Reflective Supervision Groups: Concepts and Live Demonstration

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Our goals for this workshop are to demonstrate how principles of reflective supervision can be utilized in group supervision. I hope that at the end of the presentation, if you are a manager or a supervisor, you'll be interested to consider starting reflective supervision groups in your agency; and if you are a frontline worker, I hope you'll want to ask your administrators to set up groups.

Reflective supervision should first be distinguished from administrative supervision, where supervisor and worker review whether formal aspects of work, such as caseload and paperwork expectations, are being accomplished.

By contrast, reflective supervision focuses in depth on a particular case. The word "reflection" is given such prominence in this type of supervision because the goals are to think carefully about an infant/child and her family, to develop an appreciation for the perspectives of the family members, and to identify and consider alternative approaches to intervention. Reflection implies "stepping back" and "slowing down," considering the issues of the family in some detail, *before* proposing solutions.

One common approach to clinical supervision that is different from reflective supervision emphasizes traditional teaching. The worker presents the process of the meetings with the family, and the supervisor interprets the meanings of the material, and then suggests how to approach the next meeting. The potential limitations of this teaching model for adult learners are that it is one-sided rather than collaborative, and that it may not offer room for the worker's personal reactions to and reflections on the work.

Reflective supervision does involve a fair amount of teaching, but it gives specific attention to developing a secure and trusting relationship between supervisor and supervisee as the scaffold for the supervisee's learning. Certain behaviors by the supervisor support reflective learning by the supervisee. These include: maintaining a curious and open attitude, listening carefully and attentively, taking time to reflect on one's thoughts and feelings about the material, remaining non-judgmental towards the supervisee while being ready to express concern about difficulties in the work, and attempting to attend to the parallel processes in the experiences of the infant, the parent, the worker and oneself.[1] As the supervisory relationship develops,

• the supervisor tries to convey that working with infants and parents requires us to observe details and patterns in the functioning of the family and its individual members before intervening, in Sally Provence's well-known admonition: "Don't just do something. Stand there and pay attention!".

• He or she tries to help the worker develop empathy for the situation of the family, to see the world from their perspectives.

• He or she encourages the worker to reflect on her reactions to her clients. Since reflective supervision puts emphasis on understanding one's own reactions as a potential pathway for doing more effective work with clients, I want to mention some of the possible areas these discussions might cover:

1) We can share frustrations and negative feelings about clients— for example, when no progress seems to be occurring, or when clients respond to their kids in very negative ways.

2) We can discuss boundary issues—these are especially likely to come up with clients with many needs, and we have understandable impulses to move beyond a professional role.

3) We can discuss what Mary Claire Heffron has called reflexive reactions (in contrast to reflective responses) that may actually interfere with our ability to be helpful. A good example of a reflexive reaction is the need to do something immediately, to be a "quick-fixer," a feeling that may be stimulated by the client's sense of crisis (Heffron's article is one of your handouts.)[2]

4) We can think about issues of identification with clients, for example, when a client's history or situation is similar to our own experiences, in which case there's a risk of projecting our own assumptions on to the client, rather than seeing him or her objectively.

5) We can use reflection in supervision to develop realistic expectations about our clients, to distinguish between what we wish we might accomplish and what can be accomplished.

Translation to Group Supervision

These practices and values of reflective supervision can be translated to group supervision. I'm going to discuss how to make this translation work. Let me start very concretely by describing the groups I have been leading under the auspices of MiAIMH. Groups have 8-10 members who are early childhood

workers or infant mental health practitioners. They meet monthly for 2 1/2 hours. Here is how we've structured that time.
I. "Burning Issues" (15-20 minutes). Group members bring up questions about a current case, referral questions, diagnostic questions, etc. that can be dealt with briefly. The group and leader respond.
II. Follow Up on Presentations from Previous Meeting (15-20 minutes). Presenters briefly review salient questions and issues in their last case presentation and report on developments/progress since last meeting.
III. Case Presentation 1 (45-50 minutes).
(Break 10-15 minutes)
IV. Case Presentation 2 (45-50 minutes)

The Gift of Time

You'll note that we allot considerable time to each presentation. This gift of time is important. This is in contrast to practice in many agencies where individual supervision and staff meetings to review cases are harried and hurried. Cases must be reviewed (covered), and there often is not time to slow down and reflect. In our group initially some participants worried about how to fill that much time, but in fact we've learned that time and reflection go together—when there is sufficient time to reflect, deeper understanding of families becomes possible.

