What Does Reflective Supervision/Consultation Look Like in Practice:

Examining Variation in Implementation

APRIL 05, 2022

REFLECTIVE PRACTICE CENTER, CENTER FOR EARLY EDUCATION AND DEVELOPMENT, UMN

ALLIANCE FOR THE ADVANCEMENT OF INFANT MENTAL HEALTH

Center for Early Education and Development
University of Minnesota
Driven to Discover®

Alliance for the Advancement of Infant Mental Health

FUNDING FOR THIS PROJECT WAS GENEROUSLY PROVIDED BY

THE LYNNE AND ANDREW REDLEAF FOUNDATION

Introduction

This paper reports on the results of a national survey of recipients of reflective supervision and consultation (RSC) in infant/early childhood mental health fields. The goal of the study was to explore the ways in which RSC is implemented and how RSC recipients perceive the impact of RSC on themselves and their work. This paper explores characteristics of reflective supervision that have not yet been empirically researched, yet may prove critical to the effective practice of RSC.

Background

Reflective Supervision/Consultation (RSC) is a practice that has evolved out of the multidisciplinary field of infant mental health. It is being adopted as best practice for supporting the well-being and efficacy of professionals in many fields (e.g., home visiting, clinical work, early care and education) who work with young children and families facing stressors and challenges (Susman-Stillman et al., 2020). We use the term RSC to include both reflective supervision as provided by a supervisor within an organization and reflective consultation as provided by a consultant from outside the organization. RSC focuses on relationships as a context for regulation and learning, and specifically values the unique perspectives and needs of the child, parent, and professional. RSC is based on the premise that reflective capacity, or the ability to pause and consider one's own thoughts and feelings as well as those of others, can be increased through practice (Watson et al., 2014). Work with infants, young children, and families often carries great emotional and cognitive demands. RSC is designed to help professionals process their own emotions so that they can more effectively support those whom they serve (Weatherston et al., 2010).

When considering quality of supervision across social service helping professions generally, there is evidence that it can impact practitioners' skills, knowledge, and self-efficacy (e.g., Holloway, 2012; Inman & Ladany, 2008; Ladany & Inman, 2012), and is important in reducing turnover rates (e.g., Gibbs, 2001; Mor Barak, at el., 2001). The alliance between supervisor and supervisee, which is a key aspect of RSC, has been identified as crucial to effective supervision across professions (Ladany, 2007). When specifically considering infant mental health-informed RSC, there is a rich clinical and theoretical literature that supports its use, but quantitative and qualitative empirical research about RSC is still scarce. Several studies in recent years support the claim that RSC reduces professionals' self-reported job stress and improves their job-related mental and emotional wellbeing (e.g., Begic et al., 2019; Frosch, 2018; Susman-Stillman et al., 2020). A few studies suggest that it may also increase professionals' effectiveness in working with children and families by improving perspective taking and decision-making skills (e.g., Harrison, 2016; Virmani & Ontai, 2010).

Although this emerging research is essential for understanding the impact of RSC, very little attention has been paid in the literature thus far to variations in the format of RSC. The existing studies have only examined RSC within one agency or system, and thus there has been no opportunity to compare different methods of implementing RSC. RSC can vary in dosage by length of sessions, number of sessions per month, and the duration of time it is implemented. Also, RSC sometimes occurs in one-on-one settings and sometimes in groups with varying numbers of participants. RSC can be done in-person, or virtually over the telephone or via video call (which has become increasingly common, especially due to the current pandemic).

Understanding these variations is important for designing RSC as a professional development support that both meets the needs of professionals and is as cost-effective as possible for individuals and organizations. As a first step toward a deeper understanding of variations in RSC implementation, we conducted a landscape survey of RSC recipients across the nation to gather high-level information about their experiences with RSC. The goal of the study was to provide descriptive data about the parameters of RSC implementation and recipients' perceptions of RSC, which could provide a foundation for future studies to more closely consider the impacts of these variations.

