ARTICLE

A COMMUNITY MENTAL HEALTH PROFESSIONAL DEVELOPMENT MODEL FOR THE EXPANSION OF REFLECTIVE PRACTICE AND SUPERVISION: EVALUATION OF A PILOT TRAINING SERIES FOR INFANT MENTAL HEALTH PROFESSIONALS

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ABSTRACT: The Michigan Association for Infant Mental Health identified a need for reflective supervision training for infant mental health (IMH) specialists providing home-based services to highly vulnerable infants and their families. Findings indicate that this pilot of an IMH community mental health professional development model was successful, as measured by the participants' increased capacity to apply reflective practice and supervisory knowledge and skills. Furthermore, IMH clinicians demonstrated an increase in the frequency of their use of reflective practice skills, and their supervisors demonstrated an increase in their sense of self-efficacy regarding reflective supervisory tasks. Finally, the evaluation included a successful pilot of new measures designed to measure reflective practice, contributing to the growing body of research in the area of reflective supervision.

Keywords: reflective supervision, training, reflective practice

RESUMEN: La Asociación de Salud Mental Infantil de Michigan (MI-AIMH) identificó una necesidad de entrenamiento para la supervisión para especialistas de la salud mental infantil (IMH) que proveen servicios basados en casa a infantes altamente vulnerables y sus familias. Los resultados indican que este modelo piloto de desarrollo profesional en salud mental de una comunidad IMH tuvo éxito, tal como fue medido por medio del aumento de la capacidad de los participantes para aplicar la práctica con reflexión y el conocimiento y habilidades de supervisión. Es más, los clínicos de IMH demostraron un aumento en la frecuencia de su uso de práctica con reflexión y sus supervisores demostraron un aumento en su sentido de auto-efectividad con respecto a las tareas de supervisión reflexiva. Finalmente, la evaluación incluyó un programa piloto exitoso de nuevas medidas diseñadas para medir la práctica con reflexión, lo cual contribuye al crecimiento de la investigación disponible en el área de la supervisión reflexiva.

Palabras claves: supervisión reflexiva, entrenamiento, prá, ctica con reflexión

RÉSUMÉ: L'Association de Santé Mentale du Nourrisson de l'état du Michigan aux Etats-Unis a identifié le besoin d'une formation de supervision de réflexion pour les spécialistes de la santé mentale du Nourrisson offrant des services à domicile à des nourrissons extrêmement vulnérables et à leurs familles. Ces résultats indiquent que cette tentative de modèle de développement communautaire professionnel de santé mentale a été une réussite, mesurée par la capacité croissante des participants à appliquer la pratique de réflexion et des connaissances et capacités de supervision. De plus les cliniciens de Santé Mentale du Nourrisson ont fait état d'une augmentation de la fréquence de leur utilisation de compétence de pratique de réflexion et leurs superviseurs ont fait état d'une augmentation de leur sens d'auto-efficacité pour ce qui concerne les tâches de supervision de réflexion. Enfin, l'évaluation a inclu un test pilote réussi de nouvelles mesures destinées à mesure la pratique de réflexion, contribuant ainsi au corps de recherche grandissant dans ce domaine de la supervision de réflexion.

Mots clés: supervision de réflexion, formation, pratique de réflexion

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We report no conflict of interests. Approval from the Institutional Review Board at Eastern Michigan University was maintained throughout the duration of this study. This work was supported by 2013 and 2014 grants from the Ethel and James Flinn Foundation and Eastern Michigan University, Office of Research Development and Administration. This article is dedicated in memory of Douglas Davies, who was an integral part of this project.

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INFANT MENTAL HEALTH JOURNAL, Vol. 37(6), 653–669 (2016)

View this article online at wileyonlinelibrary.com.
DOI: 10.1002/imhj.21611

ZUSAMMENFASSUNG: Die Michigan Association for Infant Mental Health (MI-AIMH) erkannte eine Notwendigkeit für Schulungen in reflexiver Supervision bei Fachpersonal aus dem Bereich der psychischen Gesundheit von Säuglingen (infant mental health, IMH), die im Rahmen von Hausbesuchen Dienstleistungen für sehr vulnerable Säuglinge und ihre Familien anbieten. Die Ergebnisse deuten darauf hin, dass die Pilotierung des "IMH community mental health professional development"-Modells erfolgreich war, gemessen anhand der erhöhten Kapazität der Teilnehmer, die reflexive Praxis und Supervisionskenntnisse sowie -fähigkeiten anzuwenden. Darüber hinaus zeigte sich bei IMH Klinikern eine häufigere Verwendung der Fähigkeiten aus der reflexiven Praxis und bei ihren Supervisoren eine Zunahme ihres Selbstwirksamkeitsgefühls in Bezug auf reflexive Supervisionsaufgaben. Die Evaluation enthält außerdem eine erfolgreiche Pilotierung neuer Methoden, die entwickelt wurden, um die reflexive Praxis zu erfassen, und trägt somit zum wachsenden Forschungswissen im Bereich der reflexiven Supervision bei.

Stichwörter: reflexive Supervision, Schulung, reflexive Praxis

抄録: ミシガン乳幼児精神保健学会The Michigan Association for Infant Mental Health (MI-AIMH)は、非常に脆弱な乳児と家族に、在宅サービスを提供する乳幼児精神保健infant mental health (IMH)専門家に内省的スーパービジョン訓練が必要であることを見出した。この乳幼児精神保健地域精神保健専門家開発モデルの試行が成功したことは、所見から示される。それは参加者が内省的臨床とスーパービジョンの知識と技術を適用する能力の増大によって、測定される。さらに、乳幼児精神保健の臨床家は、内省的臨床技術を使用する頻度が増加したことを示した。そしてそのスーパーバイザーは内省的スーパービジョンの課題に関して自己効力感が増加したことを示した。最後に、評価には、内省的臨床を測定するためにデザインされた新しい測定法の試行の成功も含まれていた。これは内省的スーパービジョンの分野での研究の増大に貢献していた。

キーワード: 内省的スーパービジョン, 訓練, 内省的臨床

摘要: 密歇根幼兒心理健康協會(MI-AIMH)確定, 需要對高度脆弱幼兒及其家庭提供家庭為基礎服務的幼兒心理健康(IMH)專家, 作反思監督培訓。研究結果表明, IMH社區精神健康專業發展模式試點是成功的, 參與者增加反思和監督知識及技能。此外, IMH臨床員工反思方法技能的頻率增加, 他們的主管反思監督任務的自我效能感亦增加。最後, 評估包括一項旨在測量反思方法的成功試點, 對越來越多的反思監督研究, 作出貢獻。

關鍵詞: 反思監督, 培訓, 反思方法

مفتاحية: أدركت جمعية ميشيغان للصحة النفسية للرضع (MI-AIMH) الحاجة لتدريب متخصصي الصحة النفسية على الإشراف التأملي وخصوصا الذين يقدمون خدمات منزلية للرضع للمعرضين للمخاطرة هم وعائلاتهم . وتشير النتائج أن هذا النموذج الاستطلاعي للصحة النفسية للرضع (IMH) قد أثبت نجاحه وذلك في ضوء مقياس زيادة قدرة المشاركين على تطبيق الممارسة التأملية والمعرفة والمهارات الإشرافية. بالإضافة إلى ذلك أظهر الاكلينيكيون في مجال الصحة النفسية للرضع زيادة في تكرار استخدامهم لمهارات الممارسة التأملية والمهام الإشرافية . وأخيرا اشتمل التقييم على مقاييس استطلاعية ناجحة مصممة لقياس الممارسة التأملية مما يسهم في إضافات بحثية لمجال الإشراف التأملي .

كلمات مفتاحية : الإشراف التأملي – التدريب – الممارسة التأملية

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Defined as the awareness of one's personal beliefs, thoughts, and feelings as well as the knowledge of how these beliefs and practices affect others, reflection is a skill that develops over time and in the context of secure and nurturing relationships (Eggbeer, Mann, & Seibel, 2007; Heffron & Murch, 2010; Heller & Gilkerson, 2009; Tomlin, Weatherston, & Pavkov, 2014; Weatherston, Weigand, & Weigand, 2010). Beginning in infancy and continuing through the early years, it is within the parent–child relationship that a child develops the capacity to be reflective and self-aware. Skills associated with reflective capacity include having and expressing one's feelings in response to something said, done, or experienced; being curious about those feelings; exploring the meaning of something and sharing one's observations with another; staying open to what others are experiencing; and taking another's perspective. A safe and trusting relationship is essential to building reflective capacity in the early years.

Equally important, a parent's capacity to function reflectively has been identified by many as related to positive parenting, the attachment relationship, and healthy child outcomes (Fonagy, Gergely, Jurist & Target, 2002; Slade, 2005). Parental reflective functioning includes the parent's ability to have and explore thoughts and feelings about the baby, to understand the baby's behavior, to take the baby's perspective, to wonder about the baby's experiences, and to hold those experiences in mind (Slade, 2005). Building reflective capacity in parents through relationship-centered infant mental health (IMH) services is an important intervention goal because it is the parent's capacity to self-regulate that informs the infant's socioemotional development (Slade, 2005). Most important, through their relationships with parents and infants, IMH professionals enhance reflective practice or functioning by encouraging parents to have and express thoughts and feelings about the infant or young child and

to explore them within a therapeutic service (Sadler, Slade, & Mayes, 2006).