Another aspect of time that needs to be mentioned: the time for the regular meetings needs to be respected and protected by group members' supervisors/managers. Lack of buy-in by administrators may result in a failure to protect the time, as when workers are told they must give priority to other work responsibilities and thus can't attend the meetings.

Confidentiality

For the group to become a secure environment for reflection that is focused on the work but also may at times encompass self-reflection, members agree at the outset that group discussions—including both information about clients and personal information about group members will be held confidential. (A copy of the confidentiality agreement we developed is in your handouts.)

Presentation format

Preparation for presentations is important. Presenters are expected to provide a write up—usually about 2 pages--to distribute to the group. The write up should cover what the presenter thinks is important, which usually will include: the presenting issues, description and observations of the child and family, the family's strengths and difficulties, the process of evaluation/intervention so far, and, in many cases, the feelings working with the family evokes in the worker. Videotape clips, if available, are also encouraged. Finally, it's essential for the presenter frame some questions she would like the group to respond to.

So we set a high standard for preparation, and but it's common for presenters to find this preparation very valuable. One person said recently, "Writing up this family and my questions about them actually helped me figure out some ideas about how to change my interventions before I even presented. And presenting today, and hearing your ideas, has taken things another step—I really understand this mom and baby better than I did on the last home visit when I felt so uncertain about how to proceed."

Issues in the establishment of reflection in groups.

The transition to reflection takes time and effort. Group members bring their previous experiences of supervision and team meetings to the reflective group, in the same sense that we carry over working models of attachment to new relationships. For example, a group member who has participated in team meetings where the emphasis seems to be "Let's solve this problem quickly and move on because we've got a lot to cover," may not take time to reflect but instead quickly offers her best guesses about what the best intervention would be. At times questions, quick solutions, recommendations for plans of action, and even segues into mini-presentations of group members' own cases may interrupt the presentation. Such interruptions are likely to be disorganizing for the presenter. She has to interrupt her train of thought, may feel challenged, may feel she's not being listened to, may find herself losing the floor to other members. This kind of group culture is destructive to the reflective process. The presentation belongs to the presenter, and she needs to be able to present it in the way she intends. Leaders need to orient the group at the beginning to how the process should go, and also need to be ready to step in and say, for example, "Those are good questions, but right now Andrea needs a chance to tell us what she thinks is important about this case, so let's defer those until she's done presenting." The leader needs to be aware of the " group contagion factor:" when one person jumps in prematurely with solutions, other members of the group are encouraged to do the same. At times it may be appropriate to reflect on a group meeting where jumping the

gun seems to have occurred. Often the difficulty and painfulness of the clinical material will have made group members anxious, generating premature attempts to come up with a solution to a case that is quite difficult.

At the same time, part of establishing a supportive group climate involves honoring the contributions of each member. How does a leader "socialize" group members towards embracing the reflective model? At the outset, a discussion of reflective listening is helpful. Group members are encouraged to listen for the following: 1) the worker's perspective and feelings; 2) the perspectives of the family members; 3) The fluency and coherence of the story the presenter is giving; 4) Their own reactions of dissonance or uncertainty. An explicit format for group sessions is also very helpful. In this group, we set up the following format:

1) The presenter frames her questions and presents the case.
2) The leader responds first, with a brief dialogue with the presenter that involves clarifying questions and initial impressions and hypotheses.
3) A general discussion follows, with emphasis on the group's addressing the presenter's questions.

Potentials in the group process when it's going well.

1) A chance experience support and to refuel.

Infant mental health work is often intense and the risks of despair, vicarious traumatization, and burnout are heightened when the worker tries to support clients facing very difficult issues while lacking professional support herself. Regular group supervision meetings offer a chance to share feelings about the work, to commiserate, to realize that one is not alone, to experience the empathy of others who are doing the same work. A presenter's feelings about a difficult case, for example, are normalized when group members acknowledge the difficulties. A group member described this as follows: "Your comments have made me feel calmer—my blood pressure is about 40 points lower than when I began this presentation." This worker's comment is a good example of Heffron's statement that "This sense of being heard and felt assists the supervisee in regulating her…feelings and sets the stage for the next steps" [in intervention].[3] (125)

2) A chance to understand Parallel Process.