Specifically, we sought to document

(1) variations in implementation and use of RSC across the nation, and

(2) RSC recipients' perceptions of the value of RSC for themselves and their work.

Method

Data in the present study were collected via the Reflective Supervision/Consultation Landscape Survey, a data collection effort between the Center for Early Education Development at the University of Minnesota and The Alliance for the Advancement of Infant Mental Health. The RSC Landscape Survey was designed to document use of reflective supervision and consultation in the United States. The online survey was distributed in three phases and used snowball sampling where each phase identified potential participants for the next phase. Data presented in this report are drawn from Phase 3. Phase 3 participants were identified via snowball sampling by Phase 2 participants as being recipients of RSC who worked in the field of Infant/Early Childhood Mental Health. Phase 3 participants completed a 22-item survey in July or August 2018.

Of the 163 RSC recipients for whom valid emails were provided in Phase 2, 67 responded to the survey (41% response rate). Participants were working in 22 states, with the most represented states being Minnesota (n = 8), California (n = 6), Michigan (n = 6), and New York (n = 5). Participants

reported having obtained degrees in a wide range of fields, including education, nursing, psychology, and social work. The majority of participants had obtained a master's degree (71%). The most common current fields were early intervention services (36%) and home visiting (30%). Participants had a range of experience in their current field, ranging from 1-5 to over 30 years. Twenty-seven participants (40%) had obtained an infant mental health endorsement or credential.

Table 1. *Participant Demographics*

	n	%
Geographic region		
Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI)	21	31
Northeast (CT, MA, ME, NH, NJ, NY, PA, RI, VT)	7	10
South (AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	20	30
West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)	19	28
Field		
Home visiting	20	30
Child welfare	4	6
Childcare	3	5
Early intervention, physical therapy, occupational therapy, or speech therapy	24	36
Education	2	3
Other (professional development and programming)	1	2
Highest education level		
High school diploma	1	1
Associate degree	0	0
Bachelor's degree	14	19
Master's degree	51	71
Doctorate	3	7
Years of work experience in their field		
1 to 5 years	12	18
6 to 10 years	16	24
11 to 15 years	6	9
16 to 20 years	15	22
21 to 25 years	5	8
26 to 30 years	2	3
Over 30 years	11	16

Findings

Table 3. *Implementation and receipt of RSC*

	M (SD) or *%*	
Received training in RSC	41.8%	
Receipt of RSC:		
All frontline workers	44.8%	
Some frontline workers	43.3%	
Administrators	28.4%	
Other staff	16.4%	
RSC format:		
Individual and group meetings	49.3%	
Group meetings only	40.3%	
Individual meetings only	10.4%	
Number of RSC providers	2.04 (1.15)	
Length of time with current RSC provider (years)	3.22 (3.23)	
	Individual	Group
Frequency of RSC:		
Weekly	25.6%	10.0%
Biweekly	23.1%	31.7%
Monthly	30.8%	51.7%
Less than monthly	20.5%	6.7%
Length of RSC:		
Less than one hour	10.3%	3.3%
One hour	53.8%	15.0%
One and a half hours	23.1%	41.7%
Two hours	12.8%	40.0%
RSC modality:		
In-person	69.2%	63.3%
Virtual	12.8%	21.7%
In-person and virtual	17.9%	15.0%

How is RSC Implemented?

A variety of reasons for beginning to receive RSC were identified by respondents. The most common reason for receiving RSC was that it was a job requirement (43.3%). For example, one survey respondent indicated that “RSC was discussed during the interview” and another indicated that the respondent’s “program has RSC built into the model.” Several respondents reported that RSC was supported at their place of work through grants, such as the “state of Alaska’s Early Childhood Mental Health grant” or “a grant from Project Launch.” Other common reasons for receiving RSC included it being optionally provided in the workplace (34.3%), sought out outside of work (11.9%), or provided through the respondent’s Infant and Early Childhood Mental Health group (6.0%).