Acknowledging the power of reflective practice or functioning for all children and families, how can we best strengthen or optimize reflective skills in those working with vulnerable families in the first years of a child's life? The answer to this question is one that many in the infant and family field have agreed on. Reflective capacity develops in a supervisory relationship that is a "relationship for learning" (Shahmoon-Shanok, 2006, p. 343) in which the practitioner is invited to explore new ideas, share personal thoughts, and express emotional responses to challenging work with his or her supervisor (Weatherston et al., 2010). Reflective supervision is a specialized approach to the supervisory experience that is closely linked with the field of IMH and has been adopted by a variety of infant and early childhood service providers (Emde, 2009; Gilkerson, 2004; Tomlin et al., 2014; Virmani & Ontai, 2010; Watson, Gatti, Cox, Harrison, & Hennes, 2014). As a distinguished leader in the infant mental health field, Charlie Zeanah (2009), outlined principles of infant mental health that included the following:

> Values, including personal, familial, ethnic, cultural, professional, and organizational, impact every aspect of infant mental health. Professionals working with infants and families need training and supervision in order to meet the social and emotional needs of children and families appropriate to the range and scope of services provided. (Hinshaw-Fuselier, Zeanah, & Larrieu, 2009, p. 535)

When trauma, domestic violence, substance abuse, or mental illness threatens the relational health of infants and families who are referred, they place practitioners at heightened risk of secondary trauma. The overlay of poverty increases the risk (Weatherston & Tableman, 2015). For some, the burden of care for families with intense needs leads to secondary trauma (Osofsky, 2009). A trusting supervisory relationship in which the IMH clinician can reflect on thoughts and feelings about what she or he observes or experiences in working with families is essential to the reduction of professional and personal emotional distress and to the ability of the clinician to respond appropriately to the complex needs. A reflective supervisory relationship provides an opportunity for the IMH clinician to "experience these fragmented feeling states" engendered by relationships with parent–child dyads marked by trauma or intense distress in a contained context (O'Rourke, 2011, p. 168). The experience of such feeling states in the safe environment of the supervisory relationship gives IMH clinicians "their own experience of being safely held in the mind of another" (p. 170), strengthening IMH clinicians' ability to provide this same holding experience for parents and infants in the face of trauma.

What are elements of reflection that have been agreed upon by service providers representing multiple disciplines and service settings? Referring to the 2016 Michigan Association for Infant Mental Health (MI-AIMH) Competency Guidelines agreed on by experts in the field and adopted for use by 23 U.S. State Infant Mental Health Associations, reflection is identified as one of eight core competency domains and includes the following abilities:

- regularly examines own thoughts, feelings, strengths, and growth areas
- discusses issues, concerns, and actions to take with supervisor, consultants, or peers
- understands own emotional response to infant/family work
- recognizes areas for professional and/or personal development.

These reflective skills develop over time and require experience-based learning and practice to be effectively integrated by providers and supervisors in the infant and family field (Carroll, 2009). Such skills must be fostered in both supervisor and supervisee because the supervisory process is a collaborative one in which "critical reflection allows participants to learn together in dialogue" (Carroll, 2009, p. 43). Training in reflective supervision therefore need not only focus on enhancing reflective practice skills but also on identifying and strengthening the relationship-based elements of the supervisory experience (Weatherston & Barron, 2009). The focus of this article is the development and exploration of an intensive training and consultation model designed to capture aspects of the supervisory relationship and the reflective learning and supervisory needs of IMH practitioners providing home-visiting services to infants, toddlers, and families at risk in a community mental health service system in Detroit-Wayne County, Michigan, a community rife with underserved and underresourced families (Zehnder-Merrell, 2015).

Based on the findings from an evaluation of a 2012 advanced competency-based training series for IMH specialists providing IMH home-visiting services in a county serving highly vulnerable infants and their families, the MI-AIMH identified a need for training in the areas of reflective functioning or practice and supervision (Boraggina-Ballard & Mills, 2013). With funding from the Ethel and James Flinn Foundation and partnership with the local community mental health administration, the MI-AIMH's leadership team designed an innovative training series designed to meet that need. Eight training modules were developed to meet the reflective supervision training needs of both IMH supervisors and IMH home-visiting clinicians. With approval from Eastern Michigan University's Institutional Review Board, the training series was evaluated to (a) develop and refine a specialized curriculum for IMH supervisors and IMH staff and (b) determine whether this training model increased both IMH supervisors' and IMH clinicians' reflective practice capacities, knowledge, and skills and increased their sense of self-efficacy regarding reflective supervision tasks and skills.

The purpose of this evaluation was to provide preliminary findings regarding the impact of the pilot training series on the self-efficacy and reflective practice skills of IMH clinicians and supervisors. The evaluation is exploratory in that it not only provided such preliminary findings but also served to highlight the need for more research in the area of reflective supervision and the current challenges faced by researchers in this area. Specifically, the evaluation included the use of new tools designed to measure reflective supervision, an area of research that has garnered

attention in recent years due to the growing need to demonstrate the efficacy of reflective supervision and the lack of available measures to fulfill this need (Eggbeer, Shahmoon-Shanok, & Clark, 2010, Watson et al., 2014). While this evaluation focused on assessing the self-efficacy of the clinicians and supervisors regarding tasks and skills associated with reflective supervision, an important step in the effort to measure reflective supervision, the IMH field will ultimately require an assessment of the impact of reflective supervision on the relationships between those infants, toddlers, and their parents receiving IMH services.

REFLECTIVE SUPERVISION AND THE FIELD OF IMH

Defining Reflective Supervision

Reflective supervision can be defined as "a partnership formed for learning and for developing a deeper awareness about all aspects of a clinical 'case,' especially the social, emotional, and overall interrelated complexity of developmental domains" (Shahmoon-Shanok, 2006, p. 344). This type of supervision differs from traditional clinical supervision in that there is a distinct emphasis on the clinician's and supervisor's emotional responses to the work and also attention paid to the parallel process (i.e., the process by which supervisor, clinician, parent, and infant unconsciously influence one another, resulting in shared emotional states and affective experiences) (Davys & Beddoe, 2009, Harvey & Henderson, 2014; Weatherston & Barron, 2009; Weatherston, Kaplan-Estrin, & Goldberg, 2009). Reflective supervision encompasses the strategic use of the supervisory relationship to enhance the IMH specialist's self-awareness and responses to complex and emotionally challenging work with vulnerable infants, toddlers, and their families (Shahmoon-Shanok, 2006; Weatherston et al., 2009). The supervisory relationship serves as a base for the work that focuses on the developing relationship as it emerges with infants, very young children, and their families. Identification of parallel process is a key component of the reflective supervisory experience and is a significant tool that leads to the clinician's understanding of the complex challenges at the center of the work as well as the opportunity for self-reflection or self-awareness (Shahmoon-Shanok, 2006; Weatherston et al., 2009).

Eggbeer et al. (2010) suggested that the adoption by the IMH field of reflective supervision as a core component of IMH practice and training evolved from an awareness that the more traditional clinical supervision used by social workers, psychologists, and counselors does not sufficiently address the IMH clinician's need to focus on the parent–infant relationship, "the intimate relationship in which one of the members is barely verbal" (p. 40). Specifically, "reflection," identified as an essential element of infant mental health training in 1990 by a ZERO TO THREE taskforce (Eggbeer et al., 2010), includes the ability to use emotional responses as a source of information about the relationships between parent and infant and between clinician and parent as well as a tool to guide clinical responses in the context of treatment (Eggbeer et al., 2010; Watson et al., 2014; Weatherston et al., 2009). IMH's emphasis on reflection suggests that one of the goals of training for IMH clinicians is to increase clinicians' sense of autonomy and self-direction in their efforts to establish relationships with parents and infants and to identify and evaluate their choice of interventions with families. Reflective supervision, therefore, differs from traditional supervision models in that a goal of reflective supervision is to "empower [IMH clinicians] to arrive at their own realizations about the family, which then increases their sense of competence," rather than serving as a forum to advise or teach supervisees about the appropriate next steps with families (Larrieu & Dickson, 2009, p. 584). Thus, reflective supervision is designed to strengthen the supervisee's capacities for reflection and hone their reflective practice skills in service of the parent–infant relationship.

