnostic classification with children from birth through 5 years old. Training options range from intensive learning experiences in which participants learn how to use the DC:0–5 content and tools in their practice, to overviews appropriate for IECMH allied professionals.

- Gain access to high-quality recordings that provide the latest research and promising practice information in a self-paced, mobile-friendly online format, available 24/7. The ZERO TO THREE Conference Library subscription includes nearly all sessions from the 2020 and 2021 annual conferences in video format for 1 year of unlimited access. Get access now!

- View the webinar series: Infant and Early Childhood Mental Health Policy

- Explore the IECMH Emerging Leadership Awards for Practice, Policy, & Research

- Learn about the ZERO TO THREE Fellowship program

- Read the December 2021 Issue of the *ZERO TO THREE Journal*, *42*(2), Diagnosing Mental Health and Developmental Disorders in Infants and Toddlers: A Five-Year Retrospective on DC:0–5™.

Act

- Help shape policy and learn How to be a Big Voice for Little Kids™ During the Federal Rulemaking Process

- Join Think Babies!

References

Alliance for the Advancement of Infant Mental Health. (2018). *Best practice guidelines for reflective supervision/consultation.* https://www.allianceaimh.org/reflective-supervisionconsultation

Alliance for the Advancement of Infant Mental Health. (2021). *Preparing competency-based learning for infant and early childhood mental health endorsement: Training guide and self-assessment.* https://www.allianceaimh.org/trainingguideandselfassessment

Arao, B., & Clemens, K. (2013). From safe spaces to brave spaces: A new way to frame dialogue around diversity and social justice. In L. Landreman (Ed.), *The art of effective facilitation: Reflections from social justice educators* (pp. 135–150). Stylus.

Ash, J. (2010). *Reflective supervision rating scale* [Unpublished assessment tool]. jordana.ash.co@gmail.com

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development Vol. 6*, (pp. 187–249). Jessica Kingsley Publishers.

Derman-Sparks, L., & Edwards, J. O. (2019). Understanding anti-bias education: Bringing the four core goals to every facet of your curriculum. *Young Children, 74*(5).

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.

Gilkerson, L., & Kopel, C. C. (2005). Relationship-based systems change Illinois' model for promoting social-emotional development in Part C early intervention. *Infants & Young Children, 18*(4), 349–365.

Harrell, S. P. (2014). Compassionate confrontation and empathetic confrontation: The integration of race-related narrative in clinical supervision. In C. A. Falender, E. P. Shafranske, & C. J. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision: A competency-based approach* (pp. 83–110). American Psychological Association. http://dx.doi.org/10.1037/14370-004

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.

Hause, N. (2020). *Attending to the space of ambiguity.* Colorado Association for Infant Mental Health: 2021 Harmon Award and Lecture.

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

Heffron, M. C. (2013). *Use of self and reflective practice skills* [Unpublished Measure]. Early Intervention Services UCSF Benioff Children's Hospital Oakland, Oakland, CA.

Heller, S. S., & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *ZERO TO THREE Journal, 37*(2), 22–28.

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

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*, 353–366.

Irving Harris Foundation. (2018). *The diversity-informed tenets for work with infants, children and families.* https://diversityinformedtenets.org

Michigan Association for Infant Mental Health. (2017). *Competency guidelines: Endorsement for culturally sensitive, relationship-focused practice promoting infant and early childhood mental health®.*

Osofsky, J. D. (2009). Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal, 30*(6), 673–677.

Paradis, N., Johnson, K., & Richardson, Z. (2021). The value of reflective supervision/consultation in early childhood education. *ZERO TO THREE Journal, 41*(3), 68–75. https://www.zerotothree.org/resources/3917-the-value-of-reflective-supervision-consultation-in-early-childhood-education#membership-required

Schmelzer, M., & Eidson, F. (2020). *The intersection of leadership and vulnerability: Making the case for reflective supervision/consultation for policy and systems leaders.* https://infantcrier.mi-aimh.org/the-intersection-of-leadership-and-vulnerability-making-the-case-for-reflective-supervision-consultation-for-policy-and-systems-leaders

Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 7–23). ZERO TO THREE.

Shea, S. E. (2020). *The implementation of a statewide reflective supervision/consultation model for infant-early childhood program professionals, supervisors and program managers by Pennsylvania's Office of Child Development and Early Learning, the Pennsylvania Key, and*

the Alliance for the Advancement of Infant Mental Health: Pilot Evaluation Report. Alliance for the Advancement of Infant Mental Health.

Shea, S. E., Goldberg, S., Davies, D., & Weatherston, D. J. (2012*). Reflective supervision case vignette for supervisors* [Unpublished measure]. Contact Sarah E. Shea, PhD, LMSW, IECMH-E®, Eastern Michigan University School of Social Work, sshea1@emich.edu

Shea, S. E., Goldberg, S., & Weatherston, D. J. (2020). *Reflective supervision self-efficacy scale for supervisees* [Unpublished measure]. Contact Sarah E. Shea, PhD, LMSW, IECMH-E®, Eastern Michigan University School of Social Work, sshea1@emich.edu. [Original work published 2012, revised 2015]

Spielmann, V. A. (2021). *Duality not dichotomy: Defining and establishing the role of professional reflection in an interdisciplinary team of allied health professionals* [Doctoral dissertation, Fielding Graduate University].

Stroud, B. (2010). Honoring diversity through a deeper reflection: Increasing cultural understanding within the reflective supervision process. *ZERO TO THREE Journal, 31*(2), 46–50.

Thomas, K., Noroña, C. R., & Seymour-St. John, M. (2019). Cross-sector allies together in the struggle for social justice: Diversity-Informed Tenets for Work With Infants, Children, and Families. *ZERO TO THREE Journal, 39*(3), 44–54.

Tomlin, A. M., Sturm, L., & Koch, S. M. (2009). Observe, listen, wonder, and respond: A preliminary exploration if reflective function skills in early care providers. *Infant Mental Health Journal, 30*(6), 634–647.

Tomlin, A. M., Weatherston, D. J., & Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant Mental Health Journal, 35*(1), 70–80.

Tummala-Narra, P. (2009). Teaching on diversity: The mutual influence of students and instructors. *Psychoanalytic Psychology, 26*, 322–334. doi:10.1037/a0016444

Virmani, E. A., & Ontai, L. L. (2010). Supervision and training in childcare: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal, 31*(1), 16–32.

Watson, C., 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 Journal, 37*(2), 14–21.

Weatherston, D. (2005). Returning the treasure to babies. In K. Finello (Ed.), *The handbook of training and practice in infant and preschool mental health* (pp. 3–30). Jossey-Bass.

Weatherston, D., Weigand, R. F., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *ZERO TO THREE Journal, 31*(2), 22–30.

Weatherston, D. J. (2012). *Reflective supervision rating scale for supervisors. Supervision log* [Unpublished measure]. Consultant, Private Practice, Deborah Weatherston, PhD, IMH-E Mentor, deborahweatherston@icloud.com.

Zeanah, C. H., (Ed.). (2018). *Handbook of infant mental health* (4th ed.). Guilford Publications.

ZERO TO THREE Infant Mental Health Task Force Steering Committee. (2001). *Definition of infant mental health* [Internal report].

ZERO TO THREE. (2021). *DC:0–5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood (Version 2.0).*

ZERO TO THREE | LEARN

2445 M Street NW • Suite 600 • Washington DC 20037 • 202-638-1144 • zerotothree.org