Preparation for receipt of RSC varied among survey respondents (see Table 3). Training in RSC was provided to a minority of respondents prior to beginning RSC. Trainings varied in length and format, including “individualized orientation,” “small groups, and larger group activities,” and

"presentation." Those who had entered the field recently (0-10 years of experience) were not significantly more likely than those who had been in their field longer (11 to 30+ years of experience) to have received such training (39% vs. 45%, respectively; $t(66) = .463$, $p = .645$).

A variety of individuals received RSC at the workplaces of survey respondents (see Table 3). Most sites offered RSC to all or some of their frontline workers. Smaller percentages offered RSC to administrators or other staff members. The most common modality of RSC was a combination of individual and group meetings, followed by only group consultation and then only individual consultation.

Table 3 shows percentages of responses for questions about frequency, length and modality of RSC answered separately for individual and group supervision. For survey respondents receiving individual RSC, the most common frequency of meetings was once per month. Others reported receiving individual RSC on a weekly or biweekly basis. A minority of participants reported receiving RSC less frequently than monthly. Those schedules ranged from receiving RSC every six weeks to three times per year. The majority of professionals receiving individual RSC reported meetings one hour long, followed by 90 minutes. The majority received their individual RSC in-person, though some received virtual services alone or a combination of in-person and virtual services.

For those receiving RSC in a group format, the most common frequency of meetings was also once per month. Others received group RSC weekly, biweekly, or rarely, less than once per month. Group RSC tended to be longer than individual RSC, with most providers reporting receiving group RSC for 90 minutes or two hours. In-person RSC was again the most common format, followed by virtual only or a combination. When looking at experiences across both individual and group RSC, 46.4% of participants received at least some of their RSC in a virtual format.

When asked to reflect on their entire experience with RSC, most survey respondents reported having received RSC from only one provider (41.8%), though others reported receiving RSC from up to five different providers over their careers. Individuals tended to have received RSC from their providers for a significant amount of time.

How is RSC Experienced?

Overall, survey respondents indicated high levels of satisfaction with RSC (see Table 4). Participants most strongly indicated that RSC had done "a great deal" to reduce their feelings of being overwhelmed or helpless (see Table 4). Ratings for each of the questions did not significantly differ for respondents who received in-person versus virtual RSC, for those who received individual RSC more frequently than monthly vs. monthly or less, or for those who received group RSC more

frequently than monthly vs monthly or less. Participants were also asked, “Do you find RSC worth the time invested?”, to which all respondents (*n* = 24) gave an affirmative response.

Table 4. *Responses to rating scale questions about impact of RSC.*

	M Rating (SD)	*% Responded “5-A Great Deal”*
Reduce feelings of being overwhelmed or helpless	4.7 (.81)	66.7%
Help consider the perspectives of others	4.4 (.88)	51.9%
Positive impact of feelings of effectiveness at work	4.5 (.69)	59.3%

Note. Questions were rated on a 5-point scale from 1 (not at all) to 5 (a great deal).

Qualitative Responses

Twenty-four participants (35% of the sample) provided a written response to at least one of the open-ended questions. In our qualitative analysis of open-ended responses, the following themes emerged from the data: Personal Impact, Work Relationship Impact, Important Qualities of RSC, and Support Needed. These themes are detailed below with quotes from the participants.

Personal Impact

Participants identified that an important impact of RSC was its impact on holding and processing the negative emotions that are present in the work. They found that having time to take a step back, reflect on the feelings, “share the pain”, and explore how emotions were affecting their work provided relief from big emotions. One person stated, “I find myself really valuing reflective supervision to process all the trauma, triggers, and other challenging aspects of the job.” Participants also specifically linked that processing of emotions to reduced job stress and burnout, and increased job satisfaction, saying it “helps keep you protected,” and “allows me to regulate myself so I can continue to work in often dysregulating environments”. One person specifically noted that, “Without it I would have to find easier work.” In addition to reducing negative feelings, participants reported that RSC promoted positive emotions such as clarity on how they were helping families, “affirmation of my value”, and “rejuvenation of energy”.