The Supervisory Relationship

The relationship between supervisor and supervisee is central to the success of the reflective supervision experience (Weatherston & Barron, 2009); in fact, it is this relationship that "allows providers the opportunity to experience the same type of support that they intend to provide to families, while they are learning to problem-solve about the challenges they have encountered in their work with young children and their families" (Watson et al., 2014, p. 4). The very nature of the supervisory relationship therefore informs the development of the IMH clinician's reflective functioning or practice skills and fosters the sense of safety that is a prerequisite for disclosure, curiosity and self-exploration so paramount to its success (Mehr, Ladany, & Caskie, 2015). Mehr, Ladany, & Caskie (2015) demonstrated that the strength of the supervisory alliance is correlated with supervisees' willingness to self-disclose, suggesting that a secure and strong relationship between supervisor and supervisee will ultimately influence the supervisee's readiness to share with supervisors what is awakened when working with vulnerable infants and families, challenging personal and professional growth. The exploration of such responses serves as the foundation for reflective supervision and provides opportunities for IMH clinicians to exercise developing reflective functioning or practice skills, particularly their capacity for self-reflection or self-awareness (Bertacchi & Gilkerson, 2009).

Given that community-based IMH services exist within a larger systemic community mental health framework, reflective supervision coexists with the reality of administrative supervision, including tasks such as reviewing clinical summaries, case documentation, and performance reviews (Michigan Association for Infant Mental Health, 2002/2015). Carving out dedicated time for the practice of reflective supervision becomes more challenging as the workload demands increase and as supervisors are accountable for many supervisees, program administration, and oversight, and in some cases, their own clinical caseloads. Despite these challenges, reflective supervision remains an essential component of IMH practice as specified in the MI-AIMH *Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health* (Michigan Association for Infant Mental Health,

2002) and numerous publications written by experts in the field (Eggbeer et al., 2010; Gilkerson, 2004; Heffron & Murch, 2010; O'Rourke, 2011; Shahmoon-Shanok, 2006; Schafer, 2007; Weatherston & Barron, 2009; Weatherston et al., 2009).

Research and Evaluation

Research regarding reflective supervision has been challenged by the difficult nature of quantifying the relational aspects of the process and determining a means for demonstrating its efficacy in terms of supporting clinicians' capacities to provide quality services to infants and toddlers and their families (Watkins, 2015; Watson et al., 2014). However, there has been recent progress in this area of research. Tomlin, Weatherston, and Pavkov (2014) conducted a Delphi study that sought to identify the essential elements of reflective supervision, providing important findings to support an empirical basis for defining successful reflective supervision. The findings have suggested that consistency and the provision of a "quiet, private space" in which to meet are essential elements of reflective supervision, including, in addition, an environment "that encourages continuous learning and improvement" (Tomlin et al., 2014, p. 77). Regarding particular characteristics of supervisors and supervisees that are critical to the reflective supervision experience, the findings have indicated that the most important characteristics of supervisors include that they are "attentive, self-aware/self-reflective, able to observe skillfully, curious and engaged, compassionate, tolerant, and nonjudgmental" (Tomlin et al., 2014, p. 76). The most important characteristics of supervisees included "being open, collaborative, and self-aware . . . non-defensive, having realistic expectations about supervision, and being able to ask for help" (Tomlin et al., 2014, p. 77). Finally, the study also explored mutual behaviors shared by both supervisor and supervisee in the establishment of a reflective supervisory relationship; the most critical behaviors in this category include "safety and trust, respect, and sharing of attention, power, and the 'journey' within the relationship" (Tomlin et al., 2014, p. 77). These findings mirror the existing theoretical literature concerning reflective supervision and strengthen efforts to create guidelines around which to evaluate the reflective supervision experience (Eggbeer et al., 2010; Shahmoon-Shanok, 2006; Tomlin et al., 2014; Watkins, 2015; Weatherston et al., 2009).

Evaluating the efficacy of reflective supervision and the ability of supervisors and clinicians to successfully participate in reflective supervision also is a current area of inquiry (Watkins, 2015; Watson et al., 2014). The need for empirically sound assessment tools is pressing, and the development of such tools is complex and challenging due to the multifaceted and relational nature of reflective supervision, which is challenging to quantify. Furthermore, the difficulty of establishing a strong empirical link between the experience of reflective supervision, the development of reflective practice skills, and outcomes for infants and toddlers and their families poses another challenge in efforts to evaluate this area of IMH practice. Currently, there are a few measures available to researchers that measure aspects of reflective supervision, and many of the existing tools assess IMH clinicians' or supervisors' skills rather than assessing the impact of IMH professionals' use of reflective practice skills and reflective supervision on infants and toddlers and their families (see Table 1). For example, Ash (2010) created the Reflective Supervision Rating Scale, which is completed by the supervisee who is asked to rate his or her supervisor regarding the supervisor's capacities with respect to reflective supervision. Weatherston (2012) created a complementary measure, the Reflective Supervision Rating Scale for Supervisors, which asks supervisors to rate their supervisees' capacities to engage in various reflective practice skills. In addition to these measures, self-report measures are another tool that has been used to evaluate reflective supervision experiences, including the Use of Self and Reflective Practice Skills developed by Heffron (2013) that asks supervisees to rate the degree to which they are using or engaging in a particular reflective practice skill. In addition, Heller (2013) created the Provider Reflective Functioning Assessment 5, which uses a coding system to identify various elements of reflective functioning evidenced in the supervisee's 5-min description of a challenging IMH case. Finally, the Reflective Interactive Observation Scale (RIOS) is another example of a measure designed to evaluate reflective supervision; this coding scheme focuses on the interaction between supervisor and supervisee (Watson et al., 2014). The RIOS involves coding 20-min segments of a reflective supervision session and is designed to rate the degree to which the supervisory experience demonstrates an "understanding of the story, parallel process, holding the baby in mind, professional use of self, and the working alliance" (Watson et al., 2014, p. 12). This promising new coding tool is unique in that it evaluates the content of the interactions between supervisor and supervisee rather than focusing solely on the supervisee's or the supervisor's experience of the supervisory experience, exemplifying the mutuality, reciprocity, and relationship-based nature that defines reflective supervision (Watson et al., 2014).

DESCRIPTION OF THE REFLECTIVE SUPERVISION TRAINING SERIES

The IMH leadership team identified two trainers who had significant expertise in the area of reflective practice with infants, toddlers, and their families and reflective supervision as well as extensive experience facilitating trainings. The IMH trainers and leadership team identified the topics, content, and process activities to be used during the training series. They designed each training module in accordance with the statewide reflective practice competencies as outlined in the MI-AIMH Competency Guidelines (Michigan Association for Infant Mental Health, 2016). The first four modules were designed for supervisors only and focused on increasing the reflective practice skills of those providing reflective supervision. The second four modules were designed for both supervisors and supervisees together and focused on increasing the reflective practice skills for both groups while also providing opportunities to enhance the quality and efficacy of the reflective supervision relationship. All of the modules included

TABLE 1. *Comparison of Reflective Supervision Assessment Tools*

Reflective Supervision Evaluation Tools				
Title	Authors	No. of Items	Areas Assessed	Uses
Reflective Supervision Rating Scale	Ash (2010)	17	Measures supervisee's assessment of supervisor's capacities to engage in and facilitate reflective supervision	A clinical and evaluation tool completed by supervisees regarding their supervisors
Reflective Supervision Rating Scale for Supervisors	Weatherston (2012)	16	Measures supervisor's assessment of supervisee's capacities to engage in reflective supervision	A clinical tool completed by supervisors rating their supervisees; piloted as an evaluation tool in this study
Use of Self and Reflective Practice Skills	Heffron (2013)	14	Supervisee assesses the degree to which they use specific reflective practice skills	A self-report measure for supervisees
Provider Reflective Functioning Assessment 5	Heller (2013)	Coding of 5-min description of a challenging IMH case	Identifies presence of reflective practice capacities in supervisees' case descriptions	A tool that assesses supervisee's capacities for reflective practice
Reflective Supervision Self-Efficacy Scale for Supervisors[a]	Shea, Goldberg, & Weatherston (2012)	17	Supervisors' sense of self-efficacy regarding specific tasks and skills related to reflective supervision	A self- assessment evaluation tool piloted in this study
Reflective Supervision Self-Efficacy Scale for Supervisees[a]	Shea, Goldberg, & Weatherston (2012)	17	Supervisees' sense of self-efficacy regarding specific tasks and skills related to reflective supervision	A self-assessment evaluation tool piloted in this study
Reflective Supervision Case Vignette for Supervisees[a]	Shea, Goldberg, Davies, & Weatherston (2013)	Four open-ended questions related to a case vignette that describes a challenging IMH home visit with a toddler and family	Supervisee's reflective practice skills are assessed in their response to open-ended questions concerning a vignette using a rubric that includes 12 specific reflective practice behaviors	An evaluation tool that rates supervisees' reflective practice skills according to their responses to questions concerning a case vignette
Reflective Supervision Case Vignette for Supervisors[a]	Shea, Goldberg, Davies, & Weatherston (2013)	Four open-ended questions related to a case vignette that describes a reflective supervision session	Supervisor's reflective practice skills are assessed in their response to open-ended questions concerning a vignette using a rubric that includes 12 specific reflective practice behaviors	An evaluation tool that rates supervisees' reflective practice skills according to their responses to questions concerning a case vignette
Reflective Interactive Observation Scale (RIOS)	Watson Gatti, Cox, Harrison, & Hennes (2014)	Coding of 20-min segments of videotaped reflective supervision sessions	Understanding of the story, parallel process, holding the baby in mind, professional use of self, and the working alliance	An evaluation tool designed to assess the reflective supervision relationship

IMH = infant mental health.
[a]Piloted in current evaluation.

didactic content in addition to experiential process activities designed to engage participants in increasing their self-awareness and capacities for reflection, personal and professional. DVDs, PowerPoint slides, and supplemental readings were prepared for each training module. Live, real-time supervision sessions provided the basis for questions and discussion about the reflective supervisory process as well as opportunities for personal responses to what was evoked by the material presented. The eight-module training was cofacilitated by the trainers, and each session was 3 hr in duration. Table 2 details the curriculum used in the training series.