In infant mental health work a major goal is to strengthen the parent-infant relationship by helping the parent see the world from the baby's perspective. This requires the worker to see things from the perspective of the baby's development. But to be able to speak for the baby effectively, the worker needs to have the ear and interest of the parent.This implies that the worker has to understand the parent's points of view and circumstances, and to be able to express empathy for the parent while speaking for the baby. In supervision, the supervisor has to understand and integrate the worlds seen through the infant's and the parent's eyes, but needs to add another level of understanding—an empathic view of the worker's experience of the family, and, very often, of the worker's affective experience and experience of self while working with the family. At each level, empathy is used to learn about another's experience, and at each level the perspectives of an increasing number of people have to be contained in one's overall understanding. In group supervision we hope that group members will be able—if not always individually, then collectively—to attend empathically to the baby's experience, the parent's experience, and the worker's experience.

3) A chance to reframe—to see a family's and one's own perspective in new ways.

Often a presenter's questions focus on aspects of the case where her understanding is incomplete, where she has the sense that something is missing or unclear. The group's attention to these elements often leads to a reframing of the worker's understanding.

A new worker talked about her sense that a mother was mistrustful of her. Even though she welcomed her cordially when she came for visits, asking her to sit down, asking how she was doing, offering her coffee, when the worker began talking about how the baby was doing, the mother would say everything is fine, and did not ask questions or raise concerns. The worker said, "I'm almost hesitant to make any observations myself, because even when I've pointed out that her baby is smiling when he hears her voice, she seems not to take it in…I mean she says, yes, but in a mechanical way. So I'm having trouble connecting with her even when I talk about the strengths in their relationship." This worker, by expressing her puzzlement, was alerting the group to the fact that something was missing from her story. The group leader said, "I wonder how she sees you, who you are to her." After talking a bit, in a speculative way, about possible transference, the worker said, "She acts like she needs to be on her best behavior around me." A group member said, "Like you're checking up on her or judging her as a parent?" At this point the worker recalled the first visit when the mother had mentioned that her older daughter had been removed by

PS for several months while she was drug addicted several years before. She said, "Oh, do you think I'm like a PS worker to her? But I doubt that. She went through rehab and has been clean for several years. And I made clear that first visit that our program's aim is to help parents understand their infants. I explicitly said I our agency was not connected with DHS." She went on to say that although this mother had some difficulties being consistent emotionally with her baby, "She's not the kind of parent that I would consider reporting to PS—that has not occurred to me." A group member said, "Yes, but maybe she thinks you're considering it, and that's why she's being both nice and shy of engaging with you." The worker and the group then discussed the possibility of raising these issues directly with the mother.

One of the most valuable aspects of supervision is that we are helped to move beyond the constraints of our own singular point of view. We've all had the experience in supervision of thinking "why didn't I see that—it's so obvious." But we're all limited to one degree or another by the way we have formulated a problem or idea. It's not that we're unable to look at a situation from multiple points of view, just from the perspective of living in our own skin that it's easy to believe our point of view makes the most sense. In this case, it was very valuable for the worker to turn the prism around, so that the worker could imagine how the mother might think she was being observed—as a potentially neglectful parent. Prior to this she had hoped to engage the mother through conveying her positive regard for her. But if the mother could not experience that regard as genuine, because of her fear of being judged a bad parent, then she would not be likely to engage.

4) A chance to develop a sense of what is possible and not possible. Sometimes, in particularly difficult cases, for example when a parent has a severe mental health issue, infant mental health workers (especially newer ones) experience a sense of hopelessness or incompetence because they are unable to see how to meet idealized goals. Or, they may formulate goals that are overly optimistic given a client's situation and problems. In presenting cases like this, a frequent outcome is that the presenter, with the group's help, develops more realistic goals. Jeree Pawl notes that a group often serves as a voice of realism, helping workers "rebalance" the goals they wish for in the light of what is achievable.[4]

5) **A chance to increase the abilities of group members to provide supervision.** In a group, especially one that is culturally and professionally diverse, ways of thinking and asking questions are modeled, and the range of individual and discipline-based perspectives helps broaden the group members' ways of conceptualizing infant work. This will enhance the group members' supervisory abilities, either in the present, or when they eventually begin to supervise.

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[1] Weatherston, D. (2007). "Supporting Growth Through Reflective Supervision," Northwest Michigan Human Services Agency, Traverse City, MI, March 28, 2007.

[2] Heffron, M.C. (2005). Reflective supervision in infant, toddler and preschool work. In K. Finello, Ed. *The Handbook of Training and Practice in Infant and Preschool Mental Health*. (pp . 114-136). Jossey-Bass: San Francisco.

[3] Heffron, M.C. (1999). Balance in Jeopardy: Reflexive reactions vs. Reflective Responses in Infant/Family Practice. *Zero to Three 20*, 15-17.

[4] Pawl, J. (2004). Consultation to the EHS consultants. *Zero to Three 24,* 33-38.