Many participants also said that RSC made them more effective in their work. They said that having conversations with their supervisor/consultant or group about complex cases provided new outside perspectives that were critical in reaching a more nuanced understanding of the situation and coming up with new and creative ways to move forward. For example, “It's helpful to have another ‘set of ears’ to help think through issues in client care. Sometimes, because I am so close to the issues, I have trouble taking a step back to see the bigger picture.” A few participants mentioned that they experienced the parallel process - being held by a supervisor or group and “feeling the great sense of being cared for and truly seen” made them better able to support their client families. Some participants even noted that the impact of RSC went beyond their work life into other relationships, such as “I am calmer at work and at home”.

Impact on Work Relationships

The second theme in the data was that participating in RSC affected how participants were in relationships with others at work, both clients and co-workers. Participants stated that RSC had taught them to be more empathetic, patient, and understanding, making comments such as “It creates space to honor another's perspective, and how that perspective can add to looking at a situation,” and “Slowing down to reflect makes us all stronger and more sensitive to the experience of others.”

When participants discussed how RSC affected their relationships with clients, they noted they were better able to withhold judgement, have more empathy, and be more reflective rather than reactive in their interactions. They also characterized their approach as more collaborative and less directive, and that RSC made more space to consider the child’s perspective. Specific examples of how this approach changed approach their work with families included, “I struggle to bring up difficult conversations so having practice and reframing before having a difficult conversation has made me more likely to have difficult conversations,” and “I recently kept a family open longer versus encouraging closing due to the supervisor helping me to see the family's perspective.”

Participants also wrote that RSC was helpful for their relationships with co-workers. They mentioned benefits such as increased communication and respect. They were more able to understand perspectives that were different from their own. One person wrote, “Being able to witness and hold space for my colleagues to express themselves and work through personal challenges they encounter while doing this work has helped to build relationship, trust, and a greater ability to expand my world view.”

Important Qualities of RC

In discussing the impact of RSC, participants also made comments about why they felt RSC was useful or effective. Some identified general characteristics, such as that RSC was most useful when "done with commitment," and reasons it was effective included "being able to…process issues earlier [rather] than having them grow unnoticed" and "richer and more focused discussions".

Many discussed that their relationship with their supervisor was key, identifying qualities such as respect, trust, and honoring feelings. Participants gave examples of why this relationship was important such as, "[My reflective supervisor/consultant] is someone I admire and a transformational leader who is able to challenge my blind spots while also maintaining safety so that I can continue to feel safe to bring in my weaknesses to RSC," and "My [reflective supervisor/consultant] expressed faith in me when I didn't have it myself which helped me to find it in myself as well."

Participants also made comments about why they valued group supervision, because such a setting provided richness in both diversity of ideas, e.g. "It's so beneficial to meet with [others] that experience similar things in their roles and to be able to talk those things through", as well as in a feeling of support, e.g. "Having others hold the story for me and walk with me has greatly helped. Sometimes it's the validation of the hard situation, sometimes it is the reflection back of what I am doing, sometimes it is the shift in looking at the situation in a different light." Participants noted that having colleagues participate with them added to the benefits of the experience.

Support Needed

Finally, participants also made comments about areas where support was still needed in their workplace. A few participants noted that they have had experiences with RSC where it was poorly executed or they weren't able to speak freely in their group. A more common theme was that while RSC is helpful, it can be limited if the larger work context does not align with the approach, and RSC is not a panacea for all workplace issues. For some, administrative details were taking priority over reflection, or the demands of the job, nature of the work, or organizational culture diluted the impact of RSC. One person noted that "some recognition, including monetary, of the worth of this work" was missing. Also, participants wrote that it can be difficult to apply reflective skills in settings and systems that do not take this approach, such as places where "I am often reteaching other systems - daycare, schools, social services - on appropriate practices for positive mental health" or "in some settings… people expect 'answers' immediately and do not want to sit with something".