METHOD

Participants

All 29 training participants completed the initial evaluation, including 13 IMH supervisors and 16 IMH supervisees. All 13 supervisors and 10 of the 16 IMH supervisees participated in the quantitative components of the 8- to 10-month follow-up evaluation. The supervisors were recruited from community mental health agencies serving families at high risk, many with histories of complex trauma. To be eligible, supervisors were required to be actively supervising IMH practitioners or interns in a community mental health setting. Each supervisor was invited to select one or two supervisees to attend the training series. Ten supervisors each invited one supervisee while three supervisors were able to each invite two supervisees.

Approximately 92% ($n = 12$) of the supervisors were female and were between the ages of 30 to 69 years. The majority of the supervisors identified as European American (46%, $n = 6$) or African American (38.5%, $n = 5$). The vast majority of supervisors (76.9%, $n= 10$) identified social work as their educational discipline. In terms of experience, an equal percentage (38.5%, $n= 5$) reported having 1 to 5 years of IMH practice experience, as did those who reported having 6 to 10 years of

TABLE 2. *Reflective Supervision Training Series Curriculum*

Training Series Curriculum Module	Module Title
1	Essential Characteristics of Reflective Supervision
2	Building and Sustaining an Effective Supervisory Relationship
3	Increasing Self & Other Awareness: The Impacts of Secondary Trauma; Cultural Backgrounds, and Differences in Personal Style/Perspectives
4	Balancing Administrative, Clinical, and Supervisory Tasks
5	Co-Creating the Supervisory Relationship: Supervisees' Contributions
6	Parallel Process and Its Relationship to Best Practices With Families
7	Reflective Supervision and Personal and Professional Growth for Supervisors and Supervisees
8	Using the Supportive Context of the Supervisory Relationship to Address Emotional Issues and Clinical Complexities

IMH practice experience. The majority of the supervisors (61.5%, *n*= 8) reported having 1 to 5 years of supervisory experience whereas 23.1% (*n*= 3) reported having 16 to 20 years of IMH supervisory experience. The vast majority of supervisors (84.6%, *n*= 11) had attended reflective supervision trainings in the past, with a mean of 10.9 hr and a range of 2 to 24 hr of training represented (see Table 3).

The demographics of the supervisee participants reflect that 100% (*n*= 16) were female and that the majority (56.3%, *n*= 9) was between the ages of 22 to 29 years, with an overall age range of 22 to 59 years. Most supervisees identified as European American (50%, *n*= 8) or as African American (37. 5%, *n*= 6). The vast majority of the supervisees (68.8%, *n*= 11) indicated that social work was their educational discipline. Approximately 43% (*n*= 7) reported having 1 to 5 years of IMH experience, 31.3% (*n*= 5) reported having less than 1 year of IMH experience, and 12.5% (*n*= 2) reported having 0 years of IMH experience. The vast majority of supervisees (87.5%, *n*= 14) had never attended reflective supervision training in the past whereas 12.5% (*n*= 2) had attended such trainings, with supervisee having attended a total of 10 hr of training and another having attended a total of 36 hr of reflective supervision training (see Table 3).

TABLE 3. *Demographic Characteristics of Training Series Participants*

	Supervisors (*n* = 13)		Supervisees (*n* = 16)	
Demographic Variable	No.	%	No.	%
Gender				
Female	12	92.3	16	100
Male	1	7.7	0	0
Ethnicity				
African American	5	38.5	6[a]	37.5
European American	6	46.2	8	50
Other	2	15.4	1	6.3
Age				
22–29	0	0	9	56.3
30–39	5	38.5	5	31.3
40–49	3	23.1	1	6.3
50–59	4	30.8	1	6.3
60–69	1	7.7	0	0
Education/Discipline				
Social Work	10	76.9	11	68.8
Psychology	1	7.7	1	6.3
Counseling	1	7.7	4	25
Other	1	7.7	0	0
Years of IMH Practice Experience				
0	0	0	2	12.5
1–.9	0	0	5	31.3
1–5	5	38.5	7	43.8
6–10	5	38.5	0	0
16–20	3	23.1	0	0
Years of Reflective Supervisory Experience				
0	1	7.7	0	0
.1–.9	2	15.4	0	0
1–5	8	61.5	0	0
6–10	1	7.7	0	0
16–20	1	7.7	0	0
Previous Participation in Reflective Supervision Training				
Yes	11[a]	84.6	2	12.5
No	1	7.7	14	87.5

IMH = infant mental health.
[a]Missing response(s).

Data Collection and Instruments

Participant measures. Pre- and posttest data were collected to assess changes in participants' knowledge and skills and changes in participants' sense of self-efficacy regarding their use of reflective practice. In addition, 8- to 10-month follow-up data also was collected to determine the degree to which such changes were sustained following completion of the training series. Knowledge and skills were measured by rating scales specific to supervisee and supervisor experiences in reflective supervision and case vignettes specifically designed for supervisees and supervisors. Self-efficacy regarding reflective practice and supervision was measured using new tools piloted with this sample. Participants responded to the pretest measures immediately prior to commencing the training; the supervisors completed pretest measures prior to Training Session 1 whereas supervisees completed their pretest measures prior to Training Session 5. Posttest data were collected within 48 hr of

TABLE 4. *Scoring Rubric for Reflective Supervision (RS) Case Vignettes for Supervisees and Supervisors*

Scoring Rubric for RS Case Vignettes for Supervisors and Supervisees Rated on a Scale of 1–5 RS Practice Ability
1. Capacity to acknowledge the importance of relationship-building and pacing
2. Capacity to focus on the relationship (not exclusively on the parent OR the infant, but on both)
3. Capacity to "be with" (as opposed to "do for" primarily)
4. Capacity to use reflective supervision/consultation
5. Capacity to be curious about the thoughts, feelings and experiences of the parent & infant/toddler (in addition to the realities of their lives), as well as those of the supervisee—to wonder
6. Capacity to be "self-reflective"
7. Capacity to appreciate parallel process
8. Interested in (helping the supervisee) development of new skills
9. Capacity to hold onto ambivalence during the session
10. Capacity to be tolerant/nonjudgmental during session
11. Capacity to share observations in detail
12. Coherence in the narrative
1 = *weak*; 2 = *below adequate*; 3 = *adequate*; 4 = *above adequate*; 5 = *strong*.

completion of the training series. In addition to the pre- and posttest data, follow-up data were collected 8 to 10 months following completion of the training series; these data included self-efficacy and knowledge and skills rating scales.

Reflective Supervision Rating Scale. The Reflective Supervision Rating Scale (Ash, 2010) was used to measure supervisees' assessment of their reflective supervision experiences with their supervisor, including the degree to which their supervisor has participated in the facilitation of a reflective supervisory relationship. This scale does not yet have psychometric data. The scale consists of 17 statements preceded by the phrase "My supervisor(s) . . . " and asks the participant to rate their opinion of each statement on a scale of 0 (*rarely*), 1 (*sometimes*), and 2 (*almost always*). The scale was administered pre- and posttraining and at the 8- to 10-month follow-up period, providing a knowledge and skills assessment of the supervisors. The results of this measure were analyzed descriptively, and pre-, post-, and follow-up results were compared with paired-samples *t* tests.

Reflective Supervision Rating Scale for Supervisors. The Reflective Supervision Rating Scale for Supervisors (Weatherston, 2012), adapted from *Supervision Log* (Weatherston, 2012), was piloted for use in this evaluation and does not yet have psychometric data. The scale consists of 16 statements preceded by the phrase, "My supervisee(s) . . . ." Supervisors completed this scale, using a scale of 0 (*rarely*), 1 (*sometimes*), and 2 (*almost always*), rating their opinion of each statement regarding the degree to which they experience their supervisee as demonstrating reflective practice skills or engaging in reflective supervision. This scale was administered both prior to, immediately following, and 8 to 10 months after the training series' conclusion and measured the supervisees' knowledge and skills. The results of this measure were analyzed descriptively, and pre-, post-, and follow-up results were compared with paired-samples *t* tests.