Conclusion

This study gave an overview of how RSC is implemented and illustrated how infant/early childhood mental health professionals participate in RSC. This study explored a number of variables regarding RSC that show considerable variation in its implementation, including individual vs. group, online vs. in-person, dosage (frequency, session duration, and length of relationships), and how it is accessed. It also examined how RSC participants experience the practice. Participants consistently rated RSC very highly, and all respondents to the question about whether RSC is worth the time invested answered positively, which is telling given the high caseloads and amount of paperwork required for many IECMH fields (Alitz et al., 2018).

The findings of the study provide information about current gaps in the field and future research that would be useful to move the field forward. Because so little is known about how to make RSC most effective and cost-efficient, each of these variables represents a line of research that could be greatly informative to the field. Overall, participants found RSC highly valuable, which, combined with the rapidly growing use of RSC in early childhood disciplines, underscores the importance of gathering data so that administrators can make informed decisions about how to provide their front-line workers with the best support possible.

This study had several important limitations. While the snowball sampling technique was useful in gaining a national sample from a wide range of fields, there is much that is unknown about how our small sample compares to the entire population who receives RSC, and thus generalizability is limited. Furthermore, many participants did not provide responses to the open-ended questions, so the themes discussed may not be widely generalizable. Also, this study was based entirely on a self-report method. Although participants' expressed investment in RSC is certainly meaningful, it will be increasingly important to gather data on these outcomes in more objective ways than self-report surveys.

Implications

- The findings around who participates in RSC, required vs. optional participation, and training point to important work to be done on both creating buy-in around RSC and decision-making about required vs. optional participation. It also brings up important access issues, as RSC done outside of work may require payment out of pocket and requires access to reflective consultants. As a field, it will be important to ensure equitable access to all who would like to participate in RSC to support a healthy workforce.

- When looking at dosage and frequency in this survey, many people are receiving a sufficient amount of RSC to meet the best practice recommendation of at least 12 hours per year (AAIMH, 2018). However, there was also substantial variation in these parameters, and a multitude of ways in which these variables combined for individuals' experiences. It will be important to gather data on how these variables relate to benefits derived from the practice.
- The most common format to receive RSC is through a combination of individual and group RSC, with 90% of respondents received some group supervision. The majority of existing literature has focused on the alliance between supervisor and supervisee in one-on-one RSC (O'Rourke, 2011; Watson et al., 2016a), yet there is clearly much to be learned about how group dynamics can impact the process during group RSC.
- In this study, which collected data prior to the COVID-19 pandemic, just under half of respondents reported having at least some of their RSC take place online. While this is a useful pre-pandemic baseline measure, it is expected that this percentage greatly increased during the pandemic. It will be important for researchers to further empirically explore whether there are aspects of forming RSC relationships that may be easier or harder to achieve online, and how the online experience may impact the efficacy of RSC.
- Overall, the written responses indicated that participants are aware of the large emotional demands their work entails and find it essential to have relational support in order to sustain high-quality work in infant/early childhood professions.
- Participants noted that if the practice wasn't supported throughout the daily operations of the agency or if they were frequently working with others who did not take a reflective stance, then it was harder to derive benefits from the practice. It has been noted that reflective supervision cannot alone is not a panacea for the intense labor requirements of the infant/early childhood workforce (Simpson et al., 2018), and this is an important lesson that any practice to promote well-being cannot solve larger issues around compensation and workload.

References

Alitz, P.J., Geary, S., Birriel, P.C., Sayi, T., Ramakrishnan, R., Balogun, O…& Marshall, J. T. (2018). Work-Related Stressors Among Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visitors: A Qualitative Study. *Maternal Child Health Journal, 22***,** 62–69.