Reflective Supervision Case Vignette for Supervisors. In addition to the two scales, participants also completed a case vignette measure, piloted in this evaluation, at posttest to assess participants' knowledge and skills (Shea, Goldberg, Davies, & Weatherston, 2012). The case vignette was developed to provide participants the opportunity to demonstrate the application of their knowledge and to engage in reflective practice. Such case vignette applications are important complementary assessment tools when evaluating clinical practice and process that cannot be fully assessed via more traditional quantitative measures (Huffman, Peterson, Baer, Romeo, & Sutton-Skinner, 2010). A case vignette was developed specifically for supervisors who were invited to read the vignette describing a reflective supervision session and respond to the following questions: "What do you find yourself wondering about concerning Tracy's [supervisee] participation in supervision and how would you respond to her request to postpone supervision? What do you think is happening for Tracy when working with the described family and for the family when working with Tracy? How might you share these thoughts with Tracy? What feelings are you aware of in yourself as you reflect on what Tracy has summarized regarding her home visits? Describe how this helps you frame possible responses to Tracy" (Shea et al., 2012). The vignette and associated questions were developed by the authors, who all have IMH clinical and training experience, and content and face validity were assessed via feedback from an expert in the field of IMH and reflective supervision. Goldberg and Weatherston (2013) developed a detailed rubric, piloted in this evaluation, which assessed the presence of 12 specific capacities related to reflective practice and reflective supervision. The first six practice behaviors were identified as essential elements of reflective practice based on administration of a different case vignette application in a prior evaluation of a professional-development training series for IMH specialists. Practice Behaviors 7 to 12 were identified based on a review of the literature regarding what it means to "use" reflective supervision as a supervisee and "offer" reflective supervision as

a supervisor. Responses were scored on a scale of 1 (*weak*) to 5 (*strong*) (see Table 4). For example, a rating of "5" indicates that the responses included 10 to 12 of the practice behaviors. Due to the small sample size, interrater reliability was established over the course of scoring the posttest results. Two of the authors independently scored all of the vignettes at posttest; in instances of disagreement, the ratings were discussed until agreement was achieved.

The following excerpt of a supervisor's response is an example of a strong response that received a rating of "5:"

I would not have begun with administrative stuff. I would have had 2 minutes of silence and asked Tracy how she was doing. She has a really hard case and I would wonder with her about this and what she expected. What is challenging, how are we doing. I would parallel this with how mom might be feeling and wonder about why I found it difficult at the time to show empathy and just sit and listen to Tracey. It is hard to balance administrative with reflection. I would remind myself how important it is to follow the client's lead and to slow down.

The next excerpt is an example of a response that received a rating of a "1," meaning that the reviewers found the response to be weak in terms of demonstrating the 12 reflective practice capacities: "I would try to meet Tracy where she is at and see if speaking about her feeling overwhelmed would help. Maybe if Tracy felt like someone else understood then she wouldn't feel so isolated and alone."

Reflective Supervision Case Vignette for Supervisees. A second case vignette measure was piloted for supervisees and completed at posttest only. As previously described, the case vignette provided the supervisees with the opportunity to engage in reflective practice skills and demonstrate their capacity for reflection as opposed to limiting the evaluation to self- and supervisor ratings of skill development (Huffman et al., 2010). The case vignette described a clinician's challenging home-visiting experiences with a toddler and her family (Shea et al., 2012). Supervisees were invited to read the vignette and respond to the following questions: What do you find yourself wondering about following the initial home visits with this family, including the family's reluctance to meet with you and their "no show" at your last home visit appointment? What feelings are you aware of following your initial visits with the family? How might those feelings inform your work with Isabella, her mother and her father? How might you use supervision to better understand what the family needs from you and how to best respond?" (Shea et al., 2012). The vignette and associated questions were developed by the authors, who all have IMH clinical and training experience, and content and face validity were assessed via feedback from an expert in the field of IMH and reflective supervision. These responses were scored by Weatherston and Goldberg (2013) using the same 5-point scale and rubric described earlier (see Table 4). The interrater reliability was established in the same manner as that described for the Reflective Supervision Case Vignette for Supervisors.

The following excerpt of a supervisee's response is representative of a response that earned a score of "5," indicating a strong demonstration of the scoring rubric's 12 reflective practice capacities:

I would use supervision to give myself the space and time to sit with the feelings that arise when I'm in the home, the why and where they might be stemming from, to be in tune with what I need from my supervisor, and how challenging that can be to articulate and communicate. This will be information about how family members feel and what they would need to move forward with me.

As a comparison, this next excerpt provides an example of a supervisee's response that earned a score of "1" and demonstrates weak mastery of the 12 reflective practice capacities: "I don't have an answer. I feel the therapist needed guidance on how to gain trust with this family."

Reflective Supervision Self-Efficacy Scale for Supervisors. Supervisors completed the Reflective Supervision Self-Efficacy Scale for Supervisors, a measure piloted during this evaluation, prior to and immediately following the training series (Shea, Goldberg, & Weatherston, 2012). Self-efficacy is a concept that captures "people's beliefs in their capabilities to produce given attainments" (Bandura, 2006). Specifically, assessments of self-efficacy "determine whether coping behavior will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences" (Bandura, 1977, p. 191). In terms of the applicability of self-efficacy constructs in relation to the field of clinical practice, many researchers have conducted studies to measure task-specific self-efficacy rates for social workers and social work students (Berzoff, Dane, & Cait, 2005; Ellett, 2009; Holden, Anastas, Meenaghan, & Metrey, 2002; Holden, Cuzzi, Rutter, Rosenberg, & Chernack, 1997; Miller, 2011; Williams, King, & Koob, 2002).

The use of the self-efficacy construct as a way of conceptualizing therapists' parallel experiences when working with infants and families is practical because attachment literature uses efficacy as a means of describing infant's competency within the context of relationships (Ainsworth & Bell, 1974). Ainsworth and Bell (1974) defined infant competency as it relates to the capacity to experience efficacy in the context of relationships. The repeated experience of failing to influence others results in decreasing an infant's general sense of efficacy (Ainsworth & Bell, 1974). As infants can experience their insecure attachment experiences as a reflection of their lack of efficacy in forming relationships with others, therapists can experience their difficulties engaging with infants and families and the supervisor as a reflection of their lack of efficacy in the treatment of this population.

The measure included 17 items preceded by the phrase "Based on your reflective supervision experiences, how confident are you that you can . . . ." The 17 items were phrases that reflected specific tasks or skills associated with reflective supervision. Participants rated their level of confidence using a scale of 1 (*no confidence*), 2 (*low confidence*), 3 (*average confidence*), 4 (*high confidence*), and

5 (*extremely high confidence*). This new measure was assessed for reliability and validity. Content and face validity were assessed via feedback from experts in the field of IMH practice and reflective supervision. The frequency distributions of the pilot test results of this measure were consistent. Cronbach's α for this measure was calculated using this sample's pretest data and was .92 (n= 13), suggesting a very high degree of internal reliability for this measure. The results of this measure were analyzed descriptively, and pre-, post-, and follow-up results were compared with paired-samples t tests.

Reflective Supervision Self-Efficacy Scale for Supervisees. Supervisees completed the Reflective Supervision Self-Efficacy Scale for Supervisees, a measure piloted during this evaluation (Shea et al., 2012). The measure included 17 items preceded by the phrase "Based on your reflective supervision experiences, how confident are you that you can . . . ." The 17 items were phrases that reflected specific tasks or skills associated with reflective supervision and reflective practice. Participants rated their level of confidence on a scale of 1 (*no confidence*), 2 (*low confidence*), 3 (*average confidence*), 4 (*high confidence*), and 5 (*extremely high confidence*). Preliminary findings suggest that this measure has a strong degree of reliability and validity. Experts in the field of IMH practice and reflective supervision reviewed the measure to provide an initial assessment of the content and face validity. The results of the pilot test were reviewed to further assess for content and face validity. The frequency distributions of the responses were reviewed and assessed to be consistent throughout the survey results. Cronbach's α for this measure was calculated using this sample's pretest data combined with data collected from another sample of supervisees and was .93 (n= 36), suggesting a very high degree of internal reliability for this measure. Results of this administration of the measure were analyzed descriptively, and pre-, post-, and follow-up results were compared with paired-samples t tests.

RESULTS

The results include the pre-, posttest, and 8-10 month follow-up self-efficacy and knowledge and skills data for both supervisors and supervisees. In addition, the results of the posttest case vignette application for both supervisors and supervisees are described.

Participant Results

Knowledge and skills. The Reflective Supervision Rating Scale for Supervisors asked supervisors to rate the degree to which their supervisees are able to engage in reflective supervision and demonstrate reflective practice skills. As illustrated in Table 5, an item analysis was conducted using paired-samples t tests; all significant results met or exceeded Cohen's (1988) convention for a moderate effect ($d = .50$) or for a large effect ($d = .80$). The following specific reflective skills were demonstrated more frequently by supervisees following the training series per their supervisors' reports: "follow parent's lead and follow infant's lead," $t(11) = 2.34$, $p = .04$, $d = .67$, "describes/discusses interaction and developing relationship between parent and young child," $t(11) = 3.92$, $p = .002$, $d = 1.14$, "express both thoughts and feelings when discussing/describing infant and parent(s), $t(11) = 2.24$, $p = .04$, $d = .66$; "demonstrates capacity to think and have feelings about self in relation to the work," $t(11) = 2.57$, $p = .03$, $d = .75$, and "demonstrates the capacity to use the supervisory relationship to be reflective," $t(11) = 1.77$, $p = .05$, $d = .51$. According to this analysis, meeting with the supervisor on time as planned decreased in frequency in the posttest assessment, $t(11) = -4.18$, $p = .002$, $d = 1.21$. Paired-samples t tests comparing pretest results with the outcomes of a follow-up assessment to the training series indicated that 8 to 10 months following the training series, supervisees maintained an increased ability to: "follow parent's lead and follow infant's lead," $t(12) = 2.9$, $p = .01$, $d = .82$, "express both thoughts and feelings when discussing/describing infant and parent(s), $t(12) = 3.2$, $p = .01$, $d = .88$, "demonstrates capacity to think and have feelings about self in relation to the work," $t(12) = 3.96$, $p = .002$, $d = 1.1$, and "demonstrates the capacity to use the supervisory relationship to be reflective," $t(12) = 2.52$, $p = .03$, $d = .7$. The analyses indicate that 8 to 10 months following the training series, supervisees did not maintain their posttest increased ability to "describe/discuss interaction and developing relationship between parent and young child," $t(12) = 1.48$, $p = .17$. In addition, at the 8- to 10-month follow-up period, supervisees were better able to "demonstrate capacity to be quiet and hold parent's feelings to 'not know or not do," $t(12) = 2.5$, $p = .03$, $d = .7$, and "understand reason(s) for service to the infant and family and puts into words what is at the center of their work together," $t(12) = 3.21$, $p = .01$, $d = .88$. Furthermore, the decrease in the supervisees meeting with the supervisor on time as planned was not maintained at the 8- to 10-month follow-up period, $t(12) = -1$, $p = .34$.

The Reflective Supervision Rating Scale asked supervisees to rate the degree to which their supervisors are able to engage in reflective supervision and facilitate their reflective practice skills. As illustrated in Table 6, an item analysis of this scale using paired-samples t tests indicate that there are two specific reflective supervision skills that decreased in frequency for supervisors following the training series, as rated by their supervisees: "is engaged through the entire session," $t(14) = -2.45$, $p = .028$, $d = .63$, and "makes me feel nurtured, safe, and supported during supervision," $t(14) = -2.26$, $p = .041$, $d = .59$. The effect sizes for these analyses ($d = .63$, $d = .59$, respectively) were found to exceed Cohen's (1988) convention for a moderate effect ($d = .50$). At the 8- to 10-month follow-up assessment, paired-samples t-test results (see Table 6) indicated that the decreases in these tasks were not maintained; however, there was a decrease in the supervisees' rating of, "my supervisor and I together set the agenda for supervision," $t(9) = -3.28$, $p = .01$; $d = 1.04$. The effect size for this analysis ($d = 1.04$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$).

The results of a posttest only case vignette assignment for supervisors demonstrated that 69.2% (n= 9) were able to adequately

TABLE 5. *Supervisee Results I: Reflective Supervision Rating Scale for Supervisors Rating Supervisees, n = 13*

	Pretest vs. Posttest				Pretest vs. 8- to 10-Month Follow-Up		
My Supervisee(s):	Pretest	Posttest			Follow-Up		
	M(*SD*)	*M*(*SD*)	*t*	*d*	*M* (*SD*)	*t*	*d*
1. meets with me on time and as planned.	1.92 (.27)	1.17 (.72)	−4.18*	1.21	1.85 (.38)	−1.00	
2. demonstrates capacity to reach out and to find, meet with infant and family, as planned.	1.85 (.38)	1.92 (.29)	1.00		1.67 (.65)	−.80	
3. demonstrates capacity to build a working relationship with family.	1.69 (.63)	1.91 (.3)	1.40		1.77 (.44)	.56	
4. follows parent's and infant's lead.	1.23 (.6)	1.50 (.52)	2.35*	.67	1.77 (.44)	2.9*	.82
5. demonstrates understanding of different ways of entering a case (e.g., concerns focusing on the infant, concerns focusing on the parent's present ability to provide care, concerns focusing on the parent's history, concerns about the home environment).	1.38 (.51)	1.67 (.65)	.90		1.54 (.66)	.56	
6. describes/discusses observations of infant or toddler, attentive to health, social, emotional, and cognitive capacities.	1.46 (.52)	1.45 (.52)	.43		1.77 (.6)	1.76	
7. describes/discusses observations of parent(s), attentive to strengths and concerns/risks.	1.31 (.48)	1.67 (.65)	1.48		1.62 (.51)	1.76	
8. demonstrates capacity to be quiet, to hold parent's feelings, to "not know" or "not do."	1.00 (.82)	1.33 (.65)	1.77		1.54 (.52)	2.5*	.7
9. describes/discusses interaction and developing relationship between parent and young child.	1.39 (.51)	1.92 (.29)	3.92*	1.14	1.69 (.48)	1.48	
10. asks questions that invited parent to talk and listened carefully and sensitively.	1.39 (.65)	1.75 (.62)	1.60		1.38 (.65)	0	
11. used observation and listening skills to assess the infant/toddler's developing capacities, strengths, risks, needs, diagnosis (if appropriate) to construct an intervention or treatment plan.	1.46 (.52)	1.67 (.49)	1.39		1.69 (.63)	1.15	
12. expressed both thoughts and feelings when discussing/describing infant and parent(s).	1.23 (.83)	1.75 (.45)	2.24*	.66	1.69 (.63)	3.2*	.88
13. demonstrates capacity to think and have feelings about self in relation to the work.	1.15 (.69)	1.58 (.67)	2.57*	.75	1.85 (.56)	3.96*	1.1
14. demonstrates capacity to share thoughts and feelings about self in supervision.	1.39 (.65)	1.42 (.67)	.32		1.77 (.6)	1.59	
15. demonstrates the capacity to use the supervisory relationship to be reflective.	1.31 (.75)	1.58 (.67)	1.77*	.51	1.77 (.6)	2.52*	.7
16. understands the reason(s) for service to the infant and family and put into words what is at the center of their work together.	1.31 (.63)	1.83 (.39)	3.92		1.77 (.44)	3.21*	.88

*$p \leq .05$.

or more than adequately demonstrate reflective practice capacities. The posttest only case vignette results for supervisees indicated that 86.7% (n= 13) were adequately or more than adequately able to demonstrate reflective practice capacities.

Self-efficacy assessment. The Reflective Supervision Self-Efficacy Scale for Supervisors was designed for supervisors to provide a self-assessment of their level of confidence engaging in specific reflective supervisory tasks and skills. As reported in Table 7, paired-samples *t* tests yielded a statistically significant increase for 16 of 17 items, and the effect sizes for 12 of these significant items meet or exceed Cohen's (1988) convention for a large effect (d = .80), with the remaining 4 significant items meeting or exceeding the convention for a moderate effect (d = .50). The one item that did not yield a significant outcome in the paired-samples *t* test was "create a supervisory environment in which the supervisee feels safe to explore their thoughts and feelings related to work with parents and infants," $t(12) = 1.48$, $p = .165$. At the 8- to 10-month follow-up evaluation, the paired-samples *t*-test results indicated that supervisors maintained their increase in self-efficacy regarding 10 of the items related to reflective supervision when compared to the pretest self-efficacy assessment. All of the significant findings exceeded Cohen's (1988) convention for a large effect (d = .80), with the exception of one item: "facilitate the discussion of the supervisee's emotional responses regarding difficult or challenging experiences with infants and families in the context of supervision,"