AAIMH - Alliance for the Advancement of Infant Mental Health. (2018). Best practice guidelines for reflective supervision/consultation. Retrieved from https://static1.squarespace.com/static/5884ec2a03596e667b2ec631/t/5d24ccf5deb9b400018b0998/1562692856382/Alliance_BPGRSC_FINAL_20190606.pdf

AAIMH - Alliance for the Advancement of Infant Mental Health. (2020). Guidelines for beginning and maintaining a reflective supervision/consultation relationship via distance technology. Retrieved from https://static1.squarespace.com/static/5884ec2a03596e667b2ec631/t/5ec58399b2ae022884fd28ae/1590002588308/Alliance_Virtual_RSC_2020_FINAL.pdf

Atkinson, R., & Flint, J. (2001). Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social research update*, *33*(1), 1-4.

Begic, S., Weaver, J., & McDonald, T. W. (2019). Risk and protective factors for secondary traumatic stress and burnout among home visitors. *Journal of Human Behavior in the Social Environment, 29*(1). doi: https://doi.org/10.1080/10911359.2018.1496051

Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically suppoted treatment: a randomized trial. *Psychiatric Services, 63*(7), 660-665.

Fenichel, E. (Ed.). (1992). Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook. Washington, DC: ZERO TO THREE.

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

Frosch, C. A., Mitchell, Y. T., Hardgraves, L., & Funk, S. (2019). Stress and coping among early childhood intervention professionals receiving reflective supervision: A qualitative analysis. *Infant Mental Health Journal, 40*(4), 443-458.

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

Gibbs, J. A. (2001). Maintaining front-line workers in child protection: A case for refocusing supervision. Child Abuse Review, 10(5), 323-335. doi:10.1002/car.707

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

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

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

Holloway, E.L. (2012). Professional competence in supervision. In J.N. Fuertes, A. Spokane, E.L. Holloway (Eds.), Specialty competencies in counseling psychology (pp. 165–181). New York: Oxford University Press.

Inman, A. G., & Ladany, N. (2008). Research: The state of the field. In A. K. Hess, K. D. Hess, & T. H. Hess (Eds.), Psychotherapy supervision: Theory, research, and practice (2nd ed.) (pp. 500 – 517). Hoboken, NJ: Wiley.

Ladany, N. (2007). Does psychotherapy training matter? Maybe not. Psychotherapy: Theory, Research, Practice, Training, 44, 392-396.

Ladany, N., & Inman, A. (2012). Training and supervision. The Oxford Handbook of Counseling Psychology, 10. doi:093/oxfordhb/9780195342314.013.0007.

Mor Barak, M., Nissly, J., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. Social Service Review, 75(4), 625-661. doi:10.1086/323166

O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. Infant Mental Health Journal, 32(2), 165-173.

Shea, S. E., Goldberg, S., & Weatherston, D. J. (2016). A community mental health professional development model for the expansion of reflective practice and supervision: Evaluation of a pilot training series for infant mental health professionals. Infant Mental Health Journal, 37(6), 653-669.

Simpson, T. E., Robinson, J. L,, & Brown, E. (2018). Is reflective supervision enough? An exploration of workforce perspectives. *Infant Mental Health Journal, 39*(4), 478-488.

Susman-Stillman, A., Lim, S., Meuwissen, A., & Watson, C. (2020). Reflective supervision/consultation and early childhood professionals' well-being: A qualitative analysis of supervisors' perspectives. *Early Education and Development, 31*(7), 1151-1168.

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.

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

Watson, C. L., Bailey, A. E., & Storm, K. J. (2016a). Building capacity in reflective practice: A tiered model of statewide supports for local home-visiting programs*. Infant Mental Health Journal, 37*(6), 640-652.

Watson, C., Gatti, S. N., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. In E. Nwokah & J. A. Sutterby (Eds.), *Early childhood and special education: Advances in early education and daycare* (Vol. 18, pp. 1–26). Bingley, UK: Emerald Group.

Watson, C. L., Harrison, M. E., Hennes, J. E., & Harris, M. M. (2016b). Revealing “The space between”: Creating an observation scale to understand infant mental health reflective supervision. *Zero to Three, 37*(2), 14-21.

Weatherston, D. J., Weigand, R., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *Zero to Three, 32*(2), 22-30.