TABLE 6. *Supervisor Results I: Reflective Supervision Rating Scale (n = 16)*

My Supervisor(s):	Pretest vs. Posttest				Pretest vs. 8- to 10-Month Follow-Up		
	Pretest ($n = 16$) $M(SD)$	Posttest ($n = 15$) $M(SD)$	t	d	Follow-up ($n = 10$) $M(SD)$	t	d
1. and I have formed a trusting relationship.	2.75 (.45)	2.67 (.62)	−.56		2.8 (.42)	−.56	
2. and I have established a consistent supervision schedule.	2.5 (.52)	2.53 (.64)	.37		2.4 (.84)	−.32	
3. questions and encourages details about my practice to be shared and explored within the supervision session.	2.69 (.48)	2.67 (.49)	0		2.5 (.85)	−.56	
4. is engaged throughout the entire session.	2.94 (.25)	2.53 (.64)	−.2.45*	.63	2.7 (.68)	−.1.41	
5. is both a teacher and a guide.	2.88 (.34)	2.67 (.49)	−.1.87		2.7 (.48)	−.1.5	
6. makes me feel nurtured, safe, and supported during supervision.	2.88 (.34)	2.60 (.51)	−.2.26*	.59	2.7 (.48)	−.1.5	
7. shows me how to integrate emotion and reason into case analyses.	2.44 (.63)	2.47 (.64)	.44		2.6 (.7)	1.5	
8. has improved my ability to be reflective.	2.5 (.63)	2.60 (.63)	.81		2.5 (.71)	−.1	
9. allows me time to come to my own solutions during supervision.	2.75 (.45)	2.53 (.74)	−.1.38		2.6 (.52)	−.1.5	
10. explores my thoughts and feelings about the supervisory process itself.	2.38 (.62)	2.27 (.46)	−.37		2.4 (.7)	0	
11. and I together set the agenda for supervision.	2.56 (.51)	2.47 (.64)	−.37		1.9 (.74)	−.3.28*	1.04
12 12. thinks with me about how to improve my observation and listening skills.	2.31 (.7)	2.40 (.63)	1.00		2.3 (.82)	.26	
13. listens carefully for the emotional experiences that I am expressing.	2.75 (.58)	2.73 (.46)	0		2.5 (.67)	−.1.5	
14. encourages me to talk about emotions I have felt while consulting and working with families.	2.75 (.45)	2.67 (.62)	−.37		2.5 (.22)	−.1	
15. keeps families' and children's unique experiences in mind during supervision.	2.88 (.34)	2.80 (.41)	−.1.00		3.0 (0)	.8	
16. wants to know how I feel about my consultation or practice experiences.	2.69 (.7)	2.53 (.52)	−.56		2.67 (.71)	1.96	
17. helps me explore cultural considerations in my work.	2.56 (.51)	2.33 (.49)	−.1.38		2.8 (.42)	.43	

*$p \leq .05$.

$t(12) = 3.61$, $p = .004$, $d = .25$, which meets Cohen's (1988) convention for a small effect ($d = .20$) (see Table 7).

The Reflective Supervision Self-Efficacy Scale for Supervisees was designed for supervisees to provide a self-assessment of their level of confidence engaging in specific reflective supervisory tasks and skills. Paired-samples t tests were used to compare the pre- and posttest results (see Table 8); findings indicate that the supervisees experienced a significant increase in their sense of self-efficacy regarding one task: their ability to "describe/discuss observations of infant or toddler, attentive to health, social, emotional, and cognitive capacities," $t(14) = 2.45$, $p = .03$, $d = .63$. The effect size ($d = .63$) exceeds Cohen's (1988) convention for a moderate effect ($d = .50$). Paired-samples t tests comparing the pretest results with follow-up data (see Table 8) show that at 8 to 10 months following completion of the training series, there were no significant differences in the supervisees' sense of self-efficacy regarding reflective supervision when compared to the pretest results, with the exception of one task in which there was a decrease: "use observations and listening skills to assess the infant/toddler's developing capacities, strengths, risks, needs, diagnosis (if appropriate) to construct an intervention or treatment plan," $t(8) = -2.53$, $p = .04$, $d = .83$. The effect size ($d = .83$) exceeds Cohen's (1988) convention for a large effect ($d = .80$).

DISCUSSION

The goals of this preliminary evaluation were to determine whether the community mental health professional development model for the expansion of reflective practice increased both IMH supervisors' and IMH clinicians' reflective practice and supervision knowledge and skills and increased their sense of self-efficacy regarding reflective supervision tasks and skills. In addition, this exploratory evaluation also served as a means to pilot new assessment measures in the area of reflective supervision and practice. The majority of supervisees and supervisors demonstrated adequate or above-adequate knowledge of reflective practice and supervision skills in a case vignette application, suggesting a capacity to apply the reflective practice and reflective supervision skills and knowledge. Based on the results of the 8- to 10-month

TABLE 7. *Supervisor Results II: Reflective Supervision Self-Efficacy Scale for Supervisors (n = 13)*

Based on your reflective supervision experiences, how confident are you that you can:	Pretest vs. Posttest				Pretest vs. 8- to 10-Month Follow-Up		
	Pretest	Posttest			Follow-Up		
	M(*SD*)	*M*(*SD*)	*t*	*d*	*M*(*SD*)	*t*	*d*
1. create a supervisory environment in which the supervisee feels safe to explore their thoughts and feelings related to work with parents and infants?	3.46 (.66)	3.92 (.76)	1.48		3.77 (.44)	1.48	
2. build a trusting relationship with the supervisee?	3.85 (.55)	4.38 (.77)	2.21*	.61	4.08 (.49)	1	
3. provide meaningful support that enhances the supervisee's self-worth and sense of competence?	3.31 (.75)	4.23 (.44)	4.38*	1.22	3.92 (.64)	2.89*	.8
4. regularly examine my own thoughts, feelings, strengths, and growth areas?	3.46 (.97)	4.31 (.63)	3.40*	.94	3.85 (.56)	1.33	
5. pay close attention to the emotional state of the supervisee?	3.54 (.78)	4.15 (.8)	3.41*	.95	3.92 (.64)	1.33	
6. function, when appropriate, as a teacher and a guide, as well as a facilitator?	3.23 (.83)	3.92 (.76)	2.42*	.67	3.85 (.8)	2.13	
7. facilitate the supervisee's ability to describe/discuss observations of the infant/toddler and use these observations and listening skills to assess the infant's capacities, strengths, risks, needs, diagnosis (if appropriate) to construct an intervention or treatment plan?	2.92 (.76)	3.92 (.65)	3.34*	.93	4 (.74)	10.38*	3
8. help the supervisee explore the parallel process that may exist by using emotional responses and experiences as means of understanding the experiences of the infant and family?	2.92 (.76)	3.92 (.51)	4.17*	1.2	3.42 (.67)	3.02*	.87
9. attend to both the content and the process?	2.92 (.76)	3.75 (.75)	2.42*	.7	3.77 (.44)	4.43*	1.22
10. consult with another professional to understand my own capacities and needs?	4 (.91)	4.42 (.67)	2.57*	.74	4.23 (.44)	.9	
11. facilitate the discussion of the supervisee's emotional responses regarding difficult or challenging experiences with infants and families in the context of supervision?	3 (.58)	4.17 (.72)	5.63*	1.62	4 (.71)	3.61*	.25
12. provide containment for the supervisee's emotional experiences expressed in the context of supervision?	3 (.71)	4.17 (.83)	3.02*	.87	4.08 (.64)	3.74*	1
13. address ruptures or misattunements that have occurred with my supervisee in the context of supervision?	2.85 (.55)	3.50 (.9)	2.60*	.75	3.46 (.66)	3.41*	1.04
14. facilitate the supervisee's description/discussion of observations of the parent(s), attentive to strengths and concerns/risks?	3.31 (.69)	4.25 (.75)	3.07*	.89	3.92 (.49)	3.41*	.95
15. facilitate the supervisee's description/discussion of the interaction(s) and the developing relationship between parent and young child?	3.15 (.69)	4.17 (.58)	4.06*	1.17	4 (.41)	4.43*	.95
16. facilitate the supervisee's understanding of the reason(s) for service to the infant and family and facilitate the supervisee's ability to put into words what is at the center of their work with the family?	3.08 (.64)	4.08 (.67)	4.06*	1.17	4 (.58)	5.2*	1.23
17. remain open, emotionally available, and curious?	3.69 (.95)	4.42 (.51)	3.00*	.87	4.23 (.44)	2.01	

*$p \leq .05$.

follow-up evaluation of the training series, the immediate posttest findings of the training series evaluation were sustained 8 to 10 months following the conclusion of the series. Specifically, the supervisors continued to report a higher level of self-efficacy regarding reflective supervisory tasks 8 to 10 months following completion of the training series, as compared to their pretest results. This indicates that the positive impact the training series had on supervisors' sense of self-efficacy regarding reflective supervision was a sustained growth and did not simply reflect an immediate posttest improvement.

The second measure used to assess supervisors' reflective practice skills was the Reflective Supervision Rating Scale that

TABLE 8. *Supervisee Results II: Reflective Supervision Self-Efficacy Scale for Supervisees*

	Pretest vs. Posttest				Pretest vs. 8- to 10-Month Follow-Up		
Based on your reflective supervision experiences, how confident are you that you can:	Pretest ($n = 16$)	Posttest ($n = 15$)			Follow-Up ($n = 10$)		
	M(*SD*)	*M*(*SD*)	*t*	*d*	*M*(*SD*)	*t*	*d*
1. describe/discuss observations of infant or toddler, attentive to health, social, emotional, and cognitive capacities?	3.38 (.72)	3.80 (.77)	2.45*	.63	3.4 (1.08)	.43	
2. build a trusting relationship with my supervisor?	4.19 (.4)	4.20 (.94)	0		4 (1.05)	−.32	
3. feel safe to discuss emotional responses to infants and families in the context of supervision?	4.13 (.81)	4.27(.88)	.76		4 (.94)	−.56	
4. regularly examine my thoughts, feelings, strengths, and growth areas?	3.69 (.87)	4.00 (.65)	1.23		3.7 (1.16)	.36	
5. remain open to feedback from my supervisor about my work with infants and caregivers?	4.31 (.48)	4.07 (.88)	−1.17		3.9 (.99)	−1.12	
6. describe/discuss observations of parent(s), attentive to strengths and concerns/risks?	4.25 (.68)	4.27 (.7)					
0		4.2 (.79)	0				
7. identify the parallels that may exist between my emotional responses and the experiences of the families and infants I serve?	3.44 (1.09)	3.71 (.91)	.68		3.5 (1.18)	.69	
8. describes/discuss the interactions and developing relationship between parent and young child?	3.88 (.72)	4.00 (.76)	.29		4 (.82)	.61	
9. consult with my supervisor to understand my own capacities and needs?	4 (.65)	3.77 (.93)	−1.00		3.56 (.88)	−1.51	
10. discuss emotional responses regarding difficult or challenging experiences with infants and families in the context of supervision?	4.07 (.8)	3.92 (.86)	−.25		3.56 (.88)	−1.84	
11. identify ways in which my emotional responses may have interfered with my ability to identify or meet the needs of infants and families?	3.6 (.83)	3.69 (.85)	.82		3.78 (.83)	2	
12. address ruptures or misattunements that have occurred with my supervisor in the context of supervision?	3.47 (.99)	3.23 (.83)	−.23		3.33 (.87)	0	
13. address ruptures or misattunements that have occurred with infants and families in the context of supervision?	3.87 (.64)	3.85 (.9)	.29		3.44 (1.01)	−1.41	
14. use observations and listening skills to assess the infant/toddler's developing capacities, strengths, risks, needs, diagnosis (if appropriate) to construct an intervention or treatment plan?	3.87 (.74)	4.00 (.58)	1.39		3.33 (1)	−2.53*	.83
15. understand the reason(s) for service to the infant and family and put into words what is at the center of their work together?	3.53 (.99)	3.85 (.8)	1.81		3.78 (.83)	1	
16. discuss instances of not knowing what to do in work with infants and caregivers?	4.07 (.8)	4.08 (.76)	.37		3.78 (.97)	−1.51	
17. integrate supervisory discussions and details into the work with infants and families?	3.6 (.74)	3.85 (.8)	1.48		3.5 (.76)	0	

*$p \leq .05$.

was completed by supervisees. According to supervisees' reports, supervisors did not show a significant change from the pretest findings at the 8- to 10-month follow-up period, with similar results at the immediate posttest period. These results may be related to the supervisees' minimal experience with reflective supervision, as many of these participants were relatively new to the IMH field at the time of the training series; approximately 44% of the supervisees had 0 to 1 year of experience of IMH practice, and the remaining 46% had only 1 to 5 years of experience. A lack of experience with reflective supervision and with the supervisor's and supervisee's shared responsibility for the success of the relationship can serve as an explanation for these findings because the average scores for this measure both at pretest and again at the 8- to 10-month follow-up period were relatively high, suggesting that the supervisees entered the training series with a high degree of confidence in their supervisors' skills and that the training

series served to reinforce that confidence. The following specific items that had previously been noted as significantly decreasing in frequency between the time of pretest and posttest no longer demonstrated a significant decrease in frequency at the time of the follow-up evaluation: "is engaged through the entire session" and "makes me feel nurtured, safe, and supported during supervision." This suggests that these decreases in frequency, while evident immediately following the training, were not sustained and did not become permanent supervisory behaviors/interactions. It is possible that supervisees became more confident or experienced a greater degree of safety within their supervisory relationship to address such ruptures, thus resulting in an improvement in those aspects of reflective supervision. The 8- to 10-month follow-up results indicated a decrease in the task "My supervisor and I together set the agenda for supervision." It can be hypothesized that this group of supervisees, the majority of whom are relatively new to the field, became more aware of the collaborative roles and responsibilities inherent in reflective supervision as opposed to relying on their supervisors to independently create the experience and relationship. It also is important to consider the impact that use of the measure, which includes a narrow scoring range, with a very small sample would then potentially magnify what amount to small changes in reality.

The supervisees' sense of self-efficacy regarding reflective supervision did not change from pretest to the 8- to 10-month follow-up period, similar to that of the posttest results. However, the supervisors' ratings of their supervisee's reflective practice skills were significantly higher at the 8- to 10-month follow-up period and at posttest, when compared to the pretest results. These findings, which appear contradictory, may again be related to the supervisees' lack of experience with reflective supervision and the lack of confidence that can accompany such inexperience. This group of supervisees may tend to rate themselves more harshly because they have not had sufficient time to engage in reflective supervision and assess their work over time. Supervisors, however, who have access to multiple supervisees and multiple reflective supervisory experiences to be used as comparisons, may be able to more objectively rate their supervisees' growth. There was one item in the supervisees' self-efficacy results that demonstrated a decrease 8 to 10 months after the conclusion of the training series: the supervisee's ability to "use observations and listening skills to assess the infant/toddler's developing capacities, strengths, risks, needs, diagnosis (if appropriate) to construct an intervention or treatment plan." It is possible that as supervisees had more practice engaging in this reflective practice skill, they became more aware of what they did not know regarding assessment and construction of an intervention or treatment plan, and therefore their sense of confidence in their ability to compete this task decreased.

It essential to acknowledge the study's limitations when the discussing the evaluation findings. First, the small sample size significantly inhibits the generalizability of the results. In addition, the evaluation is truly a pilot, and due to funding constrictions, replication of the evaluation was not possible. The collection of additional data via replication of the evaluation would have invariably provided more information about the impact of the training series on participants. Finally, and perhaps most indicative of the current state of research in the area of reflective supervision, the measures used in this evaluation were either piloted for this study or do not have published psychometric properties to verify their reliability and validity. Therefore, questions remain regarding the utility of the measures to capture the concepts that they were intended to assess: namely, reflective practice skills and self-efficacy regarding reflective supervision. For example, the findings concerning supervisees' reflective supervision self-efficacy may in fact be a reflection of the measure's lack of sensitivity to changes in self-efficacy. In addition, the lack of change between the pre- and posttest results of the supervisees' ratings of their supervisors' reflective supervisory skills also may be more a reflection of the measure's compromised sensitivity to subtle distinctions between each practice skill.

The study's limitations in terms of the tools used to evaluate change in IMH supervisee and supervisor reflective practice skills and sense of self-efficacy regarding reflective supervision set the foundation for directions for future research. The lack of empirically validated tools designed to measure reflective supervision and reflective practice skills as well as the impact of reflective supervision on outcomes for children and families pose a considerable challenge to all research in this area of IMH. Promising tools have been identified and there are efforts to begin to validate measures, such as in the case of the Reflective Supervision Self-Efficacy Scale for Supervisors and the Reflective Supervision Self-Efficacy Scale for Supervisees, both of which are being tested in multiple settings across the United States. It is important to note that these measures are designed to assess changes and growth in IMH clinicians and supervisors. To truly demonstrate the efficacy of reflective supervision and its centrality to the field of IMH, the creation and validation of tools that address the impact of reflective supervision and reflective practices on outcomes with infants and toddlers and their families is crucial. Future research should be dedicated to the design of measures that can best capture the elements of reflective supervision to be able to chart growth and change in professional use of the practice as well as to document the ways in which reflective supervision impacts practice and how that practice impacts families.

While this evaluation included a relatively small sample of supervisors and clinicians, the use of new measures designed to assess reflective supervision contributes to the growing effort to establish a research protocol to evaluate reflective supervision (Watkins, 2015; Watson et al., 2014). Specifically, the preliminary findings of the Reflective Supervision Self-Efficacy Scale for Supervisors and the Reflective Supervision Self-Efficacy Scale for Supervisees demonstrate that these measures may be effective tools for research and evaluation of reflective supervision. The self-report measures are easily administered, and the data suggest strong interreliability and validity. The measures are currently being used by various reflective supervision programs across the United States, and ongoing collection of data will serve to support further refinement of these measures. In addition, the Reflective Supervision Case

Vignettes for Supervisors and for Supervisees also constitute a new way to measure the application of reflective practice skills, and further use of these measures to learn about their use and efficacy is warranted.

In conclusion, the pilot of a community mental health professional development model for the building and expansion of reflective practice in IMH programs was successful, as evidenced by the participants' demonstration of mastery of reflective practice and reflective supervisory skills and knowledge, via the case vignette posttest. Furthermore, supervisees demonstrated an increase in their use of reflective practice skills, and supervisors demonstrated an increase in their sense of self-efficacy regarding the completion of reflective supervisory skills and tasks. Based on the findings, consideration of the potential to expand the training for supervisees beyond the four sessions would be important to insure that the benefits of the training series for this group are sustained.

These findings indicate that the community mental health professional development model for the building and expansion of reflective practice in IMH programs provides promising learning and skill-building opportunities for IMH supervisors and their supervisees. Preliminary findings suggest that this training series served to deepen supervisors' and supervisees' capacities to engage in reflective supervision while also supporting clinicians' reflective practice skills with families. Such professional development experiences can ultimately strengthen the abilities of IMH providers to meet the needs of infants and toddlers and their families.

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